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The Other Mother: A Narrative Analysis of the Postpartum Experiences of Nonbirth Lesbian Mothers

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The United States Census (2012) reported that 49 percent of lesbian couples are raising children. Homosexuality has become more accepted in mainstream society. Lesbians and gay men currently have more social and legal rights and protections than at any other time in history. These rights are largely dependent upon the geographical location in which one resides. Although the incidence of lesbian motherhood has increased, the partners of biological mothers are not automatically recognized as parents. Same-sex couples can jointly petition to adopt their partner's biological children in only 16 American states (including the District of Columbia). Throughout most of the United States, nonbirth lesbian mothers have no legal rights to their children.

The purpose of this study was to develop a metastory of nonbiological lesbian mothers' postpartum experiences. This author employed narrative analysis utilizing Riessman's (1993;2008) structural approach to thematic analysis to understand the postpartum experiences of nonbirth lesbian mothers. Ten nonbirth lesbian mothers were interviewed. Each mother shared a unique story of her first year of motherhood. Themes were individually analyzed within each story. The meta-story of the postpartum experiences of non-birth lesbian mothers revealed six overarching themes including: At the mercy of health care providers, Nursing is the major difference between us, Defined by who I am not, Trying to protect my family: The world can take them away, What's in a name?, and Epilogue: The new normal. Stories remained intact within the portrayal of the metastory illustrating the postpartum experiences of nonbirth lesbian mothers.

This study adds valuable insight to clincial practice. The perspective of the nonbirth lesbian mother is virtually absent in the literature. Nonbirth lesbian mothers have significant health disparities. Health care providers can be instrumental in providing more sensitive care to lesbian mothers and their families. Recommendations are made for clincial practice, education, leadership and research. Nursing has been silent on lesbian, gay, bisexual and transgender (LGBT) health issues. This study compels nurses to take a stand on public issues related to the LGBT community.

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The Other Mother:

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DEDICATION

I dedicate this dissertation to my wife, Jill, and my daughter, Molly. I could not have done this without you. This is your accomplishment as much as it is mine. Your love and support have made all the difference. Thank you for giving me the life I always wanted… You are my *dream come true*!

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Chapter One: Introduction

Chapter one introduces the research study, The Other Mother: A Narrative Analysis of Nonbirth Lesbian Mothers Postpartum Experiences. Significant statistical and legal information regarding lesbian mothers is presented in the background section. The significance of this study is discussed by placing this study within the framework of recommendations from prestigious health organizations. The chapter ends with the purpose of the study and an introduction to the dissertation chapters.

Background

As homosexuality has become more accepted in mainstream society, many gay and lesbian couples are choosing to create families. In the 2000 United States (US) Census, 33% of female same-sex couple households and 22% of male same-sex couple households reported at least one child under the age of 18 living in their homes. The 2010 US census reported that one fourth of gay couples in America are raising children. Sixteen percent of gay male couples and 49 percent of lesbian couples are raising children. UCLA's Williams Institute (2012) concluded that in America, 1 million gay parents are raising approximately 2 million children (http://williamsinstitute.law.ucla.edu/wp-content/uploads/Gates-CouplesRaceEthnicity-April-2012.pdf). Lambda Legal (2012), a national legal organization whose mission is to promote the civil rights of gays and lesbians, reports that there are approximately 250,000 children being raised by gays and lesbians in America (http://www.lambdalegal.org/issues/adoption-and-parenting).

Although the incidence of lesbian motherhood has increased, the partners of biological lesbian mothers have meager legal rights. Throughout most of the United States, health care providers (HCPs) have no legal obligation to acknowledge nonbiological lesbian mothers as equal parents. Same-sex couples can jointly petition to adopt their partner's biological children in only 16 states. These states include: Arkansas, California, Colorado, Connecticut, District of Columbia, Illinois, Indiana, Iowa, Maine, Massachusetts, Nevada, New Hampshire, New Jersey, New York, Oregon, Vermont and Washington. A second-parent adoption allows nonbirth lesbian mothers to adopt their children without the birth mother losing any parental rights. As a result of this adoption both mothers are recognized as legal parents. Second parent adoption grants adoptive parents the same rights as biological parents in custody and visitation matters (Human Rights Campaign, 2012). Throughout most of the United States, nonbiological lesbian mothers have no legal rights to their partners or children. Without the right to a second parent adoption, these parents have no legal rights to their children. They are legally unable to make any decisions for their children. Even when these parents have cared for their children for their entire lives, they have no legal rights. In the worst case scenario, a court of law will disregard a second parent equating them to a legal stranger to the child. This ultimately gives the first parent the conclusive right to make all future decisions and to dictate the future relationship with the second parent. (Lambda Legal, 2012).

Gay and lesbian couples remain vulnerable to the mercy of the judicial system. The 2007 Utah case, *Jones vs. Barlow* illustrates the vulnerability of nonbiological lesbian mothers. Cheryl Barlow and Keri Jones planned for, conceived, delivered and parented their daughter together. After the lesbian couple separated, Barlow barred Jones

from seeing their daughter. Jones subsequently sued for custody. In February of 2007, the Utah Supreme Court declared that parental rights are restricted to biological parents in situations of unmarried parents raising children related biologically to only one partner (http://www.utcourts.gov/opinions/supopin/Jones5021607.pdf).

In Iowa, same sex couples were granted marriage equality in 2009. Under state law, any children born to legally married couples are assumed to be the legitimate children of both spouses. Both spouses are subsequently listed on their child's birth certificate as legal parents. When Melissa Gartner gave birth to a daughter, she and her partner, Heather Martin Gartner, assumed that they would be both listed as legal parents on their daughter's birth certificate. When they received a birth certificate listing only Gartner's name, they requested a revised document listing both mothers as legal parents. This request was denied. The couple subsequently sued the Iowa Supreme Court in 2010 as a result of the state's refusal to recognize both women as parents. After a long legal battle, the state was ultimately ordered to issue a birth certificate recognizing both mothers in 2012 (Lambda Legal, 2012).

In another Iowan case, Jenny Buntemeyer and Jessica Aiken, parents of Brayden Bruce Buntemeyer, were denied recognition as parents on their son's death certificate. The delivery was a fetal demise at 30 weeks gestation. This is another contradiction to Iowa law since the couple is legally married in their home state. The assumption that married parents are to be recognized as legal parents under state law was not applied to this particular family. Although Buntemeyer and Aiken documented themselves as their son's parents on the death certificate forms, Aiken was solely named as the parent on the death certificate. Buntemeyer and Aiken are currently in litigation with the Iowa

Department of Public Health. As of October 2012, the state has refused to issue a new death certificate recognizing both women as parents.

(Lambda Legal, 2012).

Oren Adar and Mickey Smith, a New York couple, legally adopted a Louisiana born baby boy in 2006. Although New York state allows unmarried couples to adopt, Louisiana does not. The state registrar of Louisiana subsequently refused to issue a birth certificate naming both men as parents. In October of 2007, Lambda legal filed suit against the state of Louisiana on behalf of the couple claiming that the refusal to recognize the New York adoption violated the US constitution. In December of 2008, judgment was granted in favor of Adar and Smith; however, a lengthy legal battle including appeals ensued. The plaintiff ultimately advocated for the US Supreme Court to review the case. The Supreme Court ultimately denied this appeal in October of 2012 (Lambda Legal, 2012).

Although the previously mentioned case, Adar and Smith, involved a gay male couple, there are important similarities to the challenges faced by nonbirth lesbian mothers. Adar and Smith were both nonbirth parents. They were denied the right to both be recognized as legal parents of their son. Similarly nonbirth lesbian mothers are commonly denied legal recognition as their children's parents. Lesbian and gay nonbirth parents are vulnerable to being denied parental rights to their children.

Although lesbians and gay men continue to win civil rights such as the right to second parent adoptions and marriage equality, civil inequities remain throughout the majority of the US. Several cases were presented which confirmed the discrimination

experienced by nonbirth lesbian parents. These parents commonly have no rights to their children. They remain at the mercy of the laws of the particular sate in which they live.

Significance

Two prestigious health organizations, the Institute of Medicine (IOM) and the Joint Commission (TJC), have recently issued significant documents regarding the health of gay and lesbian families. The following sections will detail the aforementioned IOM and TJC publications. These groundbreaking documents support the significance of this author's study.

The IOM is a paramount organization that evaluates health research. It serves as an unbiased authority to health care leaders as well as the public. This organization represents the health contingency of the National Academy of Sciences. The IOM poses questions and offers recommendations regarding the nation's most critical health concerns.

The IOM (1999) published the report, *Lesbian Health: Current Assessment and Directions for the Future*. The Committee on Lesbian Health was summoned to evaluate the state of the science regarding lesbian health, determine methodological challenges related to lesbian health research and propose further research. This initiative was funded by the Center for Disease Control (CDC) and the National Institute of Health (NIH) Office of Research on Women's Health. The report concluded that additional data are necessary to determine the health risks for lesbians. The IOM determined that lack of funding is a barrier to conducting lesbian health research and, consequently empirical studies resulting in publications are limited. The report suggested priorities for research that included: the physical and mental health status of lesbians, diversity within the

lesbian community and the identification of barriers to lesbians accessing health care. The committee on lesbian heath made recommendations to strengthen the knowledge base on lesbian health. The IOM report on lesbian health called for public and private funding to support lesbian health research. Researchers were urged to routinely include questions regarding sexual orientation in all data collection and to encourage diverse samples from a range of racial, ethnic and socioeconomic groups. It was also recommended that lesbian health research be widely presented and published and that government, academic and health care agencies should disseminate research on lesbian health.

Although lesbians and gays have gained many social and political rights in the past 12 years since the publication of the 1999 IOM report on lesbian health, many of the challenges in lesbian health remain the same (IOM, 2011). Laws and public policies have given the LGBT community more civil rights. Although these individuals are more visible and more accepted in society, they still experience fewer rights, protections and benefits than their heterosexual peers. Laws vary from state to state. It is important to note that the freedom of LGBT individuals is often dictated by the particular state in which they reside. Although there have been significant advances for LGBT people, many of the same issues addressed in the 1999 IOM report remain significant health issues for lesbians today.

The IOM (2011) report, *The Health of Lesbian, Gay, Bisexual and Transgender (LGBT) People: Building a Foundation for a Better Understanding,* was employed by the National Institute of Health (NIH). This initiative presented a broader focus than the 1999 study. Lesbian health was considered within the context of the entire LGBT community.

An interdisciplinary committee sought to determine the state of the science on LGBT research, to gauge the health status of the LGBT population, to identify research gaps and opportunities and to present an agenda to guide the NIH to recommend research in this area (Institute of Medicine, 2011). This report was guided by a developmental life-course framework, the minority stress model and the ecology sociology perspective. The committee's work acknowledged that life events are shaped by subsequent life stages. The stigma of being a minority was recognized as attributing to the chronic stress and health of the LGBT individuals. Social ecology contributed the understanding that LGBT individuals exist within a community of influence and that these spheres of influence affect their health and well-being. The IOM report acknowledged the difficulty of conducting research in LGBT population. It may be difficult to recruit LGBT research participants since they represent a small minority within the US population and LGBT individuals may be reluctant to participate in research studies. It is crucial to maintain scientific rigor while ensuring respectful involvement when conducting research in the LGBT community.

The primary recommendation of the 2011 IOM report is to advance a research agenda that will support the NIH to conduct research in LGBT heath. This research agenda details several specific recommendations. These recommendations will be presented in the following section.

The first recommendation of the IOM (2011) report is "NIH should implement a research agenda designed to advance knowledge and understanding of LGBT health" (p. 6). All members of the LGBT community are commonly grouped together in research studies. The primary rationale for combining the entire LGBT group is that they are all

non-heterosexual and consequently experience social stigma. While lesbians, gay men, bisexual men and women, and transgender people do share the experience of stigma, each subgroup experiences this stigma quite differently. Combining these groups negates the unique experience of each individual group. Specific characteristics within each subgroup should be considered including (but not limited to) age, race, ethnicity, educational level, socioeconomic status and geographic location.

Collection of data regarding sexual orientation and gender identity is recommended on federally funded surveys (IOM, 2011). Obtaining this information would support researchers to conduct studies on LGBT issues. "Given the interactions between social and economic circumstances and health, data from social and economic surveys could provide valuable information on the context for health disparities experienced by LGBT people" (p. 9). The IOM report also advocates that electronic health records should include data on sexual orientation and gender identity. The recommendation was made to collect this data along with race, ethnicity and other demographic information. The report considers the potential awkwardness on the part of health care professionals asking questions regarding sexual orientation or gender identity. Possible barriers to collection of meaningful data regarding patients' sexual orientation or gender identity may include: potential discomfort on the part of health care providers, providers' lack of knowledge about how to ask these questions and potential hesitation of patients to disclose this information.

Methodological research and research training are included in the IOM (2011) report's recommendations. "NIH should support the rigorous development of valid, reliable measures focused on sexual orientation and gender identity" (p. 9). It is also

suggested that NIH recognize the methodological challenges of conducting research on LGBT health. Innovative methods to study small populations such as LGBT people are considered. The IOM advocates for a comprehensive research training approach to studying LGBT health. NIH is charged with focusing on the following audiences: researchers who are currently working with the LGBT population (or those who are interested in this work), researchers who are unaware of LGBT health issues, and the NIH personnel. The IOM report recommends that NIH encourage grant applicants to explicitly address the inclusion or exclusion of LGBT individuals in their samples. The IOM suggests that the NIH policy on inclusion of women and minorities could be expanded to include LGBT individuals. "Researchers would thereby be prompted to consider the scientific implications of including or excluding sexual and gender minorities and whether these groups will be included in sufficient numbers to permit meaningful analyses" (p. 10).

The IOM (2011) report addresses each developmental life stages; childhood/adolescence, early/middle adulthood and later adulthood. Since this author's research study focuses on the postpartum experiences of nonbirth lesbian mothers, it is significant to discuss the IOM's discussion of early/middle adulthood. Several physical and mental health issues are discussed including: mood/anxiety disorders, depression, suicide, obesity, cancer, heart disease and others.

The IOM (2011) revealed that few studies focused on childbearing in lesbian women. The report noted that pregnancy loss is difficult for lesbians (Peel, 2010; Wojnar, 2007 as cited in IOM, 2011) and that lesbians may be at a greater risk than heterosexual women in developing postpartum depression (Ross, Steele, Goldfinger & Strike, 2007 as

cited in IOM, 2011). The IOM (2011) report recognizes that research on reproductive technology and motherhood among lesbians remains scarce. Many aspects of reproductive health among LGBT individuals have never been studied. The IOM report recommends further study on "[the] percentage of LGBT adults who are parents, [the] effect of the likelihood of childlessness among LGBT adults, the experience of parenting, the experience and prevalence of 'chosen families'" (p. 300), "fertility, infertility, and reproductive health issues, and reproductive technology and its use" (p. 302).

TJC (2011) published a field guide, *Advancing Effective Communication, Cultural Competence, and Patient and Family Centered Care for the Lesbian, Gay, Bisexual and Transgender Community.* This guide was developed to educate hospitals on how to provide quality care for LGBT patients and their families. The goal of this publication is to make hospitals more welcoming and safe places for LGBT patients and families. Resources are provided along with exemplar case studies and strategies to improve therapeutic communication. TJC addressed the following in the aforementioned report: leadership, provision of care, workforce, data collection and use, and patient, family and community engagement. This report provides specific strategies to promote cultural competence and promote inclusion of the LGBT community. (The Joint Commission, 2011).

TJC's (2012) field guide directs health care leaders to bring LGBT family perspectives into their planning, delivery and evaluation of health care in their institutions. The leadership of an organization is ultimately responsible for the culture of that organization. Leaders are obligated to safeguard LGBT patients and their families by instituting nondiscrimination policies. TJC advocates that leaders must communicate that

discrimination of any form is unethical and will not be tolerated. Nondiscrimination policies should be developed to create a safe care environment for LGBT patients and their families. TJC addressed hospital visitation policies in particular. They recommend that visitation should include spouses, domestic partners, children, friends and anyone who patients' consider to be family. TJC's report envisions a broader version of family inclusive of those who are significant to patients rather than a narrow view that only legally related individuals constitute family. TJC encourages leaders to exhibit an ongoing commitment to the inclusivity of LGBT patients and families. They recommend that leaders should monitor outcomes of initiatives and conduct ongoing evaluation of the organization's cultural competence in caring for LGBT patients and their families. TJC also encourages leaders to hold all individuals accountable for creating a safe environment for LGBT patients and their families. Specific leadership strategies include creating a mechanism for reporting discrimination against LGBT patients, family members or staff as well as a disciplinary process to address these injustices. TJC also recommends appointing an advisory group including staff and physician champions who have expertise in LGBT issues.

Patients in the LGBT community commonly survey the surroundings in the health care setting to determine if it is an inclusive environment and if they will feel accepted (Gay and Lesbian Medical Association, 2011). TJC (2011) encourages health care facilities to create a welcoming environment for LGBT patients. Their field guide presents some specific interventions such as posting nondiscrimination policies in publicly accessible locations, providing brochures and literature which include LGBT patients, displaying décor of same sex couples and their families, and posting symbols

which indicate acceptance of the LGBT community (such as the rainbow flag or safe zone signs). TJC urges health care providers to avoid using stereotypes or making assumptions about LGBT patients. They suggest that crafting medical forms utilizing inclusive language such as parent/guardian as opposed to mother/father and relationship status/partner rather than marital status/husband or wife. Avoiding assumptions and using neutral language are additional strategies to promote inclusivity and encourage LGBT patients to safely disclose their sexual orientation.

Creating a safe space for LGBT employees is also a focus of TJC's (2011) field guide. TJC suggests strategies to promote a workforce that is able to provide sensitive care to the LGBT community. The two workforce goals are to "ensure that LGBT employees are treated in an inclusive and equitable manner and ensure that all employees are able to provide equitable, competent, and welcoming care to LGBT patients and their families" (The Joint Commission, 2012, p.19). One particular strategy suggested by TJC is to celebrate LGBT cultural events such as pride month. Public commemoration of LGBT traditions demonstrates cultural competence and acceptance of the LGBT community. These events bear witness to the organization's commitment to embracing all types of diverse groups including LGBT individuals. This further contributes to the creation of a safe environment for LGBT patients and their families.

Data collection and utilization are key recommendations by TJC (2011) to meeting the health needs of LGBT patients. The committee identifies an LGBT data collection gap and suggests opportunities to collect factual information during hospital admissions and after patients are discharged. Specific suggested initiatives included needs assessments and focus groups with members of the LGBT community. TJC

encourages patient, family and community engagement to bring about a better understanding and to meet the needs of LGBT individuals and their families.

The IOM Report, *The Health of Lesbian, Gay, Bisexual and Transgender (LGBT) People: Building a Foundation for a Better Understanding* and TJC's field guide, *Advancing Effective Communication, Cultural Competence, and Patient and Family Centered Care for the Lesbian, Gay, Bisexual and Transgender Community,* indicate that there is a need for studies on lesbian health. Nonbirth lesbian mothers face health disparities. The IOM report promotes research regarding lesbians and fertility/infertility issues and issues related to early/middle adulthood. It also recognized that qualitative studies are particularly valuable to studying this population since they may capture the unique health experiences of lesbians and gays as well as to serve as the foundation for future research (Institute of Medicine, 2011). TJC field guide strives to create a more welcoming and safer atmosphere for lesbians. Some particular strategies recommended by TJC include creating inclusive visitation policies, including LGBT patient needs within hospital policies and utilizing a broad definition of family (The Joint Commission, 2011). This author's study on the postpartum experiences of nonbirth lesbian mothers satisfies the agendas of both, the IOM and TJC.

Interdisciplinary organizations such as the IOM (1999; 2011) and TJC (2011) have recognized the health disparities in the LGBT community. The American Society for Reproductive Medicine (2009) has unequivocally affirmed that all requests for fertility treatment should be honored regardless of sexual orientation. The American College of Obstetricians and Gynecologists (2005) has asserted that sexual orientation should not prohibit a patient from receiving fertility services to become pregnant. The

Gay and Lesbian Medical Association was formed in 1981 as the American Association of Physicians for Human Rights. Their mission was to provide equity in the care of LGBT patients. The group was initially restricted to physicians and medical students. In 2002, they expanded became the Gay and Lesbian Medical Association which represents all health care disciplines from a wide range of health care specialties (http://www.glma.org). The American Medical Association (2009) published a policy statement in opposition to the military policy, "don't ask, don't tell". The America Psychiatric Association, The American Psychological Association and The National Association of Social Workers all have statements on their web sites in support of lesbian and gay health (Eliason, Dibble & DeJoseph, 2010). The American Academy of Nursing expert panel on cultural competence sited sexual orientation as a "secondary characteristic of culture" "attributes that one can more readily change" (Giger, Davidhizar, Purnell, Harden, Phillips & Strickland, 2007, p. 100). While medicine and other disciplines have embraced the health of LGBT patients and their families, nursing has not taken a stand on these critical health issues. Eliason, et al (2010) argued that nursing has remained silent on lesbian and gay issues. Despite a commitment to reducing health disparities, nursing has not sufficiently addressed some of the major issues related to gay and lesbian health.

Purpose

The lack of nurses' recognition of nonbiological lesbian mothers perpetuates silence on issues of gay and lesbian health. It is important for nurses to challenge this silence in order to provide equitable care to childbearing lesbian couples. Since nonbiological lesbian mothers are frequently not recognized as legitimate parents it is

crucial for nurses to understand their unique experiences. The purpose of this study was to develop a metastory of nonbiological lesbian mothers' postpartum experiences. The postpartum period was considered from birth through the first year of motherhood. Although the typical postpartum period is characterized as the first 6 weeks beyond birth, most mothers take much longer to fully embrace the maternal role (Mercer, 1985). Mercer declared that many mothers struggle with maternal identity issues well into their first year of motherhood. This researcher considered postpartum experiences of nonbiological lesbian mothers within their first year of motherhood.

This research investigated how nonbiological lesbian mothers make sense of these events in their lives. This study aimed to achieve a better understanding of the experiences of nonbiological lesbian mothers. This can ultimately foster more sensitive nursing care to lesbian families.

Conclusion

Despite the growing prevalence of lesbian motherhood, studies on lesbian childbearing families remain rare. There is a need for scientific studies to foster evidence based care of lesbian families. The role of the nonbirth lesbian mother is virtually absent in the literature. Studies do peripherally acknowledge the importance of the nonbiological mother (Buchholz, 2000; Larsson & Dykes, 2009; Renaud, 2007; Wilton & Kaufmann, 2001), however, studies primarily focusing on the nonbirth lesbian mothers remain rare. The concept of invisibility is considerable for nonbirth lesbian mothers. Research has demonstrated that inclusion of the nonbirth mother during the perinatal period has a positive effect on the wellbeing of both mothers (Erlandsson, Linder & Haggstrom-Nordin, 2010; Larsson & Dykes, 2009). This author's study begins to fill the gap in the

literature by listening to the voices of nonbirth lesbian mothers and providing insight into their stories.

Chapter one introduces the research study, The Other Mother: A Narrative Analysis of Nonbirth Lesbian Mothers Postpartum Experiences. Significant statistical and legal information regarding lesbian mothers was presented in the background section. The significance of this study was discussed by placing this study within the framework of recommendations from the IOM and TJC. Finally, the purpose of the study was presented. Chapter two presents an integrative review of the literature. Chapter three details the method, narrative analysis, utilizing the structural approach, Riessman's (2008) thematic analysis. Chapter four shares the results. The research participants are described. Their narratives are summarized and individual themes from each interview are presented. The metastory of the postpartum experiences of nonbirth lesbian is presented. The six overarching themes along with subthemes are depicted. Chapter five discusses the relevance of the study. This research is compared to the review of the literature. Implications for research, clinical practice and education are considered.

Chapter Two: Review of Literature

Introduction

Chapter two presents the literature related to postpartum experiences of nonbirth lesbian mothers as well as, more broadly, the childbearing experiences of lesbian mothers. This literature review categorizes the literature into the following categories: lesbian mothers' experiences with health care providers, becoming a lesbian mother, and finally, childbearing experiences of nonbirth lesbian mothers. Each category is considered and, studies are detailed throughout the literature review.

Procedure

One of the most difficult features of this literature review was locating studies focusing on nonbirth lesbian mothers. Since few studies focused on nonbirth lesbian mothers, the scope of this review was broadened to include studies related to all aspects of lesbian childbearing. Online databases such as the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Academic Search Primer, Education Resources Information Center (ERIC), Gay Lesbian Bisexual Transgender Life, PsychInfo, Pubmed, Sociological Abstracts, Proquest and Women's Studies International were searched. The search was not limited by publication dates. Key words such as: *lesbian, gay, homosexual, queer, same-sex parents, maternity, pregnancy, childbirth, birth, antepartum, prenatal, intrapartum, postpartum, motherhood, mothers, nonbirth, nonbiological, stepmothers, co-mothers, social mothers, fertility, infertility, insemination and in vitro fertilization* were used to narrow the search.

Results

Twenty-five research studies and one theoretical publication were examined for this literature review. Only two research studies were published in the 1980s and four in the 1990s. The bulk of the studies were published after 2000. Seven studies were unpublished doctoral dissertations and, eighteen were published in the literature. The publications came from a variety of disciplines. Nursing published 11. Education, Marriage and Family Therapy and Anthropology each contributed two studies. Medicine, Social Work, Psychology, Human Ecology, Creative Arts and Communication, Family Studies, Human Relations and Multicultural Education, Sociology and Human Communication each provided one study. Fifteen American studies were included. Three studies each came from Canada and Sweden. Two studies were conducted in the United Kingdom (UK). Norway and Israel each provided one study. The theoretical publication came from Australia. The majority of the studies were qualitative (24) and, only one quantitative study was located. More information regarding specific study characteristics is available in table 1. The following sections present an in-depth discussion of the literature.

Lesbian Mothers' Experiences with Health Care Providers

The first category of this literature review is lesbian mothers' experiences with health care providers. It is further divided into the following subcategories: lesbian mothers' experiences with labor/delivery care providers and lesbian mothers' experiences with care providers throughout obstetrical care.

Lesbian mothers' experiences with labor/delivery care providers. Two qualitative studies focused specifically on lesbian mothers experiences with health care

providers in labor and delivery (Buchholz, 2000; Stewart, 2002). Buchholz (2000) interviewed five lesbian couples using Colaizzi's approach to phenomenology. Stewart (2002) interviewed four lesbian couples about their experiences during labor and delivery. She described the data analysis as utilizing the constant comparative method of Glaser and Strauss. The study appears to be a descriptive qualitative study rather than a grounded theory study.

Both studies determined that the support of healthcare providers was crucial to a positive childbirth experience. Lesbian mothers desired lesbian health care providers when possible. One participant in Stewart's (2002) study recalled choosing a lesbian physician who was not covered under her health insurance. She felt comfortable with this provider, cared for and supported. Another participant was grateful for a lesbian nurse who chose to be with her during labor and remained with her throughout the birth, beyond her scheduled shift (Buchholz, 2000).

Buchholz (2000) and Stewart (2002) also reflected lesbian mothers' fear of a homophobic health care system and how these mothers attempted to protect their families during labor and birth. One particular mother in Stewart's study (2002) decided to give birth at home rather than in the hospital where she was employed. She felt that giving birth at home would protect her family from discrimination by health care providers. Participants in Buchholz's (2000) study viewed advanced preparation of hospital staff as a proactive approach to decrease homophobia during labor and delivery. Couples asked their primary care providers to inform hospital staff that they would be giving birth as a lesbian couple. Some participants created birth plans and sent them to the hospital prior to their baby's birth. They requested that any staff who might be uncomfortable caring

for a lesbian couple to not be assigned to care for them. Buchholz (2000) and Stewart (2002) recounted that lesbian mothers experienced homophobia as well as supportive care during labor and delivery.

Lesbian mothers' experiences with care providers throughout obstetrical care. Seven studies focused on lesbian mothers' experiences with care providers throughout the continuum of maternity care (Harvey, Carr, & Bernheine, 1989; Larsson & Dykes, 2009; Olesker & Walsh, 1984; Rondahl, Bruhner & Lindhe, 2009; Ross, Steele & Epstein, 2006; Spidsberg, 2007; Wilton & Kaufmann, 2001). One study explored how lesbians' self disclosure of their sexual orientation to their health care effected their gynecological and childbearing care (Zeidenstein, 1990). All of these studies focused on lesbians' experiences with health care providers.

Olesker and Walsh (1984) published the earliest study located in this literature review. Their descriptive qualitative study utilized a lengthy 74 question survey that included both demographics and short answer questions. Nine lesbian mothers were interviewed to determine if perinatal providers met their needs. The participants preferred lesbian care providers since having a lesbian provider made them feel less vulnerable to prejudice. Although lesbian mothers ideally wanted a lesbian provider, they ultimately desired a supportive provider with an understanding of lesbians' needs regardless of the provider's sexual orientation. This study concluded that health care for childbearing lesbians could be improved by health care providers' educating themselves about lesbian issues.

Zeidenstein (1990) echoed Olesker and Walsh's (1984) research. Zeidenstein's (1990) descriptive qualitative study examined the childbearing (and gynecological) needs

of 20 lesbians. She examined how self-identification as a lesbian affected midwifery care. Lesbians described their fear of revealing their sexual orientation to their care provider. This fear delayed participants from seeking care and motivated them to search for care providers who were sensitive to lesbians. Participants valued health care providers who were sensitive to lesbian issues and knowledgeable about lesbian health.

Spidsberg (2007) also considered the impact of lesbians' revealing their sexual orientation to their providers. The aim of this phenomenological study was to examine the maternity care experiences of six Norwegian lesbian couples. Spidsberg described lesbian mothers as both, vulnerable and strong. The main three themes included: "being open, being exposed and being confirmed" (p. 480). Being open was characterized as revealing one's lesbianism to her provider. Being exposed was depicted as being "an object for healthcare providers' attitudes" (p. 481). By sharing one's sexual orientation, lesbians became vulnerable to the judgments of the healthcare provider. Being confirmed corresponded to experience with healthcare provider following the disclosure. This is represented as "being in caring hands" or "being in uncaring hands" (p. 482). Being in caring hands was perceived by participants as safety, respect and recognition as parents. Being in uncaring hands was experienced by participants as providers' withdrawal of support, lack of respect and discrimination. Spidsberg's (2007) study supported Zeidenstein's (1990) study conclusions. When lesbian mothers feel safe and respected, they are more likely to reveal their sexual orientation to their health care providers.

Ross, Steele and Epstein (2006) examined lesbians' experiences with health care providers during donor insemination, pregnancy and postpartum. This Canadian study utilized three focus groups to interview 23 participants. Some of the hardships lesbians

face in trying to become pregnant were detailed. Depending upon their residential location, some participants were mandated to undergo a criminal background check and a home evaluation prior to entering fertility treatment. Care from registered nurses (RNs) was described as adequate, however, the care from nurse midwives and doulas was experienced as exceptional. Nurse midwives advocated for patients and protected them from any potentially homophobic care.

Rondahl, Bruhner and Lindhe (2009) studied the experiences of 10 lesbian parents in Sweden from antenatal through postpartum care. Several participants describe their insecurity about health care providers' reaction to their sexual orientation. Despite their initial anxiety, nearly all participants had positive experiences with providers. Some participants felt the need to educate midwives about caring for lesbians. One participant verbalized her resentment that nursing staff looked to her to educate them about lesbian health issues when they should have been caring for her during preterm labor.

Harvey, Carr and Bernheine (1989) conducted the only quantitative study located in this literature review. Thirty-five lesbian birthmothers completed an instrument, which asked questions about their evaluation of obstetrical care providers on comfort, support and satisfaction. Most of the participants rated their care as adequate to excellent. Conversely, more than half of the participants viewed their care as inadequate to poor regarding providers' understanding of lesbian health, consciousness of homophobia and comfort caring for lesbian patients.

Larsson and Dykes (2009) and Wilton and Kaufmann (2001) researched lesbian mothers' experiences during pregnancy and childbirth. Both studies utilized a descriptive qualitative approach. Larsson and Dykes' (2009) interviewed 18 Swedish lesbians.

Wilton and Kaufmann (2001) collected data from a qualitative questionnaire from 50 lesbian mothers in the United Kingdom. Most of the women in this study had positive experiences with health care providers. Positive interactions with midwives included the midwife making eye contact with both partners, showing openness to lesbian couples (Larsson & Dykes, 2009), showing sensitivity toward both partners, asking questions about lesbians and treating lesbian couples with the same respect as all childbearing couples (Wilton & Kaufmann, 2001) .

Although the majority of lesbian mothers studied recounted positive maternity experiences, some recalled significantly homophobic care (Larsson & Dykes, 2009; Wilton & Kaufmann, 2001). Participants feared disclosing their sexual orientation to their providers. They did not disclose because they feared that their homosexuality might have a poor impact on their care (Larsson & Dykes, 2009). A pregnant lesbian shared that her primary care provider expressed disapproval of her pregnancy since she was not heterosexually married (Wilton & Kaufmann, 2001).

Childbirth education classes were frequently perceived negatively by lesbians (Larsson & Dykes, 2009; Renaud, 2007; Rondahl, Bruhner & Lindhe, 2009; Ross, Steele & Epstein, 2006; Wilton & Kaufmann, 2001). Lesbian mothers felt isolated in these classes. They did not feel recognized as equal parents. Instructors frequently referred to husbands and fathers with no regard for lesbian couples as equal mothers. A prenatal instructor referred to the heterosexual couples in the class as “normal families” (Renaud, 2007). Childbirth education was frequently experienced by lesbians as heterosexist in nature. Some lesbian mothers were never offered any childbirth or parenthood education (Rondahl, Bruhner & Lindhe, 2009).

Becoming a Lesbian Mother

The second category of this literature review is becoming a lesbian mother. It is further divided into the following subcategories: contemplating motherhood, trying to conceive, pregnancy, and lesbians' childbearing experiences.

Contemplating motherhood. One study explored lesbian mothers' experience of contemplating motherhood. Chabot and Ames' (2004) descriptive qualitative study used feminist inquiry to study the decision making process of 10 lesbian couples planning motherhood via donor insemination.

Lesbian couples addressed the following seven key questions as they contemplated motherhood:

> Do we want to become parents? Where do we access information and support? How will we become parents? Who will be the biological mother? How do we decide on a donor? How do we incorporate inclusive language How do we negotiate parenthood within the heterocentric context? (p. 350).

Lesbians faced serious personal doubts as they considered parenthood (Chabot & Ames, 2004). Some participants agonized over their assumption that heterosexual women are the only proper mothers. Others worried about societal discrimination and potential homophobia their children might face. One participant resisted becoming a parent for years because she feared that her child would face discrimination from being raised by lesbian parents. Lesbians considering parenthood looked to lesbian parents as mentors. They looked to friends, the World Wide Web, health care professionals and books. When they became isolated it was helpful to attend lesbian support groups. These groups were a support for couples grappling with infertility as well as a social network

for young children with lesbian parents. One couple struggling to become pregnant was grateful for a peer support group for lesbians experiencing infertility. The group provided information, stress relief and friendship with other lesbians who were struggling to become parents.

Trying to conceive. Two studies focused specifically on lesbians' experiences of trying to conceive. Scott's (2007) descriptive qualitative study explored eight lesbian couples' stressors and coping patterns during donor insemination. Luce's (2002) ethnography captured 80 lesbians' experiences of assisted reproduction. Both studies captured the emotional and physical difficulties lesbians faced while trying to conceive.

Scott (2007) described one of the earliest stressors in the conception process as deciding which partner would biologically carry the baby. Couples pragmatically considered each partner's age as well as each partner's desire to become pregnant. Some couples chose the younger partner since they assumed that she would be more likely to become pregnant. Others chose the older partner if she had a strong desire to give birth. They believed that they had a smaller window of opportunity for successful conception and, therefore the older partner should imminently attempt pregnancy.

Couples debated between using known as opposed to unknown donors. Lesbians commonly chose anonymous donors in an effort to protect their sole legal rights as parents. They wanted the sperm donor to have no parental rights to their child (Luce, 2002; Scott, 2007). Lesbians also valued the health screening of donors provided by cryobanks such as testing for sexually transmitted diseases (Scott, 2007). They appreciated donor information, which was provided by the cryobanks, such as

photographs, medical histories, voice audiotapes and the potential of contacting the donor in the future (Scott, 2007).

Know donors were commonly chosen so that the child could have a relationship with his or her biological father. Other lesbians simply wanted their child to know where he or she came from (Luce, 2002; Scott, 2007). One particular participant revealed that she wanted the option to be able to contact the sperm donor in case her child had questions about him although she did not want him involved as a parent. Some lesbians chose known donors in order to avoid the high financial cost of cryobanks. Another participant felt that lesbians having to pay for sperm was unethical (Scott, 2007). Lesbians coped with the stress of using known donors by seeking legal counsel to protect themselves as parents (Scott, 2007).

Scott (2007) revealed a "cycle of excitement and disappointment" as lesbians tried to conceive (p. 106). They were hopeful that they would become pregnant with the start of each cycle, however, repeated failed cycles led to great disappointment. Lesbians sought support from other lesbians who were also trying to conceive (Luce, 2002). The Internet was another helpful venue for lesbians seeking information about becoming pregnant. E-mail list serves, bulletin boards and chat rooms provided information about how to increase the likelihood of pregnancy, legal issues, fertility support, lesbian friendly sperm banks and other issues. Luce (2002) concluded that modern day support groups have moved to the World Wide Web.

All couples reported stress during the process of trying to conceive (Luce, 2002; Scott, 2007). Timing was crucial to conception. Lesbians became fertility experts as they repeatedly tried to conceive. While some lesbians attempted to conceive at fertility

clinics, others became proficient at inseminating themselves at home (Scott, 2007). Lesbians experienced anxiety over the medicalization of conception. Some were reluctant to take medications and undergo medical interventions related to fears such as personal health risks, multiple births and high-risk pregnancy (Luce, 2002; Scott, 2007). Some families of origin were adamantly opposed to lesbians becoming parents. Lesbians looked to friends who they call families of choice when they were rejected by their own families. They effectively used a variety of coping mechanisms to cope with the strain of pursuing parenthood including: payer/spiritual faith, journaling, humor, relaxation techniques and physical activity (Scott, 2007).

Pregnancy. Friedman (1998) utilized a descriptive qualitative design to study lesbians' experiences of pregnancy. Friedman developed the Lesbian Pregnancy Questionnaire (LPQ). This instrument asked 42 questions including: demographic data as well as short answer questions about conception and pregnancy. The data analysis method was cited as Strauss and Corbin's (1990) version of grounded theory.

Friedman (1998) also collected quantitative data in this study. Spanier's (1976) Dyadic Adjustment Scale (DAS) was administered. This instrument measured a couple's relationship satisfaction, ability to cope with disagreements, ability to related to one another and perception of relationship longevity. General percentages were noted for some of the items on the DAS. Friedman (1998) noted that although participants completed the DAS, the results were not included in the data analysis of her doctoral dissertation.

Friedman's (1998) work is consistent with the literature in this literature review. She determined that most lesbian couples easily decided which partner would pursue

pregnancy. This was commonly determined by age or desire to become pregnant. One particular participant shared that her increasing age motivated her to realize that she wanted to be a parent. The majority of couples used anonymous donors to avoid legal complications and protect their rights as parents. Couples generally reported a closer relationship during pregnancy. Participants stressed having the right partner as a prerequisite to pursuing parenthood.

Some of the difficulties of pregnancy related to fear of rejection from family, friends and society (Friedman, 1998). The majority of families were supportive to their daughters' becoming lesbian mothers. The vast majority of participants received support and validation from lesbian friends. Pregnant lesbians recognized the necessity of coming out as lesbian. Even participants who saw themselves as secure in their lesbianism contemplated the risks and benefits of revealing their sexual orientation. Couples were faced with this dilemma at every phase of conception and pregnancy. Several participants had extremely positive experiences of sharing the news of their pregnancy as a lesbian. One couple realized that their anxiety over coming out was related to their own internalized homophobia rather than the prejudice of others.

Lesbians' childbearing experiences. Two studies focused on the entire spectrum of lesbians' childbearing experiences from preconception through postpartum (Renaud, 2007; Silber, 1991). Renaud (2007) utilized critical ethnography to study the childbearing experiences of 70 lesbian mothers. Data were collected through interviews, focus groups and observations of a lesbian mothers' support group. Silber (1991) utilized Glaser and Strauss' (1967) grounded theory method to generate a theory of the process of becoming a lesbian mother. Fifty-two lesbian mothers were interviewed who had given birth or

adopted children. This is the only study in this literature review, which included both, lesbian birth mothers and adoptive mothers. The adoptive mothers adopted their children from countries outside of the US.

Most mothers in Silber's (1991) study and Renaud's (2007) study reported wanting a child for a considerable amount of time. The strategy of how to become a parent was more significant than the decision to become a parent. Some participants always wanting to be parents and that having children did not seem like a decision to them (Friedman, 1998; Silber, 1991). This was consistent with the literature examined in this review.

Silber's (1991) and Renaud's (2007) research concurs with other studies examined in this review revealing that lesbians frequently preferred anonymous sperm donors. Multiple studies rendered lesbians choosing anonymous donors in an effort to protect their sole rights as parents (Chabot & Adams, 2004; Friedman, 1998; Luce, 2002; Renaud, 2007; Scott, 2007; Silber, 1991). Many women initially considered male friends as donors. They ultimately avoided this option since the donors also wanted to be involved as fathers (Silber, 1991). Lesbians voiced concerns that a known donor would have legal rights to their child (Chabot & Adams, 2004; Friedman, 1998; Luce, 2002; Renaud, 2007; Scott, 2007; Silber, 1991). They also feared that the nonbirth mother might be excluded as a parent if a known donor was chosen. Some couples chose anonymous donors who were willing to be contacted when the child becomes 18 years old (Renaud, 2007). Lesbians who selected a donor who was willing to be known did so because they wanted their children to have the option of meeting their biological father.

A number of studies portrayed the “emotional rollercoaster” of trying to conceive beginning with hope and anticipation, followed by depression and disappointment and then repeating the cycle again (Friedman, 1998; Renaud, 2007; Scott, 2007; Silber, 1991).

Timing of inseminations was a crucial element in achieving pregnancy (Renaud, 2007). Nearly all participants in this critical ethnography recounted the insemination process as a difficult and stressful period. The daily routine of monitoring signs of ovulation and attempting to schedule inseminations at the precise moment was quite anxiety provoking.

Pregnancy was experienced as a joyous period for lesbian mothers (Silber, 1991; Renaud, 2007). Lesbian mothers thoughtfully prepared for their babies by obtaining prenatal care, attending childbirth classes and planning for their long awaited babies. Pregnancy brought them closer to their partners. Silber (1991) described lesbian mothers’ pregnancy experiences as exciting but stressful. They characterized their experiences as living “double lives”. One participant admitted that she resented strangers assuming that she must be heterosexual since she was pregnant. Some participants in this study reported feeling like objects and receiving unwanted attention from strangers.

Most lesbian mothers delivered in hospitals and had generally positive experiences. Several lesbians brought lesbian friends with them to the hospital to help create a safe and supportive atmosphere during childbirth. Many couples had written birthing plans or verbally planned their expectations for their birth (Renaud, 2007; Silber, 1991). Participants commonly desired a natural birth free of medical interventions (Silber, 1991).

Most lesbian mothers chose to breastfeed their babies (Renaud, 2007; Silber, 1991). Breastfeeding helped them to establish a strong bond with their babies. Lesbian mothers described many stressors that are common to all new mothers such as sleep deprivation, physical exhaustion and feeling overwhelmed. Some mothers felt that the extreme fatigue made them more vulnerable to postpartum depression. Lesbian mothers preferred to focus on being mothers rather than being lesbian mothers. Being a parent became the central focus of their lives. Their careers, personal lives and relationships with extended family and friends became secondary to their new role as mothers (Silber, 1991).

Nonbirth Lesbian Mothers

The third category of this literature review focuses on nonbirth lesbian mothers. This literature review affirmed that partner inclusion is essential to a positive childbearing experience. Most publications addressed the experiences of nonbirth mothers at least peripherally. Only one study focused solely on nonbirth lesbian mothers experiences of some aspect of childbearing. Other studies in this category focused on general aspects of lesbian motherhood from the nonbirth mother's perspective. This category includes six research studies and one theoretical publication. It is presented in the following subcategories: childbearing from the perspective of the nonbirth mother, maternal self-concept and maternal jealousy.

Childbearing from the perspective of the nonbirth mother. Erlendsson, Linder and Haggstrom-Nordin (2010) conducted the only study to date focusing exclusively on the perinatal experiences of nonbirth lesbian mothers. Six nonbirth lesbian mothers in Sweden were interviewed between 6 weeks and 3 years following their child's birth. The

main finding of this descriptive qualitative study using content analysis was that co-mothers wanted to feel recognized as parents. Participants desired the same respect afforded to fathers. They voiced a need for care specifically focusing on their unique needs as lesbian mothers. One nonbirth mother recalled being grouped with the fathers during a childbirth class. This felt awkward to her since she is a mother, not a father. Lesbian mothers desired personalized care and acknowledgement as mothers. Nonbirth mothers felt valued as parents when providers personally addressed them and involved them in their partners and their newborns' care.

Maternal self-concept. One theoretical article (Brown & Perlesz, 2008) explored possible names for lesbians who mother their nonbiological children. Five research publications addressed the maternal self-concept of lesbian mothers (Ben-Ari & Livni, 2006; Price, 2007; Bergen, Suter & Daas, 2006; Suter, Daas & Bergen, 2008; Wilson, 2000).

Brown and Perlesz (2008) identified the 45 possible terms for nonbirth mothers. This theoretical publication analyzed the role language plays in portraying nonbirth lesbian mothers. The authors concluded that nonbirth lesbian mothers are represented by what they are not (rather than what they are). They compared nonbirth lesbian mothers to heterosexual adoptive mothers by noting that heterosexual adoptive mothers are not referred to as nonbirth mothers. Brown and Perlesz (2008) hypothesized that since the nonbirth mother did not give birth and is (likely) not breastfeeding, she (and others) may question her legitimacy as a mother. Co-parents, stepmothers and co-mothers are also offered as maternal titles. These titles also remain problematic. Co-parent is generic and

lacks the female gender of motherhood. Stepmother is not entirely appropriate since there is a biological mother who is also a caretaker of the child. Co-parent might be more fitting for some lesbian mothers, however, it does not differentiate between the two mothers. Although language can affirm or denounce the identity of the nonbirth lesbian mother, it is also impractical to adequately represent all nonbirth lesbian mothers with one fitting title. This is a result of the creation of each particular family combined with perceived and negotiated roles within a couple's relationship (Brown and Perlesz, 2008).

Price (2007) studied the process of nonbirth lesbian mothers' contemplating motherhood. Phenomenology was selected to understand the lived experiences of eight nonbirth lesbian mothers, however, the description of the method could have been more in depth. Methodological references are cited from secondary sources. No phenomenologist is referred to nor are any philosophical underpinnings explored in depth. The method of this study is presented on only a superficial level. Price (2007) sought to understand the causal factors of the participants' decision to become nonbirth lesbian mothers. The individual narratives were analyzed and compared to Gilligan's (1982) justice/care paradigm. Some revealed ambivalence regarding becoming a mother. Others recounted wanting a family but not personally wanting to be pregnant. A few conceded to their partner's lifelong dream of motherhood. All of the participants revealed that becoming a mother brought them great joy despite the legal and social inequities of a patriarchal society. The great happiness they achieved by becoming a parent outweighed their fears of becoming a nonbirth lesbian mother. The outcome was that all of the women in this study employed the caring perspective to manage oppression of a patriarchal culture.

Maternal identity of nonbirth lesbian mothers was investigated by Bergen, Suter and Daas (2006) as well as Wilson (2000). Bergen et al.'s (2006) grounded theory study sought to constrict a legitimate parental identity for nonbirth lesbian mothers. Wilson (2000) investigated what it was like to be a nonbirth lesbian mother. Participants in both studies articulated the social and legal invisibility of nonbirth lesbian mothers. They coped with these stressors by obtaining legal protection through wills, parenting agreements and second parent adoptions (when possible). Nonbirth mothers in both studies spoke about the importance of a common family name. Some families hyphenated both mothers' last names and others used the nonbirth mother's name for the family's last name (Bergen et al., 2006). Lesbian families stressed the importance of having a shared family last name in order to be recognized as a family (Wilson, 2000).

The following sections will consider the two previously mentioned studies in further detail and specificity. Although similar conclusions were drawn by Bergen et al. (2006) and Wilson (2000), each study contributes a unique perspective to this literature review. Bergen et al.'s (2006) grounded theory methodology was appropriate to construct a legitimate identity for nonbirth lesbian mothers. Charmaz's (2000) approached to grounded theory was chosen because of its interpretive, constructivist design . This is a fitting approach since the researchers asked participants to name their family rituals and symbols and then interpret how the rituals and symbols established their family to themselves and to others.

Twenty-one nonbirth lesbian mothers were interviewed and asked to share their family rituals and symbols (Bergen, et al., 2006). Rituals and symbols were intentionally not defined by the researchers to encourage personal interpretations. Participants

predominately identified the following three symbols: identifying titles for the nonbirth mother, last names and legal initiatives. Nonbirth lesbian mothers in this study echoed that it was critical for their child to be given some part of their last name in order for them to feel recognized as a parent. Titles for the nonbirth lesbian mother were significant. These mothers believed that it was essential for their children to address them with a maternal title. Most parents in this study utilized some maternal derivatives such as "Mommy and Mama". Being referred to as some form of "mother" enabled nonbirth lesbian mothers to feel honored as equal parents.

Lesbian parents referred to "creating a paper trail" to legitimize the parenthood of a nonbirth lesbian mother (Bergen, et al., 2006). Traditional legal documentation (as previously discussed) is the major component of this process. Nonbirth lesbian mothers commonly obtained legal documents such as wills, power of attorney and parenting agreements in order to attempt to legitimize their parental role. One participant shared that her attorney suggested that she compile personal documentation in addition to legal documentation to document her family life. She was advised to save family photographs, holiday cards with both mothers' names listed, e-mails from relatives and friends and any other personal items which documented their family life.

A subsequent publication from the previously mentioned parent study (Bergen, et al., 2006) focused on negotiating the overall lesbian family identity (Suter, Daas and Bergen, 2008). The additional contribution of this publication is the concept of "doing family" (p. 38). "Doing family" is a ritual that validates the family identity, most poignantly the nonbirth lesbian mother. Some examples included going out for walks together, attending church, displaying family photographs and talking about family at

work. Family identity was established as the entire family takes part in routine ordinary activities of daily life and made themselves visible as a family. As the family members engaged in predictable routine activities others recognized them as a family unit.

Wilson (2000) utilized a narrative approach with a grounded theory analysis method to determine what motherhood was like for nonbirth lesbian mothers. No theoretical description of the narrative method in this study was described. It was simply described as "narrative approach". The researcher noted, "a grounded theory method was employed in analyzing the content" yet no grounded theorist was referred to (Wilson, 2000, p. 27). Although this study produced robust data, methodological questions remain.

Nine nonbirth lesbian mothers were interviewed and asked the following two questions: what is it like for you as a mother? And from your story as you told it today, what do you feel are the primary themes?" (Wilson, 2000, p. 27). Many of the findings reflected the challenges of being a nonbirth lesbian mother such as: invisibility, oppression and the need for legal validation. This study concurs with Bergen et al's study (2006) as well as many of the studies on lesbian motherhood examined in this literature review. This study also chronicles the joys of being a nonbiological lesbian mother. Participants reflected on the conscious thoughtful decisions to become parents. One participant affirmed that children of lesbians are planned, cared for, valued and loved (Wilson, 2000).

The results of Wilson's (2000) study concurred with the articles in this literature review. However, the issue of one partner trying to conceive after her partner's infertility and/or miscarriage has not been previously explored in-depth. Participants in this study

recounted conceding to be the nonbiological mother after their inability to sustain a successful pregnancy.

Nonbirth mothers who ached to be birthmothers eventually experienced a great deal of personal growth following the birth of their children. Despite the enormity of their pain and loss, they were ultimately able to embrace these children as their own.

Ben-Ari and Livni (2006) examined the individual experiences and constructed meaning of biological and nonbirth motherhood. Eight Israeli lesbian couples were interviewed. Each partner was interviewed separately in order to explore her personal experiences. Giorgi's (1985) method of phenomenology was utilized. The three core themes of this study included:

Although equality is central to most lesbian relationships, having a child creates two different statuses of motherhood: biological and nonbiological motherhood, legal aspects influence the lives of lesbian mothers (especially the nonbirth mother) and stigma remains for many Israeli lesbian mothers and for some nonbirth mothers, parenthood created inequality within their relationship, which did not exist prior to becoming a family.

In most of the couples in Ben-Ari and Livni's (2006) study, both partners each gave birth. This helped to bring equality into the relationship. These couples described having balance in their relationship and in their family. They portrayed their relationships with their children as different with each parent but equal. Lesbian parents concluded that within their families each parent shapes her relationship with her children. Society does not determine the role of each parent. Despite feeling some marginalization, lesbian mothers felt like legitimate couples in Israel when they had children and became a

family. Motherhood allowed lesbians to relate to others less as lesbians and more as mothers.

Pelka's (2009) ethnographic study examined the concept of maternal jealousy in 60 parents through participant interviews (20 adoptive lesbian mothers, 20 lesbian parents who used alternative insemination (AI) and 20 lesbian mothers who used in vitro fertilization (IVF) with their partner's donated eggs). Since lesbian couples value equality so strongly, sharing motherhood through the IVF process using one's partner's donated eggs might be a viable alternative for lesbians. Lesbian couples that used AI reported the highest amount of maternal jealousy. Couples who used IVF or adopted reported less maternal jealousy than couples that used AI.

Lesbian nonbirth mothers experienced jealousy related to the following areas: desire to carry, infertility, breastfeeding and infant preference of the birth mother. Maternal jealousy was extremely prominent in couples in which at least one mother experienced infertility. Infertile lesbians often experienced grief over their own inability to become pregnant subsequent to their partner's successful pregnancy. This was often related to the nonbirth mother's jealousy of the physical relationship the birthmother had to the child. When birthmothers were unable to nurse, there was a significant decrease in maternal jealousy.

All of the mothers who experienced maternal jealousy also experienced their baby's preferring the baby's birth mother. These mothers reported sadness over not being able to have a primary relationship with their newborns. Infant preference was defined as wanting to be picked up, fed, and soothed, by one parent and preferring that parent for

nighttime routines. Infant preference was a significant issue when a partner who wanted to get pregnant was unable to do so (Pelka, 2009).

Conclusion

A limited number of research publications investigating lesbian mothers were revealed. Most of the studies focused on the experiences of couples or biological lesbian mothers. The publications were predominantly qualitative and many came from locations outside of the US including the United Kingdom (UK), Norway, Canada, Sweden and Israel. A number of unpublished doctoral dissertations were discovered related to lesbian mothers, yet only one of these examined the experiences of nonbirth lesbian mothers.

Despite the growing prevalence of lesbian motherhood, studies on lesbian childbearing families remain rare. The vast majority of publications are anecdotal accounts. These anecdotes provide valuable insight into the care of lesbian mothers; however, there is a need for scientific studies to foster evidence based care of lesbian families. Only two studies published in the literature and one doctoral dissertation specifically focused on partners of lesbian birth mothers. This author's study began to fill the gap in the literature by listening to the voices of nonbirth lesbian mothers and providing insight into their stories. The concept of invisibility is considerable for nonbirth lesbian mothers. The literature depicts the invisibility of lesbians in the health care setting. In the current heterosexist health care system, all women are assumed to be heterosexual. This assumption cultivates the invisibility of lesbians (Daley, 2003). Although the concept of invisibility regarding nonbiological lesbian mothers is not specifically investigated, the studies portraying lesbian invisibility are significant.

Chapter three presents a detailed description of the research method. The research design is described including the narrative analysis, structural approaches to narrative and the sample. The procedure is explained incorporating the protection of research participants, data collection and data analysis. The chapter concludes with a discussion of the methods to ensure research rigor.

Chapter Three: Method

Chapter three presents a detailed description of the research method utilized in this study. This section will specifically address the following areas: the research question, research design (including structural analysis), sample, procedure, protection of research participants, data analysis, and methods to ensure research rigor.

Research Question

The research question for this study is "What is the postpartum experience for nonbirth lesbian mothers?"

Research Design

Narrative Analysis

The design for this study was narrative analysis. **"**Narrative analysis refers to a family of methods for interpreting texts that have in common a storied form" (Riessman, 2008, p. 11). This qualitative method centers on the story as the object of investigation (Riessman, 1993). Narrative analysis relies on comprehensive recollections that are preserved and handled critically as units rather than divided into thematic categories, which is typical in some qualitative methods. Story telling is at the heart of narrative analysis. This methodology scrutinizes the participant's story and examines how the story has been constructed. Narrative analysis is concerned with not only the content of the story but also the reason why the story was told in a particular manner. Narrative analysis converges upon the story as the object of exploration to determine how individuals make sense of the events in their lives. This is particularly significant in matters of complex life transitions (Riessman, 1993).

Riessman (1993) described narratives as “essential meaning making structures” and urged narrative analysts to “preserve not fracture” participants’ stories

(p. 4). “Narrative scholars keep a story ‘intact’ by theorizing from the case rather than from component themes (categories) across cases” (Riessman, 2008, p. 53). Riessman contrasted narrative analysis with grounded theory. She pronounced that the narrative analyst “does not fracture the biographical account into thematic categories as grounded theory coding would do, but interprets it as a whole” (p. 57). Narrative analysis examines the story as a holistic piece of data.

The concept of narrative within the context of the research interview has been explored (Bruner, 1990; Mishler, 1986; Polkinghorne, 1988). Mishler (1986) contended that interviewers might have preconceived expectations regarding the direction of an interview. In adhering to predetermined questions, interviewers may miss the opportunity to hear the story the participants intend to tell. Mishler cautioned interviewers to avoid interrupting stories and encouraged them to be open, to allow narratives to emerge through spontaneous storytelling. Individuals define themselves through their stories. Polkinghorne (1988) commented on narrative, “We achieve our personal identities and self-concept through the use of narrative configuration, and make our existence into a whole by understanding it as an expression of a single unfolding and developing story” (p. 150). As individuals tell their personal stories, they begin to understand the meaning of their lives.

Polkinghorne (1988) equated the self with personal story telling. He further revealed the act of telling one’s story,

> We are in the middle of our stories and cannot be sure how they will end; we are constantly having to revise the plot as new events are added to our lives. Self, then, is not a static thing or a substance, but a configuring of personal events into an historical unity which includes not only what one has been but also anticipations of what one will be (p. 150).

For Polkighorne (1988) the act of story telling was a dynamic, creative process. Humans subsequently invented their realities through narratives.

Bruner (2004) declared, "We seem to have no other way of describing 'lived time' save in the form of a narrative" (p. 692). He further professed,

> eventually the culturally shaped cognitive and linguistic processes that guide the self-telling of life narratives achieve the power to structure perceptual experience, to organize memory, to segment and purpose-build the very 'events' of a life. In the end we become the autobiographical narratives by which we 'tell our lives' (p. 694).

For Bruner, the particulars of the individual's story are less important than the essence or meaning of their stories. Participants become their stories as they share their perceptions of their lives and their personal significance of these events. As they tell their stories, the self emerges.

Sarbin (1986) contended that humans apply a structure to their own experiences through narratives. Individuals begin to understand their own lives as they tell their personal stories. Sarbin qualified the direction human stories take as the narrative form. He portrayed this narrative direction as universal to all humans. Narratives are more than simply a recollection of events. Sarbin proposed that narratives might represent reality or

imagination. The concept of time perception is prominent in Sarbin's work; narratives possess distinct beginnings, middles and endings. Stories are shaped around particular themes. Stories recount the particular events of a person's life as well as the narrative form in which the story is shared.

Structural Approaches to Narrative

Narrative analysts may utilize a number of different structural approaches. There must be a congruency or a fit between the selected approach and the type of narratives to be analyzed. (Beck, 2006; Riessman, 2008). The following section will briefly consider a variety of structural approaches to narrative analysis.

Gee's (1991) narrative structure focused on the oral presentation of the narrative considering pitch, tone, silence and other linguistic intonations. Gee partitioned particular sections of the narrative text into hierarchical meaning units called: lines, stanzas and strophes. Lines constitute stanzas, the foundation of the narrative. Stanzas are typically coupled into strophes. These strophes comprise the entire story. Narrative analysts utilizing Gee's methodology must attend to the auditory component of the narrative. Analysts utilize poetic structures to hear the meaning of the story. For Gee, the focus on the narrative was how the story was told.

Labov and Waletzky (1967) proposed a practical structural approach to narrative analysis, which focused on the speech and clauses within the narrative. They purported that a "fully formed narrative" encompassed the following constituents: an abstract (synopsis of story), orientation (when, where, particulars, individuals involved), complicating action (order of proceedings), evaluation (meaning of action, viewpoint of the narrator), resolution (final outcome) and coda (outlook reverted to the present).

Regarding Labov's and Waletzky's structural categories, Riessman (1993) concluded, "with these structures, a teller constructs a story from a primary experience and interprets the significance of events in clauses and embedded evaluation" (p. 19).

Burke's (1969) structural approach to narrative analysis, pentadic dramatism, identified five central components of a story: "act, scene, agent, agency and purpose" (p. xi). The act illustrates the significant happenings. The scene describes the orientation and location in which the action took place. The agent indicates the significant person (or people) performing the action. The agency points to how the action was carried out. The purpose explains the rationale for carrying out the action. Ratios between pairs of each of the five central components are considered and, imbalances are analyzed. The dramatistic pentad provides narrative analysts with a straightforward method of understanding human behavior and the motivation behind that behavior. Burke's method is particularly suited to dramatic events.

All structural approaches to narrative analysis are concerned with the content of the story "but in thematic analysis, content is the exclusive focus" (Riessman, 2008, p. 53). Other structural approaches focus upon how a story was told or for what purpose. Riessman's (2008) thematic analysis is solely concerned with what is being said. This particular study employed Riessman's (2008) thematic analysis approach.

Riessman's (2008) narrative analysis utilizing the structural approach, thematic analysis was the most fitting method for this particular study. "Stories can mobilize others into action for progressive social change" (Riessman, 2008, p. 9). Significant social and political resistance movements began as gay and lesbian people shared their stories of their lives including discrimination and oppression they faced. Shared meaning

in these stories created a sense of community and generated social action. As gay and lesbian activists shared their stories, societal acceptance has grown and discrimination has been challenged (Poletta, 2006). The content of the stories of postpartum experiences of nonbirth lesbian mothers was significant. An understanding of these intact stories can increase social understanding and mobilize action and positive changes in the lives of lesbian families. In order to fully understand the experiences of nonbirth mothers, it was essential to preserve their stories. Riessman's (2008) structural approach, thematic analysis, was the most fitting method to preserve the postpartum stories of nonbirth lesbian mothers.

Sample

The sample consisted of 10 nonbirth lesbian mothers. The inclusion criteria were as follows: all participants must be in committed partnerships with the birth mother of their child/children, must be English speaking and at least 18 years old. There was no limit regarding the number of years since the participant's postpartum experience. All cultural and ethnic groups were eligible to participate. There were no other exclusion criteria for participants.

A purposive sample was used in this study. Polit and Beck (2012) described a purposive sample as "a nonprobility sampling method in which the researcher selects participants based on personal judgment about which ones will be most informative" (p. 739). Participants contacted the researcher in response to an advertisement for the study. The researcher determined that the participants met the criteria for the study through a brief telephone screening interview.

For the purpose of this study, the postpartum period was defined from birth up until the first year. Although the typical postpartum period is characterized as the first 6 weeks beyond birth, most mothers take much longer to fully embrace the maternal role (Mercer, 1985). Mercer declared that many mothers struggle with maternal identity issues well into their first year of motherhood. This researcher considered postpartum experiences of nonbiological lesbian mothers within their first year of motherhood.

Procedure

Protection of Research Participants

Approval was obtained from the university's Institutional Review Board (IRB). Informed consent was obtained prior to the interview (see appendix).

There was minimal risk to the human subjects who participated in this research study. Participants were asked to spend approximately one hour being interviewed. There was a risk that the sensitive nature of this study might have caused participants to become emotional or anxious. Although some participants did become emotional during the interviews, they all wished to complete the interview. They were offered a break or to reschedule the interview but they all chose to continue telling their stories. Participants were also asked to review a summary of the results of the study to validate the results of the study (after all interviews were completed). Participants were able to voluntarily withdraw from the study at any time. There were no particular personal benefits to participants in this research study.

Data Collection

Participants were recruited through an advertisement in a lesbian magazine and flyers posted at women's health settings. The researcher's professional colleagues also

distributed announcement flyers. Potential participants responded to the research announcement flyer by calling or e-mailing the researcher. After obtaining informed consent, interviews were audio taped and transcribed by the researcher. Each participant was asked to respond to the statement, "Please tell me the story of your postpartum experience beginning with your baby's birth and continuing up until your baby's first birthday (or up until today if your baby is less than a year old). Please include as much detail as you can remember as well as anything you wish to share".

Eight participants were interviewed privately over the telephone. They were located privately in their homes or professional offices during the interviews. Two participants were interviewed in their homes. These interviews took place privately in quiet rooms in each woman's home. All interviews were scheduled at times which were convenient to the participants.

Data Analysis

Each interview was interpreted as a whole using Riessman's (1993; 2008) method of thematic narrative analysis. The stories were not fragmented and each was protected as a whole. The researcher analyzed each interview separately. The events within each interview were organized into relevant events within the context of the research topic. This process was completed individually for each of the 10 interviews. Themes were analyzed individually within each story. Although the stories did remain intact, it was necessary to identify boundaries within each story to capture themes. After each of the 10 interviews was analyzed, all of the interviews were collectively analyzed to identify common themes. Distinct cases were then selected to portray broad patterns. Throughout the analysis process, the researcher remained focused on the content of the stories rather

than how or why the stories were told. Riessman (2008) described language as a "resource rather than a topic of inquiry" (p. 59).

Riessman (1993) represented five levels of experience in the research process for narrative analysts. The levels include the following:

1. Attending: the participant creates personal meaning by actively thinking about reality in new ways. The participant reflects and remembers his (or her) experiences. They compose their own realities.

2. Telling: the participant "re-presents" the events of an experience. The participant shares the event by recounting characters, significant events and his (or her) interpretation of the experience. The interviewer takes part in the narrative by listening to the story and asking questions (to clarify/further understand the story). As the participant tells his (or her) story, he (or she) is also creating his (or her) vision of himself (or herself).

3. Transcribing: the participant's story is typically captured through video or audio recording. The analyst then creates a written narrative text representing the conversation.

4. Analyzing: the researcher analyzes each individual transcript. Similarities are noted and a "metastory" is created by defining critical moments within narratives and making meaning out of each story. The analyst also makes decisions about form, order and style of presentation of the narratives.

5. Reading: the final level of experience in the research process is reading. Drafts are commonly shared with colleagues and advisors. The researcher frequently incorporates this editorial feedback into his or her final report. The final report is the

researcher's interpretation of the narrative. Riessman (1993) concludes, "all the reader has is the analyst's representation" (p. 14).

Methods to Ensure Research Rigor

The use of the term, validity, has been widely debated by qualitative researchers. Some qualitative researchers embrace the concept of validity while others disassociate themselves from it because of its positivistic connotations (Polit & Beck, 2012). Riessman (2008) examined validity in narrative research citing two levels of validity: "the story told by a research participant and the validity of the analysis, or the story told by the researcher" (p. 184). Riessman further concluded that rigid standards established for experimental research are not appropriate for evaluating narrative studies.

Riessman advocates for the concept of trustworthiness as the manifestation of validity in narrative research. The following sections will present the four facets of trustworthiness: persuasiveness, correspondence, coherence and pragmatic use (Riessman, 1993). The discussion will be enhanced by Riessman's (2008) more recent methodological discussion attending to the political and ethical aspects of trustworthiness.

Persuasiveness

Riessman (1993) characterized persuasiveness as the "cousin [of] plausibility" (p. 65). "Persuasiveness is strengthened when the investigator's theoretical claims are supported with evidence from informants' accounts, negative cases are included, and alternative interpretations considered" (Riessman, 2008, p. 191). The researcher begins with his (or her) own theoretical perspectives and then analyzes these perspectives with diverse cases. This precise analytical process generates believability of the stories and the

subsequent analysis. Riessman combined the importance of the presentation of the research with persuasiveness. Narrative analysts must select the most fitting form to reveal their findings. Riessman (2008) asked the question, "Does a story move us or get us to think differently about a phenomenon?" (p. 191). The analyst's ability to portray the story and engage the reader is a major factor in the success (or failure) of the research.

Participants in this study shared persuasive stories, which were congruent with the researcher's theoretical claims. The researcher's knowledge of the population being studied, lesbian mothers, is based upon her professional experience as well as a comprehensive grasp of the literature. The researcher continued to recruit participants and conduct interviews until a variety of cases were included. This allowed for alternative stories to be considered within this study. Diverse cases were included in this study, which ultimately yielded persuasiveness.

Correspondence

Riessman (1993) encouraged researchers to share their findings with participants. Lincoln and Guba (1985) referred to this process as member checks. Lincoln and Guba (1985) concluded that research credibility is more likely if participants concur with the researcher's interpretation of their story. Polit and Beck (2012) defined credibility as "confidence in the truth of the data" (p. 724). Riessman (1993) cautioned narrative analysts that the validity of member checks might be uncertain. She also warned researchers that it is difficult for individual participants to gauge theorizing across multiple cases. Riessman (1993) concluded that the work belongs to the researcher and, he or she is ultimately responsible for its truth.

Riessman's (2008) more recent work combined historical truth with correspondence as a facet of validity. The historical truth represents the factuality of the narrative. Riessman (2008) revealed "for certain projects situated in realist epistemologies, factual truth is important. Historians, for example, may ask whether a particular story is consistent with other evidence" (p. 186). Riessman contrasted narratives based on realist epistemologies with those based on social constructivist perspectives. She concluded that the historical truth is not as relevant in the later. For these types of narratives the participant's point of view is considerable. Understanding the meaning of the story is significantly more important than the reporting of factual events.

Correspondence was employed by returning to the participants to validate their stories. Participants were contacted by e-mail and requested to review a summary of the results. The researcher cautioned the participants that e-mail is not a secure method of communication and therefore the results were mailed traditionally to protect their privacy. Three participants responded to the researcher's request and validated the results of the study over the telephone. They concurred that the results do indeed reflect their postpartum experiences as nonbirth lesbian mothers. Correspondence was obtained through these member checks.

Participates presented their stories within the context of historical truth. Several of them spoke about their experiences as nonbirth lesbian mothers from the perspective of the current historical time. They referenced the rights they have (or do not have) based on social and legal policies. This historical truth was represented in every interview.

Coherence

Agar and Hobbs (1982) proposed three types of coherence: global, local and thermal. Global coherence refers to the narrator's purpose in telling the story. Local coherence is what the overall impression the narrator is trying to bring forth in the narrative. This may happen though the selection of particular language to portray the events of a situation. Thermal coherence encompasses the substance of the narrative. Themes are prevalent within interviews and commonalities exist. These shared themes represent thermal coherence. Riessman (2008) asserted, "coherence must be as 'thick' as possible, ideally relating to all three levels" (p. 67).

All three levels of coherence (global, local and thermal) were present in this study. Narrators told their stories with respect to their purpose of providing a better understanding to nurses about the postpartum experiences of nonbirth lesbian mothers. Participants believed that sharing their stories might generate more sensitive care to lesbian mothers. Several mothers shared that as they told their stories, they felt less discrimination and more support as mothers. These narratives provided substantial stories reflecting the lives of nonbirth lesbian mothers. All ten participants were grateful for the opportunity to tell their stories and, they all saw this as an opportunity to make the world a safer place for lesbian families.

Pragmatic Use

Riessman (1993) characterized pragmatic use as whether or not the particular study provides a basis for other investigators' future research. This aspect of Riessman's (1993) criteria for trustworthiness is future oriented. Riessman (1993) goes on to say

> We can provide information that will make it possible for others to determine the trustworthiness of our work by (a) describing how the interpretations were produced, (b) making visible what we did, (c) specifying how we accomplished successive transformations and (d) making primary data available to other researchers (p. 69).

Riesman (2008) referred to pragmatic use as "the ultimate test of validity" (p. 193). Research, which meets this criterion, is able to further the state of the science in a particular scholarly area.

This study is pragmatically useful to researchers. As presented in the review of the literature, few studies exist on nonbirth lesbian mothers. This study provides robust stories. These narratives serve as a solid foundation for future research. It would be feasible to conduct a variety of studies on nonbirth lesbian mothers and their families utilizing subsequent qualitative methodologies. Some of these might include: focus groups, phenomenology, case study and others. Researchers might also conduct quantitative studies such as an instrument development study based on the qualitative studies. This study is pragmatically useful to researchers.

Political and Ethical Use

Riessman's (2008) contemporary publication adds social justice as a facet of trustworthiness. She posited, "does a narrative inquiry contribute to social change?" (p. 196). "Stories can mobilize others into action for progressive social change" (Riessman, 2008, p. 7). She referred to the civil rights struggles of gay and lesbian people in the twentieth century. As gay and lesbian people shared their personal stories, social acceptance of them grew. This ultimately contributed to legislation and legal protection

of gay and lesbian families such as legal marriage, cohabitation policies, adoption and other supportive social policies (Poletta, 2006).

The political and ethical use of these stories is the most significant aspect of this study. The stories of nonbirth lesbian mothers can indeed contribute positively to social change. The possibility of positive social change was a major motivation for the participants to share their stories. By sharing their experiences, these nonbirth lesbian mothers imagined a better life for themselves and their families. They felt that their stories could help others to understand their lives and to ultimately increase societal acceptance of lesbian families.

Riessman (2008) urged researchers to consider the facets of validity that are relevant to narrative analysis. She portrayed validity as trustworthiness. In summarizing the facets of validity, she goes on to say, "They are not the only ways to look at the many-sided issue of validation and, like the facets of a cut gem, angles converge at points. Each looks at the validity question from a different perspective" (p. 185). Riessman (2008) expanded on her initial work by professing that narratives are partial or situated truths. Narrative analysts must construct concise lines of reasoning to persuade their readers regarding the trustworthiness of their data and their interpretation. They must present a transparent and sound methodological approach, which is grounded in ethics and theory. Sound methodology ultimately brings forth trustworthiness in scholarly research.

Summary

The method of research utilized in this study was narrative analysis. The study sample consisted of 10 nonbirth lesbian mothers. These mothers were interviewed and,

the researcher transcribed their interviews. Riessman's (2008) approach to thematic analysis was utilized as the structural approach. The protection of research participants was presented. The chapter concludes with a discussion of research rigor utilizing Riessman's criteria for trustworthiness (1993; 2008). The next chapter presents the results of the narrative analysis.

Chapter Four: Results

Introduction

Chapter four begins with a brief overview of the research participants along with the analysis of the interviews of the postpartum experiences of nonbirth lesbian mothers. The individual narratives are presented followed by a list of themes, which were derived from each participant's story. The metastory of the postpartum experiences of nonbirth lesbian mothers is then depicted. The six overarching themes are represented as well as the subthemes of each of these overarching themes. Participants' stories are protected as whole narratives through the metastory. Riessman (1993) cautioned narrative analysts against fracturing participants' stories. She advises researchers to [work] with a single interview at a time, isolating and ordering relevant episodes into chronological biographical account" (p. 57). The stories are portrayed intact as holistic individual accounts.

Research Participants

Ten nonbirth lesbian mothers took part in this research study. Their ages ranged from 30 to 61 years old. Nine of them were Caucasian and, one was African American. These ten women lived in eight different states in America. Two of them had previously given birth to children in addition to being nonbiological mothers. The ages of their children ranged from 20 months through 14 years old. Six of the participants have one child and, two of them are expecting their second baby. Three of them have two children and, one has nine children (including an adult child from a previous relationship). Five of these nonbirth mothers were able to legally adopt their children through second parent adoptions in their home states. Three of the participants were legally married in their

home states and, two were married in other states. Two participants were civilly united in their home states. Two participants are partnered with no legal relationship status. The participants have been in relationships with their current partners from ten to twenty-five years.

Narrative one: Daniella

Becoming a mother was never a consideration for Daniella. She exclaimed, "children were never on the radar for me and I just thought that was the way it was going to be". She and her partner, Norah, had been together for six years. Daniella was fulfilled in every aspect of their lives. Although they had a good relationship, their own home and satisfying careers, Norah ached to have a family and issued an ultimatum to her partner. Daniella recounted a conversation with Norah: "Norah basically said to me, 'this is what I want (to be a parent) and if you can't join me in this, I don't know if we can continue our relationship, this is something that I need'".

Daniella remembered the day of her daughter's birth as "a whirlwind and very strange". She recalled standing outside of the nursery with a group of fathers. All of these new parents stood outside of the window admiring their newborns. Daniella depicted feeling left out and not knowing her place.

> I was standing there along with two other gentlemen who also had new babies born that day. They were very congratulatory to one another but wondering why I was there. Obviously I had not given birth so it was like they were just a little confused. You know you want to be part of that, for lack of a better word, fraternity, you know the whole pat on the back, 'Hey congratulations, you kid is beautiful' and that was difficult for me. Of course I had my own family and a

> million well-wishers and that stuff but I became hyper aware of my role or actually my lack of one. That's where I was at that moment…

Nurses and other health care providers were perceived as caring by Daniella. She did, however, refer to one particular disturbing interaction with a postpartum nurse. Daniella shared:

> The nurse came in to get the information for the birth certificate. I actually felt a little bad for her. She said, "look, I don't want to ask these questions but I have to and I know it's not right but I need to see your civil union paperwork in order for your name to be on the birth certificate. I responded that if I were Norah's husband I would not be asked for my marriage license. This is unacceptable. The nurse agreed but I still needed to show our civil union license. That was the moment that we were reminded that we are not equal. The nurse also confirmed that heterosexual couples are not asked for any proof of marriage.

Daniella recalled her experience of early motherhood as a journey rather than immediately embracing parenthood. She recollected:

> For me it was a soul-searching journey. I was reluctant to become a mother but let me say that she is here and I would not trade her for the whole world. I love her more than life itself. I would have it no other way.

She reflected upon her daughter's infancy and how her partner supported her process of becoming a mother.

> The first couple of days and weeks I think I went through a postpartum more than Norah did. Because you know I had that my life is over feeling. And Norah has been so wonderful and supportive to me, never made me feel like bad about

> anything I was feeling and I knew that I could tell her anything I was feeling. She was always so reassuring. As time went on and the baby started to give back a little, it started to swing to the other side. We really did not bond until probably she was three months old and then it really started to click, I started to recognize her as my own.

Daniella legally adopted her baby in order to protect her rights as parent. She concluded that it cost over $10,000 between legal charges, adoption fees and a home study. Her family was already in debt over fertility treatments. In addition to this being a financial burden, the financial stress was also a burden on Norah and Daniella's relationship.

Names were symbolically important to Daniella as a mother. Norah wanted the entire family to have Daniella's last name. Since Norah was the mother carrying the baby, she chose to honor Daniella and her family by choosing her last name as their family name. Maternal titles were also significant for this family. Daniella pronounced,

> Norah is Mommy and I am Mama. That's what we each called our moms growing up. Our family and friends are very good about that distinction and keeping that clear. When people (like out in the public) refer to Norah and I as the wrong names (like they call me Mommy) we correct them. It's an innocent mistake but it's important to correct them. It's important that we are called by our correct names because that means that we are both recognized.

Daniella portrays her life since becoming a mother as "the new normal".

Everything in her life relates to her daughter and their family. She concludes that she has new priorities and a real sense of family now. She speaks endearingly about her daughter,

> We are all completely changed by this little baby. Not just Norah and our entire extended family but I. Things were so much easier a year and a half ago (before the baby) but I have a greater sense of family now. The baby comes first. I have a better sense of what's truly important. That's my new normal. It's been a complete 180 for me. It has really worked out. I love my daughter with every fiber of my being!

The nine narrative themes for Daniella included:

1. Children were never on my radar: Conceded to my partner's ultimatum
2. Didn't know my place
3. Postpartum nurse reminded me that we are not equal
4. Gradual bonding
5. Went through a postpartum [depression] more than my partner
6. Legally adopted to protect my rights
7. Chose my last name for our family
8. Chose the maternal names which we called our own mothers
9. The new normal

Narrative two: Katherine

Katherine has no legal rights to her children since she lives in a state where same sex couples are not granted the rights to second parent adoption nor any legal recognition

of the couple's relationship. She approached both of her children's births with a great deal of anticipation and anxiety. She shared,

> In our state at the time of both of the births of my children, I was nervous about the hospital and the doctor's visits and was completely overwhelmed by how positive the experiences were and so I was like, maybe this won't be so bad in a conservative state like ours after all. But it was pretty stressful, anticipating what might be.

Katherine was overjoyed and relieved by the positive birth experiences with both of her children in the hospital. She was present for both deliveries and treated as an equal parent by all health care providers.

During the birth of her first child she was especially anxious because the wife of one of her troopers worked as a nurse in the Neonatal Intensive care Unit (NICU) in the hospital where her daughter was born. She described the state police organization as very conservative. Katherine held an administrative position in the state police department. She was worried about breach of hospital confidentiality and feared losing her job because of her relationship. Her colleagues were not aware that she was a lesbian and that she and her partner were expecting a baby together.

Katherine was terrified,

> I just had a panic about what is this confidentiality here in the medical profession and I worried, would she go back and tell her husband and what's her husband gonna say to the rest of the force and nothing came of it until another trooper started inquiring about what my status was with this woman who had a child. So you know, that was a huge concern to me.

Aside from the aforementioned experience in the NICU, Katherine described her hospital experience as fabulous. She appreciated the NICU nurses making her feel like a mother. One particular example was a NICU nurse identifying both, Katherine and her partner, as the baby's parents on her crib identification card. Despite her lack of legal parentage the nurses respected Katherine as much as any other new mother.

Katherine attempted to legally protect her family by drawing up co-guardianship forms that were signed by a judge. She submitted this document to her job to obtain health insurance for her family. She was notified that the benefits would not be approved since her family did not meet the state's definition of a family. Fortunately her administrator overruled this decision and demanded the approval of these family benefits. Katherine shared that typically her state does everything possible to fight against the rights of gay families.

Katherine and her partner, Hannah, were both treated as equal mothers by their children's pediatric care providers. She remarked, "In such a conservative state, knowing that your children will have two moms, I was nervous about the doctor's visits." The pediatrician asked for a copy of the co-guardianship agreement to keep in the children's charts so that it would be clear to all medical staff that both women were parents. Katherine was grateful for this and felt more confident about bringing her children to health care appointments. Katherine did, however, admit, "I still worry about this. There was no problem but I still worry."

Names were symbolically important to Katherine and Hannah to recognize both mothers. The children were given both mothers' last names and, the mothers chose to

hyphenate their last names jointly. Katherine and Hannah decided that Katherine would be called “Mom” and that Hannah would be called “Mommy”.

Katherine recognized how fortunate she is to have the support of her family and her partner’s family. Both families have embraced Katherine as a mother and are extremely supportive of the children. They were very supportive during the children’s infancy. She recalled her daughter’s baptism where Hannah’s father lovingly expressed, “You all are so fortunate to have such a wonderful family and I am so proud.” Katherine described family traditions as “part of the glue of my family accepting our relationship and children and family”.

Katherine has never felt any different than Hannah as a mother. She feels equal in every way. Hannah did breastfeed the children and, she pumped to allow Katherine to bottle-feed the babies. She sees their roles as different but that is based on their personalities. She feels that she is more serious and can be counted on in emergencies while Hannah is more laid back and fun loving with a great sense of humor. Katherine worries about answering her children’s questions in the future about herself as a non-biological mother. She asserts that she will answer questions as they arise in an age-appropriate manner. She concluded her interview by saying, “Being a family, having kids has just made life so much more enjoyable. We are so blessed and it’s very fulfilling to have them in our lives!”

The nine narrative themes for Katherine included:

1. No legal rights
2. Relief over positive hospital experience: Birth, postpartum and NICU
3. Panic over breach of confidentiality from NICU nurse

4. Legal co-guardianship agreement to protect my family
5. I still worry when dealing healthcare
6. Equal mothers in every way
7. Breastfeeding combined with bottle feeding to allow both mothers to feed baby
8. Children given both mothers' last names
9. Maternal titles chosen for each mother

Narrative three: Amelia

Although Amelia never imagined herself as a mother, she immediately felt like a parent as soon as her son was born. She reflected upon his birth:

> I never wanted to have kids, to birth them, to raise them. I did not even like them. I never saw myself as a mother so this has all been a big change for me. Now I feel like I am just as motherly as Susan. I know that I felt the same bonding, connection and source of wonderment that Susan felt. When he was born and lying on the table, I was hyperventilating. I could not even believe it. I was in total shock as much as any biological parent. So amazing.

Amelia praised the obstetricians and nurses for their supportive care during labor and birth. The doctor was careful to include Amelia in the birthing process as an equal parent. Labor and delivery nurses also affirmed her as a mother. She described a nurse encouraging her to cut the baby's umbilical cord and taking pictures of her with her newborn son. Amelia fondly remembered this particular nurse

> She was really wonderful and then when she was weighing him and all that

> she explained everything she was doing to me. She said, 'Oh this is so exciting and this is a new step in your life'. She was really, really great! I definitely felt very much a part of it!

Amelia's experience with postpartum nurses was poor in comparison to the labor and delivery nursing care. She felt that these nurses ignored her as a parent. Amelia reflected on her postpartum experience in the hospital

> They did not acknowledge me at all. They would come in to check on the baby or to tell us about something or to check on Susan but they never looked at me. It was like I was not there. Basically before we went to the hospital, we just talked about this and we said, 'these few days we spend in the hospital are not the most important part and it does not matter how they treat us. I am still the mom'.

Amelia did not recollect any particular stories about postpartum nurses. She described an overall cold atmosphere. Her perception was that she was not recognized as a mother.

The pediatrician's office was another place where Amelia did not feel recognized as a mother. She explained

> I think my son's pediatrician is very religious and, I think it's a little weird for her. She would often say things like, even though Susan and I were both there, she would say things like, for instance, we were trying to get him to sleep in his own bed when he was about 9 or 10 months. She'd say things like, 'Well, after he is done sleeping with mom and dad he will…' She could have said sleeping with you or his parents or whatever. That has happened a couple of times. It's kind of weird.

Amelia lamented over a visit to the hospital emergency department (ED) with her baby. Both Susan and Amelia brought their son into the hospital because he had an elevated temperature. Amelia recalled visiting the ED of a small community hospital in a rural location.

> He was really, really sick and his fever was like 106 so we took him to the ER. It's a really small rural community. We went there against our better judgment. But the doctor asked 'which one of you is the mom?' and we said 'both are' and he said 'NO, which one of you gave birth to him?' And Susan said, 'I did'. Then he asked 'do you know who the father is?' And he was insistent. This didn't seem like it had anything to do with the fact that my son had a fever and had croup. It was awkward. There were all these nurses listening. It felt weird and ugly. I did not like that. This made me mad.

Amelia expressed concern that she might not be able to bond with her baby since she did not give birth to him. She was pleasantly surprised that she felt as bonded to her son as Susan did. Susan remained very sensitive to Amelia's feelings. As a couple they read about ways to help Amelia bond with the baby as the nonbirth mother. Amelia reminisced about trying to bond with her infant

> Susan breastfed the baby and that was another thing that had me worried about the bonding. It made me think that he was more bonded to her. But something that I did was that I spent a lot of time with my shirt off and held the baby skin to skin against my chest. We tried to read about stuff that would help and that's one thing I read about.

Names were important to Amelia and Susan. Their son was given Amelia's last name in order legitimize her role as a parent. Although Amelia is not his legal parent, he has her last name. Amelia and Susan live in a state where there is no legal sanctioning of their relationship nor is second parent adoption an option. Naming their son by Amelia's family name has simplified the process of taking him to medical appointments and gives the impression that she is his legal mother. Amelia deduced, "He has my last name so it is not questioned that I am his mother. I think it's helped a lot especially when I take him to the doctors."

Amelia and Susan carefully considered what name their son would call each of them by. He refers to Amelia as "Mommy" and Susan as "Mama". Amelia proclaimed,

> That was intentional. 'Mommy' is a little more traditional in our society than 'Mama'. I think it helps people accept me especially in public, hearing that. 'Mama' might be questioned since that's not the typical name for a mother. 'Mama' might be a friend, grandmother or aunt but 'Mommy' helps others to see that I am the mother.

The nine themes for Amelia included:

1. I never wanted kids,
2. Embraced as a parent by labor/delivery staff,
3. Ignored by postpartum nurses,
4. Not recognized as a parent by pediatrician,
5. Discriminatory care from physician in ED,
6. Fear of not bonding with baby,
7. Partner breastfed combined with my skin-to-skin contact,

8. We took my last name as a family name
9. Maternal titles carefully chosen

Narrative four: Sarah

Sarah's story is unique since she is both, a nonbirth mother and a birth mother. She and her wife have a son and a daughter; each gave birth to one of their children.

Sarah has come to understand that bonding with her non-biological daughter was difficult. She considers several reasons including her prematurity, autism and the challenge of caring for her older son while the newborn remained in the NICU. Sarah did not have difficulty bonding with her biological son. She did ultimately bond with her daughter but this took a very long time. Sarah admits

> There were a lot of bonding issues with her that I did not have with my biological son. And so Nicole and I have spent a lot of time talking about why it's different. Is it because she was in the hospital for a month? Is it because Nicole was nursing so I was almost like single parenting our son (our older child, my biological child) and she felt almost like she was single parenting the baby but I can say that it took me a long time to really bond with her. With my daughter, she was in an incubator and she was two and a half pounds and I didn't know if she was going to make it and Nicole was really, really sick so it was surreal. I don't even know if I came out of that for a really long time even when she came home at three pounds, fourteen ounces. And even then I was really even afraid to hold her. Um so the whole first year I really struggled with just feeling connected to her like I did not know she was my daughter (but of course I did theoretically and intellectually she was just as important as my son, I knew all that.) Because they were so sick and

needed extra care I wanted to make sure that our son did not feel neglected or left out so I gave him lots of extra attention so then I felt guilty that I did not give the baby enough um but there… I no longer think that it does not matter.

Through her tears, Sarah painfully recounted her daughter's premature birth by emergency cesarean delivery.

I remember not being able to get to Nicole and then I remember the discrimination, me not being able to get to her and that really pissed me off. I had to bully my way into the hospital. I did not know if it was about being gay or about her being black or if it was because we did not have the proper records with us and they could not find her in the system and they would not let me back in the emergency room to look because I understand because if confidentiality the ambulance could not tell me. And then I'm like, she's a black woman, because I did not know if they were looking for somebody white. But it was 45 minutes and then somebody else um came out and I just asked the same questions. I told them that I am looking for my wife who was dropped off… She looks in the system and [immediately] there she is. So I was like, what the hell was it? Why was I discriminated against, ignored etc.? She was out of it when the ambulance took her in. The medical team is in the corner, near the door huddled talking about whose life they need to save first because both of them are in distress. I will never forget that. I'm like, I could lose them both (teary). It was nuts. And then they decided… Nicole's blood pressure was 300 over something and the baby's heart rate started going crazy. They took her in for a (cesarean) section. They let me come in (which of course they are supposed to do anyway) but after bullying my

> way into the ER um I was not sure. Nicole threw up on my feet and at that point I could see the humor in it. She was awake, she had an epidural. And then they wheel out this little thing that looks like a chicken, she was so tiny. She was so small. I did not now how small two and a half pound was. I think I was afraid to get attached to her because anything could happen…

One particular labor and delivery nurse provided comfort and reassurance to Sarah. She characterized her as "Pretty awesome. She would spend time, she at least three or four times looked over at me and asked if I was okay. During the birth, this nurse was the only one I had contact with."

Sarah's daughter remained in the NICU for a month. She renders the NICU nursing staff as amazing and incredible. Her daughter received excellent care and both mothers were treated with respect. She concluded her recollection of the NICU experience by saying, "In the NICU, I felt recognized as an equal mother."

Sarah and Nicole intentionally changed their names to create a new family name by combining a portion of each of their last names. Their children share this last name, which symbolizes their family unity. Sarah is Mommy and, Nicole is Mama to their children. For Sarah, names validate her identity as a mother and are symbolic of her family. She clarified the significance of names in her family; "I think we did this [chose these names] to make a statement to everyone else that they could not see us a separate."

Although Sarah and Nicole are legally married in their home state, Sarah was legally advised to do a second parent adoption. She was encouraged to complete this process since her marriage is only legally recognized in a few additional states.

> I did a co-parent adoption and that was pretty humiliating going through a process which the state agency for child protective services has to recognize but you have to pay for it and then go in front of a judge to ask to be the parent of the child you are already parenting and planning for before they were even conceived um. The judge did not challenge it but we still had to shell out over $2000 and we had a cheaper person and having a baby in the NICU wiped out our savings. I cannot even imagine less fortunate families doing this. This is a financial hardship….

Despite the financial burden of the adoption, Sarah chose to adopt her daughter to try to protect her family.

> In summing up her first year of non-biological motherhood, Sarah resolved, There's nothing to prepare you to be a non-bio parent. There's a ton written for pregnant moms, classes, books etc. But there's nothing for a non-bio mom. We have to work harder. Non-bio parents have to work harder and I think that that's true. It's not that you cannot compensate for it. But just to know that it's gonna feel hard. Don't be ashamed of it, keep trying, know that it gets better; maybe you are focusing on the first year because that's the time that it matters. Not because there is anything special you have to do that year but to be patient with yourself. Maybe there needs to be a book for those moms. Maybe the nurses in the Maternity ward should educate these moms and say 'A lot of parents who are not biological parents feel that it's harder for them to bond, that it can take some time. It can take up to a year so don't blame yourselves, don't blame each other. Just be patient.' That would have made a big difference for us. We just did not know and so we wondered if it was about us or about our kids, or about Autism or about

being sick or about this or that. A lot of it is fear. Sometimes I think nurses were just afraid to ask questions so that they would understand our family, our specific needs.

The seven narrative themes for Sarah included:

1. Difficulty bonding
2. Discriminatory care: Bullying my way in
3. Inclusive labor/delivery nurse
4. Recognized as an equal mother by NICU nurses
5. Combined last names to symbolize family unity
6. Adoption worth the cost
7. We have to work harder as nonbirth mothers

Narrative five: Lilah

Lilah has a biological child of her own from a previous (heterosexual) marriage. She is the nonbirth mother to a son. In addition to this son, she and her partner, Gina, have five adopted children. Gina gave birth to their son since Lilah is fifteen years older.

Lilah compared her experiences of being a biological mother with being a non-biological mother. She felt that it was very different being a nonbirth lesbian mother. She asserted, “It was very different not necessarily being recognized as a mother because I had not gone through pregnancy and birth.” She also spoke of not being recognized as a mother by her own family since they did not approve of her being in a lesbian relationship.

Lilah captured her experience of her son's birth as very positive and inclusive of her as a parent. She appreciated being able to take an active role in the birth and being involved in decision making. She elaborated her thoughts about birth

> I have given birth and raised the kids I gave birth to. I have raised children that I did not give birth to. Giving birth is a great experience but it is not the major part of motherhood. It's important, I see that it's more a process of days and months and years of supporting and interacting and learning this new little person it's a much more complicated process. The actual "who gave birth" fades, diminishes over time. The nurturing is most important. Birth is not the be all and end all like some psychologists would have you think.

Lilah reflected on the importance of maternal bonding in the first year. She shared her experience of bonding with her nonbirth son

> I think there is a certain biological tie that you have. I remember how fiercely attached I felt to my birth children. And when they were really little. I don't think I felt that quite that much with him (my nonbirth son) but I love him just as much now. Bonding with my son… Well I think it grew naturally. I did not do anything to make it happen. We took lots of pictures of him! It was fun to discover the world again through him.

Lilah did feel some jealously toward Gina and the way the baby bonded to her initially

> I think I had some jealousy; it was a little hard, that this little guy came between us. Talking a little bit about the jealousy I felt… He was really attached to her (Gina) because she was nursing. He did not prefer her when he was not nursing. He did bond with me too. But she was less available to me before he was born.

> It's hard to be jealous of a little baby. But I think it is very similar to what fathers go through when mothers give birth.

Although Lilah and Gina are legally married in their state, they were not married when their son was born. Lilah completed a second parent adoption soon after her son's birth. She shared,

> To protect myself as the mother legally, we did a second parent adoption. We paid a lawyer and we did that. It is kind of scary because we did this in our own county which is somewhat more conservative but our lawyer said that 'I don't know if this judge has made any decisions before but we'll just take our chances and he was a republican appointee'. But he was fine and he signed it off. It was a weird process because Gina had to meet with a social worker who came to our house who was supposed to evaluate us and discourage her from giving up her parental rights because she had to give up her parental rights and then get them back in order for me to do the second parent adoption. We had to have a home study (not a complicated one) but we had to have something it was not always granted and we had to spend a couple thousand dollars.

Lilah and Gina changed their family name to both of their last names hyphenated soon after their son's birth. They also strategically decided that their son would call them Mommy and Mama to recognize Lilah as an equal mother. Names were important to Lilah in order to validate her maternal identity.

The seven narrative themes for Lilah included:

1. Being a nonbirth mother is very different than being a birth mother
2. Positive hospital birth experience

3. Bonding grew naturally over the first year
4. Nursing caused jealousy
5. Legally adopted to protect parental rights
6. Hyphenated both names to create a family name
7. Maternal titles to validate both mothers

Narrative six: Della

Della recognized a real difference between being a biological mother and being a non-biological mother. She based this difference on gender identification. She did not relate to the mother role. She has heard other lesbians say that there is no difference between each mother but for her there is a very real difference. She did not feel comfortable with a maternal title. She went on to say

> She's very much "Mommy" [my partner] and I am not. That just fits for her. I actually struggled with that as like a gender not gender but as a butch thing. I identify more as an androgynous lesbian. I struggled with that piece. I was talking with my six-year-old[step] child who calls me by my first name. We were ready for a name [for the baby to call me] and I don't want to be "Mamma". I just don't want to do that. We came up with "Poppy-Mom". That was our word for sort of the first year and a half. What was interesting was that it was more of a gender thing than a non-bio thing.

Creating the title of "Poppy-Mom" helped Della embrace her role as a parent rather than as a mother. She loves her children as much as her partner does, however, she does not feel affinity for the maternal role.

Della compared her relationship with her partner to a mother and a father. She described her partner, Talya, as being one unit with their twins. Della viewed her role as to support this unit. She specifically referred to the breastfeeding relationship. In order for Talya to be completely focused on breastfeeding the twins, Della took care of every other aspect of their home and family. She bathed, diapered and held the children. She would get up with them during the night. Della went on to say "there was nothing I could give them except to support the unit, to support breastfeeding".

Della spoke of the ease of bonding with her twins, "Because I did not carry them and get sick for nine months, I also felt like I had the energy to devote to bonding with them and it made it really natural to be there all night long". These twins were planned for and wanted by Della and Talya. Della further shared,

> The twins felt safe with me. The second they were born I wanted them to know what it means to feel that security especially because there's two. I held them both at them the same time when they were born against my chest.

For Della, bonding with her babies was a seamless process, which immediately began during their birth.

Della voiced her insecurities as a nonbirth lesbian mother. She felt that these insecurities helped her to grow as a parent. She reflected

> I have more insecurities and each time I am grappling with them, I am growing as a parent. There are lots of insecurities for parents in general but that's part of being a lesbian family. It's as intentional as it is to become a family. I think when we're really thoughtful about it; the non-bio parent is vulnerable to more insecurities that come for any parent but even more so for the non-bio parent.

> Talking a little more about the vulnerability as the non-bio parent… The world can take them [my children]away; she [Talya] can take them away. She wouldn't but she could and the world probably wouldn't but I have lived in a conservative state for a long time and I know that it happens. The world can take away my kids.

Della discussed the possibility of doing a second parent adoption in order to be granted parental rights to her children.

> An adoption costs $5000. Even with adoption, you know that's making it sort of this legal thing in our family and to just be honest, it's to deal with our fear that the world can take them away. If we split, they can be taken away. That's part of the legacy right now in this millennium at this moment in history of being a lesbian family. It's a lot more progressive in our state than some others but ya know you have to do adoption and if I had $5000 I would pay for my kids' private school tuition, would pay for health insurance, would pay for ya know a lot of things. I am not on the birth certificate. But we are legally married in another state (for whatever that's worth). So… We do have second parent adoption; we would have to have a home study etc., that's where the $5000 comes in. We'd have to get legal counsel. Instead of spending energy/money raising our kids, we'd have to spend it on legalizing that we are raising our kids. But not every lesbian is astute to legal issues, which you need to be, and we are not giving this our attention. We are just raising our family. But what we want to be able to say is hey, we are legally married. That means something so let me apply to adopt these kids as if I were a step-parent because that's less expensive.

> If a guy and a woman get married, he can just be a step-parent and it is not $5000 and there is no home study so does that make sense? But there is something about me that does want to spend the time, energy and money to find a lawyer to get that guidance and then I am willing to do it under step-parent and I already have been a step-parent. I know what that is. That also comes with it's own bag of vulnerability and feelings. And I don't want to say that these kids are my step kids… So instead I sit looking at my own, my own discrimination and my own feelings or whatever that brings up and just stay paralyzed. I am hoping that things we'll change nationally and… it'll be better for us… exactly.

The lack of legal recognition as a parent caused Della a great deal of anguish. Although she and her partner are legally married, this is not recognized in their home state. This marriage remains a sentimental rather than a legal union and affords Della no recognition as a spouse or as a parent.

Della stressed the significance of a family name as a way to protect her family. After she and Talya got married, they chose the middle name Talya's older son as their family last name in order to symbolize family unity. Della revealed

> So we all have the same last name. It was purposeful to change our name in regard to having kids. And that, I think, has been the best thing. If anyone were coming to me and asked what can I do as the non-bio parent to prepare for this journey ahead? I would say get lots of sleep and be really good to your wife now and get all those papers in order (which we had done like what happens to our house? All those kinds of things) those things that don't cost a million dollars and the fourth thing I would say is consider having one family name. For sure, having

> the same last name helps in dealing with the health care system/pediatricians etc. I've taken the kids to the doctor a lot of times without Talya and it just makes matters easier.

Being an advocate for her family was Della's primary role in the hospital after the birth of her twins. She recounted the postpartum nurses wanting to give the babies formula in the hospital. Exclusive breastfeeding was a priority for Della and Talya. Della recalled her experience

> They wanted to give formula in the hospital and Talya, my partner, she's a strong woman but she's exhausted, she just gave birth. You know, so I was the one who said absolutely not. You cannot give formula, it can only be nursing. I had to be the one who was a loud advocate. Whether somebody is loud or soft as a lesbian, we have more practice doing that. As lesbians we are not heard and we have to advocate for ourselves, many times. I was her voice, the protector of both, Talya and the babies in the hospital.

Della tried to safeguard the plan that she and Talya had for her family. Nursing staff sometimes ignored Della and tended to give directions only to Talya. Della felt excluded from the postpartum and newborn care in the hospital.

Della lamented over the pure exhaustion of caring for her newborns and her partner. She felt like since Talya had given birth she needed to be the one to care for their family. Della characterized her beginning weeks of parenthood

> As the non-bio mom, I was the one who had the energy to be in the world. She [Talya] really did not. She really was the one who had this cocoon and with twins it really is different. This cocoon of the three of them, an in home cocoon. So I

was the one who sort of managed the world. I remember I was so sleep deprived; the sleep deprivation is just huge. I remember being in, it's a co-op for us, like a natural food market, standing with my son in the middle of the isle that has all the vitamins and I was looking for something homeopathic to help him sleep, chamomile or something, and the natural food person who is usually there in the vitamin department was not there. And I remember just breaking down just crying and crying and being like, I don't know how to make you sleep and I need help. I didn't break down in the store but I sort of asked, "How come she is not working today?". But in the car I was just crying with him and thinking that my job was to keep him safe and I could not get him to sleep so I could not keep him safe. I was just overwhelmed with that responsibility. And then I cried for a while holding him, feeling like I just cannot do this. And then we sort of managed our way back from the store. But there was a lot of navigating the world and my kids um you know a lot of fear, because I think that's what happens with new parents is a lot of fear um. You know, he's not looking at me, he cannot sleep at night, he must have autism. Like reading everything there is to read about autism. But part of that, being in it and being vulnerable and fearful, and in the world creates an incredible bond like I will do whatever it takes to keep you safe. That's the flipside of all that. And I know that my partner who is the biological mother had the same experiences but different and hers was really about her body and being in her cocoon, not about being in the world. My experience was about being with them, my family, and being in the world. It's just different.

The eight narrative themes for Della included:

1. Protector of my family in the hospital
2. Ignored by postpartum nurses
3. Pure Exhaustion
4. Real difference between being the birth mother and the nonbirth mother
5. Ease of bonding
6. I am the more vulnerable parent
7. Adoption is cost prohibited
8. Chose common family last name

Narrative seven: Chloe

Chloe saw no difference between herself and her partner, Amy, as mothers. She proclaimed "We are both mother… the same. Nothing different about us in the first year, complete partnership. We have always wanted this and approached it from the same place". Perhaps the one difference was that Amy breastfed the baby, however, she frequently pumped so that Chloe could feed the baby. Both mothers felt completely bonded to their son.

When the baby was four months old, Chloe began the process to legally adopt her son. This process did not differentiate between a traditional adoption and a second parent adoption. It was frustrating to Chloe that her financial status was the primary focus rather than her character and her ability to parent a child.

> I had to go through as if we were adopting complete, a child that we had never seen before, it focused so much on the financial matters in our lives and not so much on what kind of people we were and it really, I mean I think the home study was a little bit about the kind of people we were but ya know the focus of it was

> asking if we could afford this child. And I am thinking, well, he's here, I mean he's not going anywhere and do you see some of the people who have children, that was really, I think, a little unsettling.

Chloe narrated the story of asking her primary care physician for a court mandated letter endorsing her as a parent.

> I needed a letter from my physician stating that I was capable of taking care of this child. At the time we had switched doctors because of insurance. So we called our primary care doctor and we had both seen him a couple of times and told him, you know, we need this and he said, "I'm sorry I can't provide that for you". [I said] I was like "what, why?" [The doctor said] "I am a devout Roman Catholic and I don't feel that you are capable of caring for a child." [I said] "That isn't what they are asking you". Sort of getting over shock, he said "but I am happy to continue treating you". I said all kinds of things to him (which I won't repeat). We called our OB/GYN who went on an absolute rampage and reported him to the hospital and to the board and to the AMA. She was just livid! She wrote us an outstanding letter but it was like she was just so beside herself.

Chloe believed that legally adopting her son was an important message to him. She concluded, "I did it because I wanted him to know that he is my child." If Chloe and Amy were civilly united, both mothers would be listed on their son's birth certificate. Chloe believed that she would still adopt her son even if she were subsequently listed on the birth certificate.

Names were important to Chloe as the nonbirth mother. Both mothers desired a maternal title. Amy was called "Mommy" and, Chloe chose to be called "Mum" which

was reflective of her English heritage. Chloe and Amy chose to hyphenate both of their last names as a family name. This further emphasized Chloe's role as her son's mother.

Chloe lovingly described how much she values being her son's mother. She stressed how hard it was to have her son but that makes her value him even more. "I wanted him so much and that's the hard thing with all of this… knowing how hard we had to fight for every piece of it and then knowing how many unwanted kids there are. I am so lucky. I really am."

The seven narrative themes for Chloe included

1. No difference between us as mothers
2. Breastfeeding combined with bottle feeding to allow both mothers to feed baby
3. Frustrating legal adoption process
4. Discriminatory provider
5. Maternal titles chosen to validate both mothers
6. Hyphenated both names to create a family name
7. Fighting for every piece of motherhood

Narrative eight: Yanna

Yanna remained opposed to having children until she met her partner, Carol. Carol wanted children and, Yanna thought that she would be the perfect partner to co-parent with. Yana affectionately remembered her daughter's birth as the best day of her life. She reminisced,

> You never realize how much you can love someone until your child is born. She started to cry and I told her it's okay, it's Mama, and she just stopped crying and

> she looked back and forth as if she recognized my voice. It was a really wonderful moment.

Yanna bonded immediately with her daughter. She eloquently shared, “When I think of her birth, I just think of loving her so fully, so completely, I’d do anything for her!”

Yanna and Carol opted for Carol to exclusively pump breast milk so that both mothers could feed their daughter. Yanna feared that breastfeeding might isolate her from her newborn. Both mothers felt that this would help Yanna to bond with the baby. Yanna reflected on this choice

> It felt very odd to me, the idea of not being able to feed my child. And Carol agreed and she pumped exclusively and we both fed her. Pumping was not difficult for her but it would have been difficult for me if she was breastfeeding and we tried to do a bottle and it did not work. How would I feel about that? On one level I felt that I was being selfish but ultimately it’s the milk and the nutrition she gets from the milk that matters. To imply that she would not be attached to me if I did not breastfeed is kind of silly. When we were looking for pediatricians they would ask Carol, “Are you breastfeeding?” and she would say, “No, I am going to exclusively pump” and pretty much everyone tried to talk us out of that. They’d say it’s too much work and you cannot pump exclusively or you can breastfeed and you can pump but No, Carol said that this is what we want to do. As a result we parented equally. Both got up in the middle of the night, we both did all of the feedings. When Carol would get up in the middle of the night to pump I would feed her. I feared that if Carol were to breastfeed when our baby cried someone would say, “oh, she needs Mommy” but she needs me too. I was

> really worried about that for a long time. Once she arrived those worries went out the window.

Being able to participate in feedings helped Yanna to feel like she was as much of a mother as Carol was.

Yanna remembered that she and Carol were not given a social security form for the baby in the hospital and, they subsequently had to go to the government office to complete it.

> So we went to the town office to fill out the form and of course it's a federal form so it asks for mother's name and father's name. So we cross off father and they say you have to choose which one of you will be (listed as) the dad. So Carol says I'll be the father and you be the mother, it was the most ridiculous thing. I love that in those moments they don't know who carried her, they cannot tell but we do and I love that in those moments Carol sort of recognizes me first, I don't know how to describe it. I just love that she does that, that she fills in the father component and lets me take the mother component. I don't know if it's challenging the perception, I love that she does that. It is a credit, validation recognition of me. It is just a sweet thing to do. It really is. I cannot put it into words. And you don't realize that it matters to you until you see a form and you are missing.

Yanna appreciated being recognized as "the mother". By Carol filling in "the father" portion of legal forms she legitimized Yanna's role as a mother to their baby.

Yanna considered doing a second parent adoption even though she is listed as a legal parent on her baby's birth certificate. She feared that if Carol were to die, her

parents might try to take the baby from her. The couple is legally married in their home state. Rather than the adoption, they obtained wills, which clarified their wishes for their daughter if they should die. This was much less expensive than an actual adoption.

Yanna voiced her initial concerns about being a non-biological parent, “My biggest concern as the non-bio mom was that I did not have a biological connection to our daughter and that people in our lives would not see me as equally her mother, particularly Carol’s parents”.

Carol’s parents were not supportive of their daughter’s relationship with Yanna nor did they endorse their decision to become parents. Yanna and Carol made a conscious effort for Yanna to be recognized by them. They were careful to always speak of themselves as a couple and as a family. Carol’s father told Yanna that they were “not an optimal family” since they are two mothers. Yanna defended herself to him,

> I had a mother and father. My father was abusive and I was not better off having him in the house. We are two loving people who love our children. That is sufficient. Define optimal for me. What is it about a penis and a vagina that makes it an optimal family? He did not have an answer. That was the first time he and I really talked. I listened to him/his concerns (even though I found him offensive). That’s his perspective. I said, “look we are great parents”.

Yanna and Carol demand their respect and, they insisted that Yanna was acknowledged as a mother. They have ultimately recognized Yanna as the mother of their granddaughter. Yanna has no involvement with her own family.

Yanna and Carol hyphenated their last names in order to create a family last name. They felt that this united them as a family. Yanna revealed “We wanted to force

people to recognize us as a married couple as a family and so we changed our names, we all have the same last name." She shared a story of having to take the baby to the hospital Emergency Department one night.

> I hate going to hospitals with the three of us because I always just have in the back of my mind that they will make one of us go and they'll ask who carried her and which one of us is the real mom because people define real family in terms of biology so it always helps when they say what's here name and they ask my name and I say the same last name. It feels good to say that to make it clear that she is my daughter. Fear…going to hospitals and medical…

The common family name helped to ease Yanna's fear of her maternal role being questioned. Names offered Yanna a sense of family security. She chose "Mama" and Carol chose "Mommy" as their maternal titles. These were the names that each of them called their own mothers. Names represented family legitimacy to Yanna.

Yanna remarked that parenthood requires her to repeatedly come out as a lesbian. She recalled shopping with her partner and their baby

> We were buying a sofa and we always get the stupid question, who's is she, [and we say] "Ours". We hate being asked this. We wear wedding rings, we are affectionate, we hug/hold hands (Are you really that stupid?). It's annoying to that when you have kids especially, the coming out process is just nonstop, it's just always [happening] because it's important for your kids to realize that there are many different ways to be a family, there's nothing wrong with our family and we have to force other people to recognize us as a family and not allow ourselves to be invisible.

Being clear to others that Yanna and Carole are their daughter's parents helps to validate Yanna's family.

The eight narrative themes for Yanna included

1. I never imagined myself as a mother until I met my partner
2. Fear of not being recognized as a legitimate mother
3. Immediate bonding
4. Exclusively pumped and bottle-fed breast milk so that both mothers could feed baby
5. Adoption cost prohibited
6. Hyphenated both names to be recognized as a family
7. Chose the maternal names which we called our own mothers
8. The coming-out process is just non-stop

Narrative nine: Abby

Abby and her partner, Jan, discussed the possibility of having children for over 10 years. After finally reaching the decision to have children, Abby tried to become pregnant for two years unsuccessfully. Ultimately, Jan became pregnant after just one attempt. Abby described her daughter's birth as "a scary experience". She was delivered by an emergency cesarean delivery performed under general anesthesia; therefore Abby was not permitted to be present for the birth. The hospital staff was very inclusive of both women as mothers. Registration forms were worded with "partner rather than husband and wife". This helped Abby to feel recognized. Abby remembered the first time she saw her daughter,

They came out and got me and said, "she's screaming for you" and I thought they

> meant Jan, but it was the baby. Jan was asleep. I was the first one to see and touch our baby. I felt that powerful bond that other parents talk about.

The baby briefly went to the NICU but there were never any questions about Abby's role. Jan was recovering from the surgery. Abby accompanied her daughter to the NICU. The staff embraced her like any other new parent. In general, Abby had a very positive experience with health care providers in the hospital.

Abby viewed nonbiological motherhood as a unique experience. She reflected on her role as the nonbirth parent:

> I found myself feeling conflicted, kind of like I needed to be their protector and provider of this family so that sort of led me to this sense that being a nonbirth lesbian mom, it is an experience of its own that is really in between motherhood and fatherhood, that it kind of has characteristics of both as well as characteristics of its own. My feeling is that continues well after the birth into the first year.

Abby considered the ambiguity of her role as a nonbirth lesbian mother. She felt like she had to do a lot more explaining to do that Jan did. She became a mother although she did not personally go through a pregnancy. She characterized this as an "interesting situation where you do have to explain more to people who might not be aware of the whole situation." Abby contended, "as a nonbirth mother she was forced to repeatedly come out as a lesbian". She described a situation where a new coworker did not necessarily know she was a lesbian. The coworker overheard another coworker congratulating her on having a baby. Her new coworker said something like, "Wow, you had a baby. You look great!" Abby had to clarify that she did not give birth rather her partner had given birth to

their daughter. Abby saw her experience as somewhat similar to women using a surrogate or adopting a baby.

A clinic nurse asked Abby if she was jealous that Jan would be nursing their daughter and offered her information on how she as the nonbirth mother could nurse. Abby laughed "Oh that is just too weird for me!" She viewed nursing as the major difference between the birth mother and the nonbirth mother. Abby pondered the breast-feeding experience "Jan loved breastfeeding and in some respects I was envious of the closeness they shared but it was also very painful and exhausting for Jan." Jan breastfed and also pumped so that Abby could bottle-fed their daughter. This helped Abby to feel more involved as a mother. Abby was an integral part of her daughter's care since she stayed at home with her for the entire first year while Jan worked part time.

Abby depicted the dramatic effect having a baby had on her relationship with Jan. Even though she had longed to be a mother for years, she was unprepared for the profound effect motherhood would have on her as a partner. Abby proclaimed:

> It had like a bone rattling impact on our relationship and our lives in ways that I had not expected. We had been together 18 years we thought we talk about everything anyway so we thought we were so covered here you know we've got this all figured out but it was much, much, much harder to shift into parenthood and family than I had anticipated.

As mothers, both Abby and Jan experienced guilt. Abby felt guilty that she was not working and not able to financially contribute to her family. Jan felt guilty for going to work and not being home with her family. Abby referred to this as "double maternal guilt".

Abby experienced a great deal of anxiety as a new mother. The baby was a poor sleeper for most of the first year and she also had some health problems. It was difficult for her to be a stay at home mother. Before the baby, Jan and Abby had similar professional lives and interests. After the baby was born, Abby's life was focused on her newborn's care. Abby cared for the baby during the night so that Jan would be able to sleep and function at work during the day. Jan was exhausted and depressed when she came home from work so it was difficult to sustain their relationship. Abby reflected on the difficulty of Jan's Postpartum Depression:

> Jan doesn't get depressed; I am the one that gets depressed so it was scary. It wasn't scary in the sense that I thought she was going to harm herself or any anything like that but it was just hard to know how to deal with this. My experience was largely to try and manage it, not necessarily in helpful ways, but I would just try to do all the baby stuff, which I could do except for feedings. I think we just sort of went into a pattern; we picked up a pattern that was most obvious and accessible to us.

Abby felt like the best way for her to help Jan recover from her depression was to manage every aspect of their home and family. This was very difficult for Abby as a new mother.

Since Jan and Abby were not legally united in any way, the initial birth certificate listed Jan as the only parent. Abby adopted her daughter when she was two months old. There were several steps involved in this process. They had to search the father's registry to ensure that there was not a father looking for this child (despite using an anonymous sperm donor). Abby petitioned the court and successfully waived the home study. Jan's

and Abby's parents had to submit affidavits recommending that Abby be granted adoption of the baby. The adoption was easily granted but it did cause Abby a great deal of anxiety. An updated birth certificate was then issued recognizing both, Jan and Abby, as their daughter's legal parents.

After the adoption, Abby added Jan's last name to her own. Their daughter shares this last name as well as Abby's family name as a middle name. The entire family now has the same last name. Abby reflected on changing her name

> I added "Smith" to my name legally, mostly for perception purposes. That does nothing really in terms of making you a legal parent. But it does a lot for perception… Yes it does a lot for that and it just makes things easier. It helps people understand we are a family rather than having to explain yet another layer. There was the perception but it helped me personally to feel more like I am part of this family unit.

For Abby, her legal name change helped her to feel validated as a mother. It also helped others to recognize her as part of this family.

As a nonbirth mother, Abby learned a great deal about her partner but also about herself. She described being 'in a class of her own" and "being defined by what she is not rather than what she is… not the biological mother, not the legal other (until the adoption), not the father…". Abby saw the role of the nonbirth mother as "a new territory to be discovered". In this emerging role, she learned a lot about herself. She discovered that she enjoys working. She found it very difficult to be a full time stay at home mother. She asserted, "We live in a world where people say that taking care of a child is the hardest job in the world but nobody really believes that… people think that

stay-at-home parents are not working". Abby longed for some personal and professional fulfillment beyond motherhood. She revealed, "There were times when I just felt like I need to do less of this. I need to do some other stuff for my own life that is not about being tied to putting a baby to bed every night." Abby ultimately became a freelance writer and lecturer. This was the perfect balance of caring for her family and pursuing her own career.

The eight narrative themes for Abby included:

1. Positive experience with all hospital staff
2. In a class of my own: In between motherhood and fatherhood
3. Forced to repeatedly come out as a lesbian
4. Breastfeeding is the major difference between us
5. Parenthood had bone-rattling impact
6. Adopted to gain legal parental rights
7. Family last name to show that we are a family
8. Discovering myself as a mother

Narrative ten: Rachel

Rachel recalled her daughter's birth as an exciting but fearful time. She recounted her daughter's birth story:

> What can I tell you about her birth? Her birth was exciting. It was really exciting but scary too because she got stuck when she was coming out. Her cord was wrapped twice around her neck and when she came out she didn't have a heartbeat and she was not breathing so that was scary but it was kind of a time, (and this is weird) and I don't know if this seems selfish or not but it was an

> affirming time for me as a mom because my partner still had not delivered the placenta and of course she was recovering from giving birth to her anyway so the baby had to be rushed to the NICU and it was all on me to go with her. It was all on me to make the decisions, to be with her and make decisions and to be reporting back to the family about what was happening. It was kind of like in a strange way an affirming thing of, yes you are the mom and you are important. I don't know if it makes sense at all. It kind of was yes it was validating. All of a sudden I am really important in this little person's life. So the doctors and everybody treated me really great.

Rachel experienced mixed emotions on the day of her daughter's birth. She feared for her newborn's safety and well-being. She was also relieved to be recognized and respected as her baby's mother. This gave her great satisfaction as a new mom.

Rachel has no legal ties to her partner or her daughter. Her home state does not legally recognize same sex unions nor does it offer second parent adoptions. She and Anna drew up a parenting agreement, which recognized here role as the mother before the baby was born. Rachel spoke about her daughter's birth certificate,

> We had a co-parenting agreement. I have a really hard time when it comes to paperwork. Like I'm not the real mom when it comes to signing paperwork and the legal side, the legal side of being a mom. So when Amy had to sign the birth certificate and sign the Social Security card and stuff like that, it was hard for me because I wasn't allowed to be recognized. There was no place for me for my name. That continues to be difficult for me because it is kind of like the line in the sand. It was really hard for me to not be able to be on her birth certificate that

> really was difficult. The nurse who did her birth certificate and her footprints, they have a little vanity birth certificate, the keepsake one and she offered to white out the place where it says father and put my name there instead and I told her no it's okay because it would serve as a history lesson someday. You know one of these days we will laugh about this that there is no place to put my name there. It is hurtful and it is a scary thing. In my state I don't have any rights to my daughter.

Rachel would prefer to move to another state where she could legally adopt her daughter, however, her partner is unwilling to move. Although Rachel does not have legal ties to her daughter, she did change her last name to her partner's last name so that all three of them share the same family name.

Rachel's biggest fear as a nonbirth mother was not bonding with her daughter. In order to help her bond she did non-nutritive nursing. Rachel fondly reflected on breastfeeding her daughter:

> I know that it helped me, and I hope that it helped her. We don't really tell anybody, the only person that we told was a lactation consultant because we wanted to get more information about that, but it is just called non-nutritional nursing. Sometimes adoptive mothers do it when they get an infant just because they crave to have that closeness with the baby so I did that with our daughter and I think it helped me a lot more than it helped her. I don't know if it was selfish on my part or what. It was just a way for me to bond with her and we have a really great bond now. I think she considers me her mother and I absolutely consider

> her my daughter. There is nothing that could ever take that away. I absolutely feel like her mother.

Breastfeeding was important to Rachel. It helped her to feel like a mother and to share closeness with her daughter. She feared that others might be judgmental of her nursing her baby for comfort but ultimately it calmed her fears. Nursing helped her to bond with her newborn.

Rachel explained her role as her daughter's primary caretaker. She cared for the baby during the night and during the day. Her partner worked during the day and, she worked during the evening. Rachel fed her daughter, bathed her, and took her to appointments and outings. She cared for her in every way as a mother. Rachel recounted her daily routine with her infant:

> While I was going it alone with childcare, my partner had a lot of help. Since her parents did daycare for us at that time (in the afternoon for a few hours), when she would get out of work to go pick up the baby, she would end up staying at her folk's house until it was time for the baby to go to bed at night. That meant she had two extra sets of hands to help her care for the baby. Her mother made dinner for her. She had adult conversation to engage in. During that time, I admit I felt jealous. Not because I wanted the extra help with the baby, but jealous because I felt like her mom and dad were taking my place as a parent to our child. It wasn't that I wanted my partner to sit home alone when she didn't have to, but I just felt really threatened by her parents bonding so much with my child. I felt like she would bond with them more than with me.

Being her daughter's primary care provider strengthened Rachel's maternal bond.

Although Rachel received great joy from mothering, she described her daughter's first year as a lonely and isolating experience.

Rachel worried a great deal about others' acceptance of her as a mother. Her friends and own family recognize her as her baby's mother (although her family does not live locally). Rachel questioned whether her in-laws see her as the baby's equal parent. She also shared her doubts about Anna's acceptance of her as a parent to their daughter:

> My partner says that she sees me as an equal parent, but I don't think she treats me that way all the time. In day-to-day goings on, I think she kind of defers to me.... for instance, I set the guidelines about TV watching, I decide if the kiddo's had too much sugar for the day, etc. But when it comes down to bigger decisions, like whether or not to get our daughter's ears pierced, or where she will go to school (someday), etc., she has the final say. She has admitted that she sees me as an equal parent until it comes to making big decisions, and then it's what she says that goes. Honestly, it's really hard for me to be in that position. Sometimes I feel like, what's the point of me, then? What am I doing here if what I feel or want, when it comes to the important things, doesn't matter? It makes me feel invalid and kind of pointless.

Rachel voiced serious concerns about others' perceptions of her maternal role. Her biggest concern remained her partner's selective recognition of her as a mother. Anna's lack of acknowledgement of Rachel as an equal parent has caused Rachel great despair.

As a nonbirth mother, Rachel has much insecurity. People, especially her in-laws, comment about her daughter's similarities to Anna. Rachel shared how uncomfortable this made her:

> Something that was kind of hard for me during that first year, and even now, was that people are always commenting on how much our daughter looks and acts like my partner. I knew going into things that, obviously, she wasn't going to look like me, and I thought I was prepared for that. But now that people are making comments, and I see how similar they are in appearance and action, I feel sad and a little like an outsider.

Comments about the traits Anna and her daughter share are a source of insecurity for Rachel. These remarks emotionally isolate Rachel from her family.

Becoming parents put a great deal of stress on Rachel's relationship with her partner. The couple has been having problems since their daughter's early months. They discussed separating but Rachel feared losing her daughter. She has no legal connection to her and she fears that if she leaves her partner, she may lose her daughter. Anna experienced postpartum depression.

> Anna had postpartum depression after she delivered. She is just now being treated for it, so I am glad for that. She had the affair and that was just devastating. She had the audacity to say that having the baby was part of why she was having the affair. She didn't totally blame the affair on the baby but it was just that it was one of the things that pushed her over the edge and it is just crazy. She said that she felt insecure and lonely and someone just came into her life and that met needs that I couldn't fulfill and she couldn't fulfill herself.

Rachel does not know if her relationship will survive, however, she is reluctant to leave this painful relationship out of fear of losing her beloved daughter.

The first year of motherhood was extremely stressful for Rachel. She had little social and family support. Her relationship with her partner has deteriorated. She has no legal rights to her daughter and, staying in her current relationship might be her only way to maintain a relationship with her daughter. Despite all of the agony, Rachel is grateful for the experience of motherhood. She concluded her interview by resounding:

> The first year of motherhood was very hard but I would not trade it for the world. We are having these problems and we talked about separating and I have no legal rights to my daughter at all, nothing. So that is really scary and it is one of the things that keep me here because I can't imagine not being part of my daughter's life. I don't know… I really love this kid, absolutely as if she came from me.

Although Rachel initially feared not bonding to her daughter, she is completely bonded to her in every way. The first year of motherhood was lonely and challenging, however, Rachel can never imagine her life without her daughter. Rachel's final comments beautifully summarized her feelings about being a nonbirth lesbian mother:

> What surprised me, being the non-bio mom, is how completely I feel like she is MY child. I knew that I would bond with her, but the absolute certainness that I feel about her being my daughter surprises me somehow. I didn't know I'd love her this much.

The ten narrative themes for Rachel included:

1. My daughter's birth was scary and exciting
2. Having her in the NICU was affirming to me as her mother
3. No legal rights, Adoption not an option
4. Changed name to partner's last name to have a family last name

5. Nonnutritive nursing (in addition to partner breastfeeding) to help bonding,
6. Going it alone
7. I’m an equal parent until it comes to the big decisions
8. Our deteriorating relationship
9. Completely bonded to my child.

A Metastory of the Experiences of Nonbirth Lesbian Mothers

Six overarching themes revealed the story of postpartum experience of nonbirth lesbian mothers. These themes emerged through the unification of the ten narratives. The stories remained intact as holistic interpretations of individual stories to create a metastory. This metastory represents a shared voice of nonbirth lesbian mothers’ reality during their first year of motherhood.

These six overarching themes include the following: At the mercy of health care providers, Nursing is the major difference between us, Defined by who I am not, Trying to protect my family: The world can take them away, What's in a name? and Epilogue: The New Normal.

Overarching Theme One: **At The Mercy of Health Care Providers**
Subthemes for overarching theme one
1. Labor/delivery: Treated like an equal parent
2. Postpartum nurses reminded us that we are not equal
3. The NICU advantage
4. Condemned by homophobic health care providers in the ED and primary care
Overarching Theme Two: **Nursing is the Major Difference Between us**
Subthemes for overarching theme two
1. Supporting the breastfeeding unit
2. Combining breast and bottle-feeding helped me to feel involved
3. Insecurities and fear about breastfeeding
4. Exclusive pumping: She needs me too
Overarching Theme Three: **Defined by who I am not**
Subthemes for overarching theme three
1. I still worry
2. We have to work harder
Overarching Theme Four: **Trying to protect my family: The world can take them away**
Subthemes for overarching theme four
1. Fighting for every piece of motherhood: Second Parent Adoption
2. Adoption not an option
3. We are legally married: Isn't that enough?
Overarching Theme Five: **What's in a name/**
Subthemes for overarching theme five
1. A family name makes the statement that we cannot be separated
2. The name of the "real" mother
Overarching Theme Six: **Epilogue: The New Normal**
Subthemes for overarching theme six
1. The glue of our family
2. Bone rattling impact
3. Going it alone
4. Repeatedly coming out as a lesbian
5. My process of self discovery

Prologue to Postpartum

It is significant that every participant discussed their lengthy journey to becoming mothers prior to sharing their postpartum experiences. Participants reflected on many topics including: infertility, pregnancy, miscarriages, and other meaningful experiences. Although the events prior to birth were was not the focus of this particular study, they provided valuable insight to this researcher. These recollections offered a poignant introduction and served as a prologue to the postpartum narratives. It was essential that participants shared their stories in entirety to be able to fully portray their postpartum experiences as nonbirth lesbian mothers. The following section will present the six themes from of postpartum experiences of nonbirth lesbian mothers.

Overarching Theme 1: At the Mercy of Health Care Providers

All participants recalled their interactions with health care providers in perinatal, pediatric and primary care settings. Nonbirth lesbian mothers felt vulnerable to these providers. They approached health providers' care with trepidation and fear that they would not be recognized as parents. Their experiences with labor/delivery and NICU providers were very positive, however, their interactions with postpartum nurses and ED, pediatric and primary care providers were negative. Participants felt that the way health care providers treated them determined their perception of their care. Regardless of how they were treated, these nonbirth lesbian mothers felt vulnerable to healthcare providers. This vulnerability is characterized as being "at the mercy of health care providers". This category is further subdivided into the following four categories: Labor/delivery: treated like an equal parent, Postpartum nurses reminded us that we are not equal, The NICU

advantage and Condemned by homophobic health care providers in the ED and primary care.

Subtheme 1. Labor/delivery: Treated Like an Equal Parent

Seven of the participants shared the particulars of their labor/delivery stories. One particular participant remarked that she "was completely overwhelmed by how positive the experiences were and so I was like, maybe this won't be so bad in a conservative state like ours after all". All of the mothers who recalled their experiences with labor/delivery staff reported positive experiences. Obstetricians and nurses embraced them as new parents. They were included in the care and respected as equal parents.

Another participant remembered her sheer panic after her wife experienced eclampsia several weeks before her due date and was rushed into the hospital by an ambulance. No medical personnel would give her any information nor did she know the status of her wife and unborn baby. She acknowledged, "I had to bully my way into the hospital [ED]". She approached labor and delivery with a great deal of fear and vulnerability. She dreaded being denied access to her wife during the birth of their baby. This participant was relieved when a labor and delivery nurse shepherded her through the entire emergency cesarean birth. She characterized the nurse as her "only contact during the birth". The nurse emphasized the nonbirth mother's role as an equal parent by frequently checking to see if she was okay, making eye contact with her regularly and spending time with her.

Participants appreciated when health care providers encouraged them to take an active role during childbirth. One nonbirth mother applauded a particular nurse for explaining everything she did, taking pictures of the new family and expressing genuine

regard for her as a mother. Although many of the participants anxiously entered labor and delivery, a supportive and accepting health care team calmed their fears.

These mothers praised health care providers for demonstrating genuine empathy and happiness for their new families.

Subtheme 2. Postpartum Nurses Reminded us that we are not Equal

Postpartum was the area of least satisfaction for nonbirth lesbian mothers. Four mothers criticized postpartum nurses for a lack of caring. The most common contention was that nurses ignored nonbiological mothers and did not recognize them as legitimate parents. One participant faulted postpartum nurses for never addressing her and not including her in any of their teaching or care. She pronounced, “they never even looked at me”. Another participant revealed that the nurse came in to give discharge instructions and only spoke to the birth mother. This nonbirth mother argued, “What does she think, you’re going to do this alone?”.

A postpartum nurse asked to see legal documentation of one couple’s relationship. This deeply disturbed both mothers. The nurse admitted that if they were a heterosexual couple, they would never be asked to show a marriage license or documentation of their relationship. This participant asserted “that was the moment I was reminded that we are not equal”.

Nonbirth lesbian mothers recalled advocating for their partners on the postpartum unit. One participant considered herself to be the protector of her wife and twins in the hospital. Postpartum nurses wanted to bottle-feed her babies with formula. She and her wife had objected to any supplemental feedings, therefore, the nonbirth mother confronted the nurses and insisted upon exclusive breastfeeding. Since the birth mother

was recovering from a cesarean delivery, her wife described herself as needing to be the "loud voice" of her wife.

Another participant who also felt disregarded by postpartum nurses concluded "basically before we went to the hospital, we just talked about this and we said, 'these few days we spend in the hospital are not the most important part and it does not matter how they treat us. I am still the mom'".

Subtheme 3. The NICU Advantage

Four of the participants' babies went to the NICU immediately after birth. One nonbirth mother admitted that her daughter being in the NICU affirmed her as a mother. The baby was transferred to the NICU urgently therefore her partner was unable to accompany the baby since she had not even delivered the placenta. The NICU staff relied on her to make decisions and provide information. She was also the one to report information back to the family. She was relieved to be fully recognized as her baby's mother. Despite having no legal rights to her baby the NICU staff respected her as a mother.

All four participants described their experiences with NICU providers as very positive. They all felt included in their babies' care and recognized as equal mothers. They asserted that NICU care providers made no distinctions between the two mothers. They were both treated with tremendous respect. One participant fondly remembered a NICU nurse making a crib card listing the names of both mothers. This gesture was very special to her as a new mother. Nonbirth lesbian mothers perceived their baby being in the NICU as a beneficial to them as mothers.

Subtheme 4. Condemned by Homophobic Health Care Providers in the ED and Primary Care

Four participants encountered homophobia from health care providers in EDs and primary care offices. One nonbirth mother recalled bringing her daughter to the ED with a high temperature. The ED physician incessantly questioned the mothers about the father of their baby. This had nothing to do with the reason for the ED visit. This nonbirth mother recounted that the physician made her and her partner feel extremely uncomfortable. She called this line of questioning awkward and inappropriate.

Another participant reported her primary care physician's refusal to write a letter to the court endorsing her to adopt her baby because of his religious beliefs. He believed that lesbians are not appropriate parents to raise children. A pediatrician who was also known to be religious would refer to "mom and dad" in the presence of both mothers. When nonbirth lesbian mothers entered health care settings they felt vulnerable to the possibility of discrimination. One participant admitted, "I hate going to hospitals [EDs] with the three of us because I always just have in the back of my mind that they will make one of us go and they'll ask who carried her and which one of us is the real mom".

Overarching Theme 2: Nursing is the Major Difference Between us

All participants' babies were breastfed for at least two months. Nonbirth mothers supported their partners with breastfeeding since they believed that this was the healthiest choice for their babies. They saw breastfeeding as the major difference between the two mothers. This category is further subdivided into the following four categories: Supporting the breastfeeding unit, Combining breast and bottle-feeding helped me to feel

involved, Insecurities and fear about breastfeeding and Exclusive pumping: she needs me too

Subtheme 1. Supporting the Breastfeeding Unit

A nonbirth mother of twins described how she supported her wife to exclusively breastfeed. She cared for her babies in every way except feeding. She bathed them, changed diapers, held them and cared for them. She maintained all aspects of her home and family. This participant reflected on her role as a nonbirth lesbian mother of her twins, “there was nothing I could give them except to support the breastfeeding, to support the breastfeeding unit”. Since nursing was something that she was physically able to do she managed all other aspects of life. She described having more energy than her wife after giving birth to twins and breastfeeding them. She saw supporting breastfeeding as the way to nurture her family.

Subtheme 2. Combining Breast and Bottle-feeding Helped me to Feel Involved

Most of the mothers in this study reported that their babies were fed through a combination of breast and bottle-feeding. Newborns were fed pumped breast milk, however, one baby was not getting adequate nutrition from the breast milk and needed formula supplementation. This helped the nonbirth mothers to feel more involved in their infants’ care. Birth mothers were physically exhausted from breastfeeding. They were able to rest when their partners bottle-fed the babies. In addition to nursing, the nonbirth mothers who bottled fed their babies equated feeding with nurturing and love. Bottle-feeding their babies helped nonbirth lesbian mothers to bond with their infants.

Subtheme 3. Insecurities and Fears Related to Breastfeeding

Some of the participants envied the closeness that birth mothers experienced breast feeding their babies. One nonbirth mother admitted feeling jealousy toward her partner since the baby seemed to prefer the breastfeeding mother. She also divulged that she resented the breastfeeding since it was so demanding on her partner and thus her partner was less available to her.

A clinic nurse offered a nonbirth mother information on how to initiate lactation. Even though she desired the closeness of breastfeeding she exclaimed, “that’s just too weird for me”. This participant also concluded, “nursing is the major difference between us”. She was relieved when her partner pumped so that she could participate in feedings.

Another nonbirth mother feared that her baby might not bond with her since her partner breastfed. This participant frequently did skin-to-skin contact by holding the baby wearing only a diaper against her bare chest. The closeness of the skin-to-skin contact gave her great satisfaction and helped her to bond with the baby.

One nonbirth mother did non-nutritive nursing. She and her partner did not tell anyone that she was also nursing because they feared judgmental attitudes. She worried that her daughter would not bond to her since they did not have a biological connection. Nursing for comfort helped her to feel the closeness she desired to her baby. The experience eased her insecurities and helped her to easily bond with her daughter.

Subtheme 4. Exclusive Pumping: She Needs me too

One nonbirth mother exclusively bottle fed her baby with pumped breast milk. She and her partner carefully made this decision in order for them to both feel like equal mothers. Both mothers got up in the middle of the night. The birth mother pumped and, then the nonbirth mother bottle-fed the baby. The nonbirth mother remarked, “On one

level I felt that I was being selfish but ultimately it's the milk and what she gets from it that matters". Pediatricians and nurses discouraged this decision remarking that it would be too labor intensive to manage. This process worked quite well for this family. The nonbirth mother revealed, "I feared that for instance if [my wife] were to breastfeed [our daughter] when she cried someone would say, "she needs mommy", but she needs me too…". Exclusive pumping helped both mothers to feel like equal parents.

Overarching Theme 3: Defined by who I am not

Five of the participants specifically discussed their role as the nonbirth mother as uniquely different from the birth mother's role. One nonbiological mothered described this as a unique experience "somewhere in between motherhood and fatherhood". She recalled "being a in a class of [her] own". Another nonbirth parent did not see herself as a mother at all. The motherhood role did not fit her, however, she absolutely felt like a parent. For her there was a very clear distinction as a nonbiological mother. Another participant went on to say that this was a difficult experience since she was defined by what she is not rather than what she is. These mothers identified with who they are not. They are not fathers. They did not give birth. They are not breastfeeding. They do not have immediate legal rights to their children. This category is further subdivided into the following two categories: I still worry and We have to work harder.

Subtheme 1. I Still Worry

Nonbirth mothers described their fears about not being recognized as mothers. They worried that their own family members and their partners' families would not identify them as mothers. One nonbirth mother even had doubts about her partner recognizing her as an equal parent. They also had fears about people outside of their

family not acknowledging them as mothers. One mother remarked that her biggest concern was that since she did not have a biological connection to her baby people would not see her as an equal mother. They worried about taking their babies to medical appointments. They feared that their authority to make decisions as parents might be questioned. Nonbirth mothers described bringing legal documents, which gave them the authority to make legal parental decisions to medical appointments. They described themselves as "the more vulnerable parent". One nonbirth mother lamented, "the world can take them away, she [her partner] can take them away, she wouldn't but she could…". She has no legal rights to her children. She and her partner are married in another state and, they have been partnered for many years. This nonbirth mother feels secure in her relationship and her yet she concludes, "I still worry". If she and her partner were to separate or her partner was to die, she would have no legal claim to her children.

Subtheme 2. We Have to Work Harder

One participant acknowledged that there was a very real difference between being a birth mother and being a nonbirth mother. She and her partner each gave birth to one of their two children. Since she has experienced both, biological motherhood and nonbiological motherhood, she believed that each was unique. As a nonbirth mother, she felt that boding with her daughter was more difficult. This was a more gradual process as compared to immediately bonding with her birth son. This participant concluded that bonding for nonbirth mothers can take up to a year. She believes that nonbirth mothers have to work harder to bond with their infants. It is not as natural a process as it is for birth mothers.

Another nonbirth mother shared her experience of bonding with her infant. “As time went on and the baby started to give back a little, it started to swing to the other side. We really did not bond until probably she was three months old and then it really started to click, I started to recognize her as my own.” It took time for this participant to see her baby as her own. She had to work at bonding with her baby. Motherhood was initially difficult for her. She experienced great anxiety over becoming a mother. Her partner was extremely supportive to her during their first few months of motherhood. She ultimately embraced motherhood. She humbly acknowledged how grateful she is to be a mother, “For me it was a soul searching journey. I was reluctant to become a mother but let me say that she is here and I would not trade her for the whole world. I love her more than life itself. I would have it no other way.”.

Overarching Theme 4: Trying to Protect my Family: The World Can Take Them Away

All ten participants discussed trying to protect themselves as parents through adoption or other legal agreements. Six of the participants legally adopted their children. Two chose not to adopt and, two lived in states where gay parents were not allowed to legally adopt. This category is further subdivided into the following three categories: second parent adoption: Fighting for every piece of motherhood, Adoption not an option and We are legally married: Isn’t that enough?

Subtheme 1. Fighting for Every Piece of Motherhood: Second Parent Adoption

Five of the participants were able to legally adopt their children through second parent adoptions. A nonbirth mother characterized the adoption process as “having to fight for every piece of motherhood”. The adoption process for these mothers was not

streamlined in any way despite them adopting a baby that they were already parenting. Home studies were required for all but one family (one family petitioned the court and had the home study successfully waived.)

Participants who legally adopted their babies reported that this was a financially expensive process. One participant called the adoption "a financial hardship". Her baby spent a number of weeks in the NICU, which exhausted all of her family's financial savings. The second parent adoption process required a home study evaluation by a social worker, which cost thousands of dollars. Another nonbirth mother expressed frustration about her adoption process, "the focus of it was asking if we could afford this child. And I am thinking, well, he's here, I mean he's not going anywhere and do you see some of the people who have children, that was really, I think, a little unsettling".

Nonbirth mothers felt anxiety over having to defend themselves as mothers. One mother had to prove that she was the only other possible parent to her child. She had to search the father's registry to ensure that there was not a father looking for this child (despite using an anonymous sperm donor). Another participant recalled the adoption process as "humiliating, going through a process which the state agency for child protective services has to recognize but you have to pay for it and then go in front of a judge to ask to be the parent of the child you are already parenting and planning for before they were even conceived".

Despite all of the disparity of second parent adoption, nonbirth mothers were grateful for this legal right. They felt privileged to be able to legally secure their status as parents. Second parent adoption was a means to protect their families. Becoming a legal parent was described as one mother as "a battle worth fighting for".

Subtheme 2. Adoption not an Option

Three participants lived states where second parent adoption was not a legal option. These nonbirth mothers obtained legal documentation to try to document some parental relationship to their children. One participant completed a guardianship agreement. This did not give her parental rights but named her as the biological mother's preferred guardian. She provided a copy to her daughter's pediatrician. They did accept this agreement and allowed her to authorize medical care for her children even though she was legally not a parent. The guardianship agreement did not give her any rights as a parent. Another mother completed a legal parenting agreement with her partner. This agreement outlined their shared responsibility to equally care for their child and named them both as parents, however, it does not give the nonbiological mother any parental rights.

Subtheme 3. We are Legally Married: Isn't that Enough?

Two participants decided not to do a second parent adoption even though it was a legal option in their home states. Both families could not afford the financial burden of the adoption including legal fees and the required home evaluation. One couple completed wills designating their partner as the intended parent to raise their child. The other couple did not compose any legal documents to try to protect themselves as parents. One participant remarked, "Instead of spending energy/money raising our kids, we'd have to spend it on legalizing that we are raising our kids" [if we adopted]. Both couples were frustrated with the requirements for adoption. They were both legally married, one in their home state and one in another state. These couples resented that marriage did not provide them automatic parental rights to their children. They hope that they will

eventually have automatic parental rights and that all marriages will be recognized federally rather on a state-to-state basis

Overarching Theme 5: What's in a Name?

All ten participants discussed the importance of names to validate them as parents. A shared last name represented family unity. It was also crucial to nine of the ten participants that they have a maternal title. This facilitated them being recognized as mothers. This category is further subdivided into the following two categories: A family name makes the statement that we cannot be separated and The name of the "real" mother.

Subtheme 1. A Family Name Makes the Statement that We Cannot be Separated

A shared last name was important to the participants as mothers. One mother appreciated that her partner wanted the family to take her last name to honor her. Since she did not give birth this was a symbolic way to validate her as part of the family. Another nonbirth mother shared that she and her wife combined both of their last names to create a new family name. This helped to substantiate this participant's role as an equal mother. She remarked that "just like the names cannot be separated, we cannot be separated, we are one family unit". Having a shared family last name helped nonbirth mothers to personally feel authentic as mothers and it also helped to identify the family as a cohesive unit.

Having a family last name was also important for perception purposes. One participant pointed out, "When I bring the baby to the pediatrician, because we have the same last name, the staff assumes that I am her legal mother". Having a family last name helped nonbirth mothers to be recognized as mothers by health care providers. This took

away some of the anxiety of having to repeatedly explain their family with every medical appointment. This was especially important to mothers who were not able to legally adopt their children. Having the same last name gave the appearance that the nonbirth mother was legally a parent. Having a family last name provided nonbirth mothers with some security that they would be treated like any other parent. Nonbirth mothers recognized family last names as a concrete way to protect their families. All ten families had a shared family last name.

Subtheme 2. The Name of the "Real" Mother

Nine of the ten participants chose a maternal title. Having a name, which included some derivative of "mother", helped the nonbirth mothers to feel recognized as genuine mothers. Some of the titles included Mommy, Mama, Mum and Uma. One nonbirth parent did not feel affinity toward the mother role and created the title "Poppy-Mom" but eventually was called "Uma" which reflected her Jewish heritage. This mother felt like she was an equal parent to her partner in every way, however, she did not identify as a mother. She related the title of "Uma" more to her cultural traditions rather than to being a mother. Another nonbirth mother chose to be called "Mum" since this acknowledged her British heritage.

Some of the participants chose to be called the name that they called their own mothers. They selected the title, which they were most comfortable with. One nonbirth mother chose to be called "Mommy" since this is the traditional name a mother is called by a young child in America. Since she had not given birth, she and her partner chose this name so that she would be most immediately identified as the mother. She remarked, "Children are always asked, 'Where is your mommy?' no one ever asks 'Where is your

mama?'". Another participant chose to be called "Mama" since that is what she called her mother. She recalled,

> Most people mean mommy when they think of a mother and they think that mama is not equivalent. I think it is equivalent because growing up in the black community I did not know anyone who called their mother "Mommy". That would be very strange for me to hear. Everyone said "Ma" or "Mama" but not "Mommy". But I know that in mainstream society it's the assumption that the person who is the mommy is the real mommy and the person who is the mama is somehow less than. When people just assume that if you are a mother your name is "mommy" to your child that makes me feel invisible.
>
> This nonbirth mother recognized that "Mama" is not the most obvious maternal title in American culture; however, she chose to be called "Mama" since ultimately it is the name that authentically symbolizes motherhood to her.

Overarching Theme 6: Epilogue- The New Normal

Nonbirth lesbian mothers did not anticipate the profound lifestyle changes they would experience in their first year of motherhood. One participant captured her daily life as completely revolving around her baby. She named her recent reality, "the new normal". This category is further subdivided into the following three categories: The glue of our family, Bone rattling impact, Going it alone, Repeatedly coming out as a lesbian and My process of self discovery.

Subtheme 1. The Glue of our Family

All of the participants described their first year of motherhood as very satisfying. One particular nonbirth mother characterized her children as "the glue of our family".

She recounted closer relationships with her extended family since her baby was born. Her first year of motherhood was the beginning of family traditions for holidays and special events. Another participant remarked that her entire family has been changed by the birth of her daughter. Her wife's parents are more accepting of her as a mother and of their relationship as a couple. Although some of the parents might not have been accepting of their daughters' lesbian relationships they have embraced their children as grandchildren. One participant concluded,

> We are all completely changed by this little baby. Not just us but our entire extended family. Things were so much easier a year and a half ago (before the baby) but I have a greater sense of family now. The baby comes first. I have a better sense of what's truly important. That's my new normal.

Subtheme 2. Bone Rattling Impact

Nonbirth mothers were not emotionally prepared for the lifestyle changes, which took place during their first year of motherhood. One particular nonbirth mother described the effect of parenthood on her relationship with her partner as a "bone rattling impact". The majority of participants in this study had been with their partners for many years. Several of them became parents after countless courses of infertility treatment. Despite anticipating motherhood for many years, they still felt unprepared. Participants detailed exhaustion, sleep deprivation, anxiety and stress. One nonbirth mother described her long-term relationship with her partner as solid. She admitted, "I thought, we've got this all figured out but it was much, much, much harder to shift into parenthood and family than I had anticipated."

Two participants experienced anxiety and a difficult postpartum adjustment

themselves. One participant shared, “The first couple of days and weeks, I think I went through a postpartum [depression] more than my partner did. Because you know I had that ‘my life is over’ feeling. And my partner has been so wonderful and supportive to me…”. Another nonbirth mother reported feeling completely overwhelmed when her son was not able to sleep. Having to adjust to new routines and a lack of sleep while functioning in the world was difficult. Since birth mothers were physically and emotionally recovering from birth, nonbirth mothers felt an urgent responsibility to manage all aspects of home and family. As one participant so eloquently shared, “the weight of motherhood rested squarely on my shoulders. I was exhausted, thrilled, and terrified.”

Subtheme 3. Going it Alone

One participant experienced loneliness and isolation during her daughter’s first year. She was the primary caretaker of her daughter since her partner worked during the day. She worked during the evening but received no support with childcare during the day, however, her partner’s parents helped with childcare every evening. As a nonbirth mother she has no rights to her daughter in their state and, her partner does not allow her to make any important decisions about their daughter. She sometimes feels “like an outsider” especially with her partner and her partner’s parents. There has been a tremendous strain on the couple’s relationship since the baby was born. Her partner had an affair with another woman months after the baby was born. Their relationship has deteriorated since they became parents. Although the first year of motherhood has been extremely painful and lonely, she adores her daughter. She has very little support as a mother but she remains extremely grateful for her daughter.

Subtheme 4. Repeatedly Coming out as a lesbian

Three participants concluded that when you are a nonbirth lesbian mother, you must repeatedly come out as a lesbian. Since they were obviously not pregnant, coworkers and acquaintances might not know that they are mothers. Participants recounted having to explain how they became mothers to people who might not even know that they were partnered with a woman. In order to be recognized as a mother, they must come out as a lesbian. This process frequently happens over and over again.

Three nonbirth mothers had to repeatedly explain their family to strangers. One mother recounted being questioned by a physician about who her baby's father was. She adamantly believed that it was very important for her to be open about her family and willing to repeatedly come out as a lesbian. She felt that being so open teaches her children to be proud of their family and themselves. If she chose not to come out as a lesbian, this would teach her children to be ashamed of their family. This participant concluded that being a parent has forced her to repeatedly come out s a lesbian and, this is essential for her children's emotional health and well-being.

Subtheme 5. My Process of Self-discovery

Becoming a mother taught participants a great deal about themselves. Three of the nonbirth mothers were adamantly opposed to becoming parents. One recounted her partner's ultimatum that their relationship would end if she could not agree to have a family. Despite their reluctance, all three of these mothers adored their babies. They had very positive experiences in their first year of motherhood and, they cannot imagine their lives without these children.

Participants described their fears that their social lives were over. Their social lives certainly did change along with their priorities. After their babies were born, their social lives were focused on their children. Family became the center of their lives. It took several weeks and up to a few months for some of the participants to embrace motherhood. Once they acclimated to the maternal role, they were deeply fulfilled.

Another participant who provided primary care of her daughter at home realized that she needed her career along with being a mother to feel fulfilled. Time with her daughter was very precious to her; however, she also needed a creative outlet. She did part time teaching and consulting along with freelance writing. This helped her to achieve some balance in her life as both, a mother and a professional.

The first year of motherhood taught these mothers a great deal about themselves as nonbirth lesbian mothers. Although they did not go through pregnancy and birth, they were equal mothers to their partners who had given birth. They might not have ever imagined themselves as mothers; however, they happily focused their lives on their babies and families. The first year of motherhood was a process of growth and self-discovery for these ten nonbirth lesbian mothers.

Summary

This chapter presented a brief description of the research participants along with a detailed synopsis of each narrative of the postpartum experiences of nonbirth lesbian mothers. The metastory followed revealing the six overarching) themes as well as subthemes for each overarching theme. The themes from each individual narrative were analyzed and ultimately combined to arrive at six overarching themes representing the

entire research sample. Stories remained intact within the portrayal of the metastory illustrating the postpartum experiences of nonbirth lesbian mothers.

Chapter five presents a discussion of the research findings. The study is briefly summarized and, final conclusions are drawn. This research is compared to the review of the literature. Implications for research, clinical practice and education are considered.

Chapter Five: Discussion

Introduction

Six overarching themes revealed the metastory, *The Other Mother: Childbearing Experiences of Nonbirth Lesbian Mothers.* These six overarching themes included: At the mercy of health care providers, Nursing is the major difference between us, Defined by who I am not, Trying to protect my family: The world can take them away, What's in a name? and Epilogue: The New Normal. These themes emerged through the unification of 10 narratives. The stories remained intact as holistic interpretations of individual stories to create the meta-story.

Chapter discourses the results of the study within the context of the literature review. The 6 overarching themes will be discussed within the current state of the science on nonbirth lesbian mothers. Recommendations for practice, education and research are made. The strengths and the limitations are also addressed.

Discussion

At the Mercy of Health Care Providers

The vulnerability of nonbirth lesbian mothers confirms the prior research in this area. Although the studies in the review of literature were predominantly about lesbian couples or lesbian birth mothers, they do confirm the vulnerability of all lesbian mothers (Olesker & Walsh, 1984; Zeidenstein, 1990). Nonbirth lesbian mothers experienced anxiety, fear and panic prior to their babies' births. They felt vulnerable to HCPs fearing that they would not be recognized as parents.

The specific experiences of nonbirth lesbian mothers were very limited in the literature. Erlendsson, et al. (2010) conducted the only study to date focusing exclusively

on the perinatal experiences of nonbirth lesbian mothers. This study revealed that nonbirth lesbian mothers wanted to feel recognized as parents. Personalized care and acknowledgement, as mothers were desired by nonbirth lesbian mothers. Non birth mothers felt valued as parents when providers personally addressed them and involved them in the care of their partners and their newborns'. This author's study substantiated the literature. One mother in this author's study described her intense fear of being denied access to her wife and baby during labor and delivery. She remembered the nurturing presence of one labor/delivery nurse. This nurse supported her through a very critical emergency cesarean birth. She demonstrated genuine empathy by maintaining eye contact with the nonbirth mother, keeping her informed of what was going on during the surgery and respecting her role as an equal parent. Although most of the participants in this study entered labor and delivery with a great deal of trepidation, a supportive and accepting health care team calmed their fears. The experiences of the nonbirth mothers in this study confirm prior research. Studies revealed that most lesbian mothers had positive birth experiences; however, they frequently took defensive measures such as creating birth plans (Buchholz, 2000; Renaud, 2007; Silber, 1991), asking their primary care physicians to prepare hospital staff to care for a lesbian couple (Buchholz, 2000) and bringing lesbian friends with them to the hospital during labor/delivery (Renaud, 2007;Silber; 1991).

The literature documents the childbearing experiences of lesbian mothers in perinatal settings in general. Most studies did not speak about the specific settings lesbian mothers encountered (labor/delivery, postpartum, NICU, ED, pediatric/primary care) but rather made generalizations about the entire perinatal experience. Bucchholz (2000) and

Stewart (2002) recounted that lesbian mothers experienced homophobia as well as supportive care during labor and delivery. Ross, et al. (2006) described lesbian mothers experiences during labor/delivery. Care from staff RNs was described as adequate, however, nurse midwives and doulas were seen as patient advocates protecting lesbian couples from any potentially homophobic care. The nonbirth lesbian mothers in this author's study specifically described their experiences in all perinatal care areas. The most positive experiences came from labor/delivery and the NICU. Conversely, the most negative experiences came from the postpartum unit, the ED and pediatric/primary care settings. The literature review does not address lesbian mothers' particular experiences in postpartum, the NICU, the ED or primary/pediatric care settings.

Nursing is the Major Difference Between us

Breastfeeding was frequently discussed by the participants in this author's study. The topic of breastfeeding was also mentioned commonly in publications about lesbian mothers. Most lesbian mothers chose to breastfeed their babies (Renaud, 2007; Silber, 1991). The experience of breastfeeding from the perspective of the nonbirth mother, however, is absent in the literature review. This author's study provides unique insight into the nonbirth mother's experience of breastfeeding. Every participant talked about breastfeeding. These mothers had a wide range of perceptions related to breastfeeding. Some nonbirth mothers felt that their role was to support their partners' breastfeeding and, others shared that combining bottle-feeding with breastfeeding helped them to feel involved in their babys' care. Some nonbirth mothers voiced personal insecurities about their partners' breastfeeding.

Participants in this author's study envied the closeness that birth mothers experienced breastfeeding their babies. One mother admitted feeling jealousy toward her partner since the baby seemed to prefer the breastfeeding mother. Another nonbirth mother described her partner exclusively pumping so that both mothers could bottle-feed the baby. Brown and Perlesz (2008) hypothesized that since nonbirth mothers do not generally breastfeed, they may question their legitimacy as mothers. The participant in this author's study who chose to exclusively feed her baby pumped breast milk did so in order for both mothers to feel like equal mothers. Being able to feed her baby helped to legitimize her role as a mother. This mother felt that if her partner breastfed the baby, she might feel resentment and jealousy. The concept of maternal jealousy related to breastfeeding was discussed by Pelka (2009). When birth mothers were unable to nurse, there was a significant decrease in maternal jealousy. Exclusive pumping as a means to create equality between the two mothers is not mentioned in the literature.

Another participant in this author's study described doing nonnutritive breastfeeding. She felt that this helped her to feel like a mother and to share closeness with her daughter. This participant feared that others might be judgmental of her breastfeeding her daughter therefore she did not share this with anyone. The literature does not explore breastfeeding with nonbirth lesbian mothers.

Defined by who I am not

Nonbirth mothers discussed their role as uniquely different from the role of the birth mother. Some identified themselves more by what they are not rather than what they are. They did not experience pregnancy, give birth or breastfeed. One participant even described herself as "the more vulnerable parent". The literature review validates the

nonbirth mother as defined by who she is not. Brown and Perlesz (2008) listed 45 possible terms for nonbirth mothers. The literature articulates the social and legal invisibility of nonbirth lesbian mothers (Bergen, et al., 2006; Wilson 2000). Some mothers in this author's study described having to work harder as nonbirth lesbian mothers. They experienced maternal infant bonding more gradually. One participant recalled bonding taking about one year and that it was not as immediate as it was with her birth child. Another nonbirth mother recalled not bonding with her infant until she was about 3 months old. It was difficult for her to recognize this baby as her own. This participant was initially reluctant to become a mother. Although bonding with her baby was a great deal of work, she ultimately embraced her baby as her own. The concept of maternal infant bonding between nonbirth mothers and their infants remains absent from the literature.

Trying to Protect my Family: The World can Take Them Away

The legal privileges of civil marriage and second parent adoption were discussed by many of the participants in this author's study as vehicles to protect their families. Marriage was not specifically discussed in the literature review; however, obtaining legal documentation was discussed as a means to protect lesbian families (Bergen, et al., 2006; Wilson, 2000). Nonbirth mothers tried to legitimize their rights as parents by second parent adoptions and legal parenting agreements when second parent adoptions were not lawful. They also compiled anecdotal evidence of their family life including: family photographs, holiday cards with both mothers' names listed, e-mails from relatives and friends and other personal items which documented their family lives. . They referred to this as "creating a paper trail" to legitimize the parenthood of the nonbirth lesbian mother

(Bergen, et al., 2006). The literature is supported by this research study. Most participants in this author's study were legally married or did second parent adoptions when legally possible. Some participants completed second parent adoptions even though they were legally married and both mothers were subsequently listed on the baby's birth certificate. This served as an attempt to provide extra protection of the nonbirth mother's legitimacy as a parent. Another couple was legally married outside of their home state. Since their marriage was not legal in their home, the nonbirth mother was not listed as a parent on the baby's birth certificate. Couples voiced resentment over the legal process of second parent adoption including home studies and having to prove their worthiness as parents. Second parent adoption was financially prohibited for some nonbirth mothers in this study. This is a disparity for couples that do not have the financial means to afford and adoption and/or are unable to be legally married. Participants who lived in states where second parent adoption and same sex marriage were not legal completed parenting agreements and wills to attempt to protect themselves as parents.

What's in a Name?

The importance of a shared family name in lesbian families was prominent in this author's study. All participants had a shared family last name. This was also endorsed by the literature review. Nonbirth lesbian mothers spoke about the significance of all family members sharing the same last name in order to be recognized as a family (Bergen, et al., 2006; Wilson, 2000). The participants in this study created family names by hyphenating both mothers' names, combining both last names to create a new last name or choosing the name of one of the mothers for the entire family. One participant in this author's study appreciated that her partner wanted their family to take her last name to honor her

as a mother. Participants revealed that having a shared family last name was important for perception purposes. This was especially true when nonbirth mothers took their children to medical appointments. The nonbirth mother's parenthood was not questioned by authorities. She was assumed to be the legal parent since she had the same last name as her children. The magnitude of last names in this author's study confirms the literature review. Nonbirth mothers professed that it was critical for their children to be given some part of their last name in order for them to feel recognized as a parent (Bergen, et al., 2006).

Maternal titles were important to nonbirth lesbian mothers in this author's study. Nine of the 10 participants chose a maternal name for themselves, which included some derivative of "mother". These names helped nonbirth mothers to feel recognized as genuine parents. This confirmed the findings from the literature review. Nonbirth mothers echoed that it was critical for their children to address them with a maternal title. This enabled them to feel honored as equal mothers (Bergen, et al., 2006).

One participant in this author's study did not identify with the maternal role. She initially chose "Poppy Mom" but was eventually called "Uma" to represent her Jewish heritage. Although this woman did not see herself as a mother she did see herself as a parent. She felt that she was an equal parent to her partner in every way. This was a unique situation. The concept of a lesbian mother viewing herself as a parent rather than a mother was absent from the literature review.

The New Normal

The first year of motherhood was filled with profound changes for nonbirth lesbian mothers. One particular mother referred to her life since the birth of her child as

her “new normal”. This new normal was completely focused on the baby. Partner relationships, social relationships and professional careers all became less significant than caring for their newborns. One mother characterized her children as “the glue of our family”. Holiday and family traditions emerged during the baby’s first year. Relationships with extended families also changed as a result of babies being born. Even family members who had difficulty accepting the lesbian couple embraced the children. One particular mother shared that although her in-laws were opposed to her marriage to their daughter and their choice to become parents, once the baby was born they lovingly welcomed her as their grandchild. Having children helped family and community members to recognize the lesbian couple as a family. Becoming parents gave nonbirth lesbian mothers a greater sense of family and a sense of what is most important in life. Homophobia seemed to decrease as a result of couples becoming parents. Perhaps this is because others had more in common with them. As parents, lesbian couples bonded with other adults who were parents. Some individuals who were previously unaccepting of lesbian relationships developed tolerance. The birth of these babies decreased some of the homophobia of parents, in-laws and others.

The “new normal” described in the previous paragraph supports the Suter, et al.’s (2008) notion of “doing family”. “Doing family” is described as lesbian mothers and their children engaging in routine activities, which allows others to recognize them as a family unit. These might include routine activities such as attending church, going for walks or any activity done as a family. This sends a message to others that both mothers and their child are family. This is especially important to validate the nonbirth mother as a parent. It allows her to be seen as an equal parent. As nonbirth mothers engaged in predictable,

routine family activities, others recognized them as parents and considered them to be families.

Nonbirth mothers in this study stressed that in order to be recognized as a mother it was necessary for them to repeatedly come out as a lesbian. Mothers felt that it was essential for them to come out in order to validate their families. Remaining secretive about their sexual orientation might cause children to become ashamed of their family. Nonbirth mothers believed that coming out, as a lesbian family, was essential for the emotional health and well being of their children. Although the literature does not discuss the coming out process for nonbirth lesbian mothers, the notion of "doing family" (Suter, et al., 2008) does reflect the essentiality of being visible and authentic as lesbian families.

Nonbirth mothers also experienced difficult adjustments to motherhood. A particular mother in this author's study characterized this as having a "bone rattling impact". The physical and emotional exhaustion of motherhood was difficult for nonbirth lesbian mothers. Two nonbirth mothers described anxiety and stress after their baby's birth. One nonbirth mother labeled this as "postpartum" [depression]. The literature does not reflect the physical and emotional changes experience by nonbirth lesbian mothers within the first year of motherhood. Postpartum depression is studied from the perspective of the birth mother. This study suggests that it would be meaningful to study the postpartum emotional and physical adjustment of nonbirth mothers.

One participant in this author's study experienced a difficult emotional transition to motherhood after years of unsuccessful fertility treatment prior to her partner becoming pregnant with her first attempt. Pelka (2009) reported that infertile lesbians often grieve over their own inability to become pregnant subsequent to their partner's

successful pregnancy. This was especially difficult if infants preferred their birth mother. Pelka's study is the only publication, which explores this significant notion. This is a deficit in the literature.

Ben-Ari and Livni (2006) discovered that although equality is central to most lesbian relationships, having a child creates two different maternal statuses: biological motherhood and nonbiological motherhood. This author's study confirmed the work of Ben-Ari and Livni (2006). One participant shared that her relationship with her partner is in jeopardy. She feels obligated to remain in this relationship since she has no legal rights to her child. Staying in this difficult relationship might be the only way she can maintain a relationship with her baby. Her first year of motherhood has been lonely and painful and has placed a strain on her relationship with her partner. She has very little support but she remains extremely grateful for her baby.

During their first year of motherhood, nonbirth lesbian mothers ultimately learned a great deal about themselves as individuals and as new parents. Some of the mothers always imagined having children and, others were quite reluctant to start a family. Despite the wide range of readiness for parenthood, all of the mothers in this study adored their babies and embraced their new roles as parents. This overall process of growth and self-discovery for nonbirth lesbian mothers is not reflected in the literature.

Recommendations for Nursing Practice

TJC (2011) published a field guide, *Advancing Effective Communication, Cultural Competence, and Patient and Family Centered Care for the Lesbian, Gay, Bisexual and Transgender Community.* This guide educates hospitals on how to provide quality care for LGBT patients and families by providing specific strategies to improve

therapeutic communication. This document recommends creating a more welcoming environment for LGBT patients and their families. Specific strategies are suggested including posting nondiscrimination policies in publicly accessible locations, providing brochures and literature which include LGBT patients, displaying décor of same sex couples and their families, and posting symbols which indicate acceptance of the LGBT community (such as the rainbow flag or safe zone signs). Visible signs such as LGBT safe zone would affirm GLBT patients and families. This could serve as a message that all families are respected regardless of their sexual orientation. Participants in this author's study described their trepidations entering hospitals and health care settings. They voiced fears that they would not be accepted or recognized as parents. Several nonbirth lesbian mothers were questioned by physicians and nurses regarding the legitimacy of their relationship to their partner and/or children. Perhaps if TJC's previously mentioned recommendations were instituted, LGBT would feel less vulnerability and anxiety as patients.

Hospital visitation policies, which are inclusive of LGBT families, are a major mandate in TJC's (2011) report. The field guide stresses that visitation should include spouses, domestic partners, children, friends and anyone who patients' consider to be family. Many LGBT individuals have been rejected by their biological families. Friends and significant others commonly constitute family for LGBT individuals. It is essential that health care facilities recognize a more inclusive view of family for LGBT patients. One participant in this author's study told the story of her pregnant wife being rushed to the hospital by ambulance, following an eclamptic seizure. She was not given any medical information and remembered "discrimination and not bing able to get to her

[wife]". She described having to "bully [her] way into the hospital". This participant feared for the life of her wife and baby. She also had the unnecessary burden of trying to prove that she was a legitimate family member. A hospital nondiscrimination policy might have created a safer atmosphere for this family.

TJC (2011) recommends that hospitals appoint an advisory group including staff and physician champions who have expertise in LGBT issues. Perhaps hospitals should display the contact information for LGBT champions who can be called if they experience any type of homophobia. This could be displayed publicly along with their nondiscrimination policy. This would continue to encourage an inclusive and welcoming environment for LGBT patients and families. This could also serve as a reminder to all health care providers to be sensitive to LGBT families.

It is important that medical forms are inclusive of LGBT families (TJC, 2011). One participant recalled having to complete a form after her child's birth, which asked for the name of the mother and the father. Medical forms should utilize gender-neutral terms such as parent rather than mother/father and partner/spouse rather than husband/wife. Utilizing gender-neutral terms provides further recognition and validation of LGBT patients and their families.

The Gay and Lesbian Medical Association provides an online directory of health care professionals who are sensitive to LGBT issues (http://www.glma.org/index.cfm?fuseaction=Page.viewPage&pageId=939&grandparentID=534&parentID=938&nodeID=1). If patients could be assured that they will not experience discrimination from their providers on the basis of their sexual orientation they might experience less stress and ultimately better health. It would be valuable for

providers to display evidence of their membership in an organization like Gay and Lesbian Medical Association. This would be a welcome sign of acceptance of the LGBT community. One participant in this author's research study admitted, "I still worry" [when taking her children to medical appointments]. She worries that medical providers and their staff will question her legitimacy as a parent. Health care providers need to display evidence of being accepting too LGBT patients and their families. It is important for patients and families to feel safe and respected as they enter the heath care setting.

Recommendations for Nursing Leadership

The leadership of an organization is ultimately responsible for the culture of that organization. TJC (2011) mandates that leaders are obliged to safeguard LGBT patients and families by instituting and enforcing nondiscrimination policies. Leaders must hold their staff accountable for providing culturally sensitive care to LGBT patients and their families. TJC recommends that leaders should monitor outcomes of initiatives and conduct ongoing evaluation of their organization's cultural competence in caring for LGBT patients and their families. Mechanisms for patients to safely report any discrimination as well as disciplinary processes to address these injustices should be managed by leaders as well.

Recommendations for Nursing Education

Eliason, et al. (2010) specified that education related to LGBT issues remains rare in nursing curricula. "Carla Randall reviewed 8 widely used nursing textbooks and found no reference to LGBT health in 4 of them, and only cursory mention of homosexuality in the other 4" (Eliason, et al., 2010, p. 208). All case studies and examples in these textbooks involved only heterosexual clients. Eliason, et al. (2010) suggest that LGBT

issues are frequently overlooked in nursing education since these issues are commonly thought to be about sex. Consequently LGBT issues are relegated to being a taboo subject. Health disparities in the LGBT community are not predominantly connected to sexual behaviors but rather are chiefly due to societal stigma. This stigma results in harassment, discrimination, denial of human rights, and violence (Eliason, et al., 2009). LGBT issues have been significantly absent from nursing education. Nurse educators must impart content related to LGBT health within their curricula. Eliason, et al. (2010) offer specific suggestions to increase LGBT awareness in nursing students. LGBT issues should be part of all education related to cultural diversity in all clinical specialties. Lavenderhealth.org provides up to date health information for educators, consumers and clinicians regarding the LGBT community (http://www.lavenderhealth.org/). This is a robust resource for nursing faculty. Case studies, videos and textbooks are provided along with other valuable educational resources. It is crucial that nursing educators begin to recognize the health care needs of the LGBT community in order for future nurses to be able to fully care for all people within our culturally diverse world. Eliason, et al. (2010) also recommends that nursing education must acknowledge their own members of the LGBT community including: nursing faculty, staff and students. Nursing education should welcome diverse viewpoints from within its own scholarly community.

LGBT professionals and students possess a wealth of information regarding LGBT health. Nursing education should utilize the knowledge and talents of this group to provide education about LGBT health.

Nursing students should be educated on caring for lesbian mothers. Renaud (2007) contended that the most commonly used *Maternal/Child Health* textbooks barely

mention lesbians and their families. As discussed in the introduction of chapter 1 of this dissertation, the 2010 U.S. Census reports that 33% of lesbian couples have at least 1 child under the age of 18 living with them. This is a significant number. Nurses cannot simply assume that all mothers are heterosexual. Culturally sensitive education must begin with nursing students. In order for nurses (and other health care professionals) to be able to provide culturally competent care to LGBT families, students must be educated about lesbians and their families.

Recommendations for Nursing Research

The primary recommendation of the IOM (2011) report, *The Health of Lesbian, Gay, Bisexual and Transgender (LGBT) People: Building a Foundation for a Better Understanding,* is to advance a research agenda that will support the NIH to conduct research in LGBT health. The IOM report specifically revealed that few studies have focused on childbearing in lesbian women. The report noted that pregnancy loss is difficult for lesbians (Peel, 2010; Wojnar, 2007 as cited in IOM report, 2011). Studies on pregnancy loss among lesbians are limited in the literature. Pregnancy loss is a unique experience for lesbians. They may have decreased social support, increased financial burdens and doubts about their worthiness to become parents. A number of participants in this author's study recounted numerous difficult pregnancy losses. Only two studies document the pregnancy loss experiences of lesbians (Peel, 2010; Wojnar, 2007). Further studies on the pregnancy loss experiences of lesbians would be valuable to nursing.

The IOM report (2011) recognized that lesbians might be at a greater risk than heterosexual women in developing postpartum depression (Ross, Steele, Goldfinger & Strike, 2007 as cited in IOM, 2011). Two of the participants in this study revealed that

their partners experienced postpartum depression. Two other participants also shared that they experienced depression and anxiety after becoming mothers. There are few studies on lesbian mothers experiences of postpartum depression (Ross, et al., 2005; Khajehei, Doherty & Tilley, 2012). This is an opportunity for research to further the state of the science on postpartum experiences of lesbian mothers. Although they do not experience the physical and hormonal changes, the results of this study clearly demonstrate that nonbirth lesbian mothers do experience an emotional postpartum transition. It would also be beneficial to study the emotional adjustment of lesbian nonbirth mothers after delivery

Research on reproductive technology and motherhood among lesbians remains scarce (IOM, 2011). Many aspects of reproductive health among LGBT individuals have never been studied. The IOM report recommends further study on "fertility, infertility, and reproductive health issues, and reproductive technology and its use" (p. 302). Every participant in this author's study discussed a lengthy process of trying to conceive prior to telling the story of their postpartum experience. Participants recounted lengthy fertility treatments, financial hardship, pregnancy failures, miscarriages and countless disappointments. The fact that every mother began with an unsolicited emotional account of her journey to becoming a mother is significant. There are few studies describing the infertility process experienced by lesbian mothers in general and none focusing exclusively on the partners of women undergoing infertility treatment. Further studies in this area would provide a more comprehensive understanding of lesbian mothers.

Maternal jealousy was a significant finding in this author's study; however, it is rarely mentioned in the literature. Pelka (2009) examined the concept of maternal jealousy in nonbirth lesbian mothers. This study suggested a unique option to maintain

equality between both mothers by using one partner's eggs for the other partner to become pregnant through IVF. Pelka's research is unique since she is the only author who studies sharing motherhood through IVF with a partner's donated eggs. This could be a viable, innovative option for lesbians especially after lengthy infertility. Further studies on sharing motherhood might offer lesbian mothers new hope to become mothers. It might also provide a more positive postpartum adjustment and less postpartum jealousy of nonbirth lesbian mothers.

Elaison, et al. (2010) advocate that "well-intentioned faculty members stop telling nursing students and new faculty members to avoid research on LGBT topics. Instead, we need a system to mentor and develop the skills of the next generation so that they will do the research that fills in the current gaps in the knowledge base" (p. 214). The recent reports from TJC (2011) and the IOM (2011) endorse grant-funded research in the area of lesbian health. The Lesbian Health Fund, which is a branch of the Gay and Lesbian Medical Association, also supports research in the area of lesbian health. The mission of the Lesbian Health Fund is to support research to improve the health of lesbians and their families (http://www.glma.org/index.cfm?fuseaction=Page.viewPage&pageId=594).

The results of this author's study suggest several possible research opportunities. Studies focusing on nonbirth lesbian mothers' experiences specifically in each maternal/child specialty area would be beneficial since participants had such varied experiences in different clinical areas. Studies related to breastfeeding and nonbirth mothers would be advantageous especially further exploring nonnutritive nursing as well as exclusive pumping. Since postpartum nurses were viewed negatively by some participants, perhaps researchers should specifically study postpartum nurses attitudes

toward lesbian mothers. It would be valuable to study the postpartum adjustment of nonbirth lesbian mothers including maternal-infant bonding as maternal identity in nonbirth mothers. Grounded theory would be a valuable method to study "what is the basic problem nonbirth lesbian mothers experience during the first year postpartum and what is the process they use to cope with or resolve this process?".

Strengths and Limitations of this Study

This study has much strength. Narrative analysis was a fitting method to capture the postpartum experiences of nonbirth lesbian mothers. As the stories were recounted, the narrative analysis using Riessman's (2008) method of thematic analysis revealed a metastory of the postpartum experiences of nonbirth lesbian mothers. The narratives remained intact, not fractured. Riessman's (2008) thematic analysis was an appropriate method for this study since "in thematic analysis, content is the exclusive focus" (p. 53). Riessman's structural approach to narrative is also most fitting since she focuses on the social and political aspects of stories. In light of the current social and political issues related to the LGBT community, Riessman's thematic analysis provided the best methodological fit for this author's study.

The participants came from eight different American states. Participants were recruited from a variety of strategies including: from a women's health office, from professional colleagues and from an advertisement in a lesbian magazine. This varied recruitment strategy yielded a geographically diverse sample. This was significant since the eight states represented possess unique laws and social policies regarding the civil rights of LGBT citizens. Participants living in the most liberal state represented have the right to legal marriage and second parent adoption. Participants residing in the most

conservative state within the study have no legal right to their children or partners. A wide range of social and political environments is represented within this study; however, this sample did not represent ethnic and socioeconomic minorities well. All of the participants were college educated and middle class. Ninety percent of them were Caucasian and, only 10 percent of them were African American. The lack of economic and racial/ethnic diversity is a limitation of this study.

Conclusion

Nursing has remained silent for too long on the issues of LGBT health. In July of 2012, the American Academy of Nursing (AAN) released a position statement on health care for sexual minority and gender diverse populations. This recent statement acknowledged that nurses should address the unique health care needs of this population as well as health disparities experienced by LGBT people. AAN adamantly opposes any discrimination of LGBT individuals in the health care setting and in society at large and supports initiatives that enhance the health of this group. In July of 2012, AAN also endorsed marriage equality as a significant civil and human rights issue. AAN also links the right to legally marry the person of one's choice to emotional health and well-being. The organization links their support of marriage to the 2001 Code of Ethics for Nurses. The AAN pledges to collaborate with other nursing groups to take similar positions. The AAN statements on the support of LGBT individuals represents a monumental shift in nursing. The organization is the very first professional nursing body to formally embrace LGBT health and specifically marriage equality as a significant healthcare issue. Professional organizations from medicine, psychology, social work and other organizations have publicly embraced the health of LGBT individuals. This is the very

first time nursing has taken such a bold stand to embrace LGBT patients and families. Nurses must urge their own professional organizations to emulate the work of the AAN. Marriage equality remains a significant issue in the health and well-being of lesbian families. It is time that nursing joins the interdisciplinary group of supporters for LGBT health.

This author's research study on the postpartum experiences of nonbirth lesbian mothers adds a valuable insight to the literature. The perspective of the nonbirth mother is virtually absent in the literature. These mothers have significant health disparities. The timing of this study is appropriate. It meets the research agenda of the IOM (2011) and the recommendations from TJC (2011). There is a deficit in the literature regarding the health of nonbirth lesbian mothers. The results of this study offer opportunities for nurses to conduct research on LGBT health. Grant funding is available to support further studies on LGBT health and lesbian nonbirth mothers in particular. This study offers significant results not previously reported in the literature. Now is the time to create healthier experiences for nonbirth lesbian mothers. The results of this study can provide nurses with a better understanding of the postpartum experiences of nonbirth lesbian mothers. This can ultimately lead to more culturally sensitive care of lesbian mothers and their families. This study provides the beginning of a program of research with the goal of providing better care to lesbian mothers and subsequently healthier lesbian families.

Summary

This dissertation began by introducing the topic, lesbian nonbirth mothers postpartum experiences. The background and significance was presented to make a strong argument for the importance of the study. The review of the literature was

detailed. The existing literature was discussed along with the opportunity for this study to enhance the state of the science. Narrative analysis utilizing Riessman's structural approach of thematic analysis was depicted. The significance of this particular method was detailed. The results were presented. The 10 cases were individually described followed by the meta-story of nonbirth lesbian mothers. The dissertation ended with a discussion of the results within the framework of the literature review. Recommendations were suggested for nursing practice, nursing leadership, nursing education and nursing research. The strengths and limitations of the study were considered. The dissertation concluded by acknowledging nursing's history of silence on LGBT issues and advocating that nursing take a stand on public health issues related to the LGBT community.

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Appendix A

Table 1: Characteristics of Individual Studies Included in the Review of Literature

Author(s) & Year	Country	Discipline	Focus	Design	Sample Size	Publication Type
Ben-Ari, A Livni, T (2006)	Israel	Social Work	Experiences & constructed meanings of biological and nonbiological lesbian mothers	Descriptive qualitative, Phenomenological approach	16 (8 couples)	Journal publication
Bergen, KM Suter, E Daas, KL (2006)	USA	Creative Arts & Communication	Parental identity for nonbiological lesbian mothers	Descriptive qualitative "Grounded theory approach"	16	Journal publication
Brown, R Perlesz, A (2008)	Australia	Family Studies	Exploration of names for non-biological lesbian mothers	Theoretical	NA	Journal publication
Buchholz, SE (2000)	USA	Nursing	Childbirth experiences of lesbian couples	Descriptive qualitative	10 (5 couples)	Journal publication
Chabot, JM Ames, BD (2004)	USA	Education	Decision making in lesbian couples planning motherhood	Feminist inquiry, Descriptive	20 (10 couples)	Journal publication
Erlandsson, K Linder, H Haggstrom-Nordin, E (2010)	Sweden	Nursing	Lesbians' Experiences of partners' pregnancy & childbirth	Descriptive qualitative	6	Journal publication

Foster (2006)	Canada	Human Ecology	Experiences of planed two mother families	Phenomenology	12	Unpublished doctoral dissertation
Friedman (1998)	USA	Psychology	Pregnancy experiences of lesbian couples	Descriptive qualitative	34 couples	Unpublished doctoral dissertation
Harvey, SM Carr, C Bernheine, S (1989)	USA	Nursing	Lesbian mothers' experiences during conception, pregnancy & birth	Quantitative	35	Journal publication
Larsson, A Dykes, A (2007)	Sweden	Nursing	Lesbians' perspective of care during pregnancy & childbirth	Descriptive qualitative	18 (7 couples, 4 single mothers)	Journal publication
Luce, JM (2002)	Canada	Social Anthropology	Lesbians' experiences of assisted reproduction	Ethnography	80	Unpublished doctoral dissertation
Olesker, E Walsh, LV (1984)	USA	Nursing	Childbearing needs of lesbians	Descriptive qualitative	9	Journal publication
Pelka, S. (2009)	USA	Marriage & Family Therapy	Maternal jealousy among lesbian co-mothers	Descriptive qualitative	60 (30 couples)	Journal publication
Price, J (2007)	USA	Anthropology	Choice etiology for nonbiological	Phenomenology	8	Unpublished doctoral dissertation

			lesbian mothers			
Renaud, M (2007)	USA	Nursing	Childbearing experiences of lesbians	Critical Ethnography	70	Journal publication
Rondahl, G Bruhner, E Lindhe, J (2009)	Sweden	Nursing	Lesbians' experiences of perinatal care	Descriptive qualitative	10	Journal publication
Ross, LE Steele, LS Epstein, R (2006)	Canada	Medicine	Lesbians' experiences of perinatal care	Focus groups	23	Journal publication
Scott, KE (2007)	USA	Education	Stressors and coping patterns during donor insemination	Descriptive qualitative	8 couples	Unpublished doctoral dissertation
Silber, L (1991)	USA	Sociology	Becoming a lesbian mother	Descriptive qualitative	61	Unpublished doctoral dissertation
Spidsberg, BD (2007)	Norway	Nursing	Lesbian mothers' experience of maternity care	Phenomenology	12 (6 couples)	Journal publication
Stewart, M (2002)	UK	Nursing	Lesbian mothers' birth experiences	Phenomenology	8 (4 couples)	Journal publication
Suter, E Daas, KL Bergen, KM (2008)	USA	Human Communication	Negotiating lesbian family identity	Grounded theory	32 (16 couples)	Journal publication

Wilson, CM (2000)	USA	Family therapy	Experiences of lesbian co-mothers	Descriptive qualitative, Narrative approach	9	Journal publication
Wilton, T Kaufmann, T (2001)	UK	Nursing	Lesbian mothers' experience of maternity care	Descriptive qualitative	50	Journal publication
Zaidenstein, L (1990)	USA	Nursing	Chidbearing needs of lesbians	Descriptive qualitative	20	Journal publication