

Queering the birthing space: Phenomenological interpretations of the relationships between lesbian couples and perinatal nurses in the context of birthing care

Lisa Goldberg

Ami Harbin

Sue Campbell

Abstract:

As health care institutions continue to promote diversity initiatives within the context of Family-Centered and Woman-Centered Care, the taken-for-grantedness of heteronormativity and homophobia remain pervasive in health care practices, including those of perinatal nurses, to the extent that nurses' relationships with lesbian birthing couples are often thwarted. Attending to the complexities of queer (lesbian) orientations embedded in the philosophical tenets of feminist and queer phenomenology, this article draws upon experiential findings derived from interview data to understand lesbian couples' relationships with perinatal nurses in the context of birthing care in eastern Canada.

Keywords:

Lesbian birthing, queer parenting, feminist research, perinatal nursing, phenomenology

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I feared a lot of homophobia, to the point where we did two things; one was that I reassured myself that if something happened to my partner in childbirth, and she was unable to speak, or she died in childbirth, I was really worried that [health care providers] would challenge that I was the child's parent. And I remember thinking...my boss will stand up for me; she will not let anything bad happen to me...and also, we did a signed and witnessed letter that, if anything were to happen to my partner, that child was mine; it was like a form of protection.

(Jen, Non-birthing partner & Co-mother)¹

Introduction

As health care institutions continue to promote diversity initiatives within the context of Family-Centered and Woman-Centered Care, the taken-for-grantedness of heteronormativity and homophobia remain pervasive in health care practices, including those of perinatal nurses, to the extent that nurses' relationships with lesbian birthing couples are often thwarted. Despite good intentions and caring practices by skilled and competent nurses, fears and misunderstandings of queer orientations shaped nurse-patient interactions in the context of our phenomenological study. Although nurses typically intend to provide "safe" and "good" care for lesbian birthing women, the impact of under-recognized heterosexism and homophobia often makes such well-intended practices fraught. Commitments to "treating everyone the same" can contribute further to homophobia in birthing environments.

By attending to the complexities of queer (lesbian) orientations, this article, embedded in the philosophical tenets of feminist (Beauvoir, 1989: 38; Young, 2005: 27) and queer phenomenology (Ahmed, 2006a: 65; 2006b: 543; Zita, 1998: 1), draws upon experiential findings derived from interview data to understand lesbian couples' relationships with perinatal nurses in the context of birthing care in eastern Canada. Lesbian couples in the study, although

cognizant that care “met standards and policies,” and in some cases was “very good,” nevertheless revealed themes of negative expectation, fear, mechanistic birthing, homophobic practices, and lack of inclusivity. Relationships between lesbian birthing couples and the nurses who cared for them often lacked the very initiatives promoted under the frameworks of diversity and Family-Centered and Woman-Centered Care.

Recent cross-disciplinary research has clarified the structures, challenges, and politics of lesbian parenting. Our analysis provides a distinct contribution to this literature in terms of the spaces, life stages and the particular relationships it evaluates by detailing lesbian birthing experiences within hospital environments—an area which remains seriously under-analyzed.² Our research suggests new insight into the particular relationships that form between lesbian parents and nurses in the birthing environments that are an early and crucial point of contact between lesbian mothers and health care structures.³ Such environments can have a formative role in the development of healthy queer-parent families.

Phenomenology: A methodology for gendered and queer bodies

Because the embodiment of birthing often takes place within the heteronormative and homophobic landscape of health care practices, a research framework capable of bringing such pervasive and complex prejudices to light was required. Queer orientations are often only cautiously disclosed by patients within the Canadian health care system, for fear of retribution from health care providers (Ahmed, 2006a: 65; 2006b: 543; McNair, 2003: 643; Wilton, 2001: 6). Given this, an experiential methodology mindful of how lesbian bodies are both gendered and sexually oriented towards self, others and the life-world provided a framework to phenomenologically locate our project.

As a feminist project our thinking was guided by the phenomenological writings of such philosophers as Beauvoir (1989: 38) and Young (1990b: 27; 2005: 3).⁴ Together, Beauvoir and Young compel us to imagine bodily dwellings of feminist realities outside patriarchy, encouraging us to move the phenomenological project beyond male models of the body (Goldberg, 2002: 446; 2005: 401). While further developments of feminist phenomenology draw on Merleau-Ponty and others to account for developments and harms of body image (Weiss 1999), complexities of bodily disorder (Grosz 1994), and embodied reproductivity and generosity (Diprose 1994, 2002), we have found Beauvoir and Young particularly informative for our study.⁵ They remain innovative not only in their concerted focus on embodied experience, and on the impact of gender on our embodiment and affect, but also in the connections they draw between feminist phenomenology and ethics. Their particular ethical considerations are about bodies and how to understand and treat them. Our ethical action is also importantly *embodied*, and our embodied experiences of ethical action are significant.⁶

Although Beauvoir's (1989: 38) work is at times controversial, she nevertheless constructs a phenomenological text on woman's embodiment "with unparalleled depth of tenderness that continues to inspire young and not-so-young women with recognition" (Young, 2005: 99).⁷ Building on her work, Young (1990b: 27; 2005: 3) considers philosophical approaches to conceptualizing woman's embodiment as liberated and free within alternative orientations outside patriarchy. In such works as, "Breasted Experience" "Throwing like a Girl", and "Menstrual Meditations," Young emphasizes the female body as a lived and situated reality that is often experienced by women as unreliable, restrictive, and limiting (1990b: 34). Young's 1983 article "Pregnant Embodiment" emphasizes a male-dominated health care profession as presiding over women's experiences of birth, and shows how gendered relations of authority and

privilege can prevent women from being recognized as agents in birthing situations (2005: 59). In a retrospective reflection, Young claims that while technology has changed considerably, the importance of women's *embodiment* for gaining knowledge and understanding about their pregnancies and births is still neglected. Beauvoir and Young's imaginings prove relevant to our research endeavor, inasmuch as relationships between lesbian couples and perinatal nurses are grounded in the bodily and gendered practices of birthing. Investigating mothers' descriptions of embodied experiences in birthing rooms can help clarify tangible ways in which nurses have provided, and should change how they provide, care. Thus a feminist phenomenology guides us in understanding how gendered bodies of lesbian birthing couples and perinatal nurses navigate their locatedness within the institutional and hierarchical environments in which they reside.⁸

As the research project evolved and queer orientations became a focus of the phenomenological framework, we turned to the writings of Zita (1998: 1) and Ahmed (2006a: 65; 2006b: 543). In her complex text, *Body talk: Philosophical reflections on sex and gender*, Zita illustrates a way of understanding how "unruly" bodies jettison normative assumptions of "straightness." Articulating particular embodied forms that heterosexism and homophobia can take (Zita 1998, 37), she charts how non-normative bodies can make others uncomfortable (Zita 1998: 56), and how indeterminacy of queer desire can allow for new ways of practicing and shaping our erotic lives (Zita 1998: 137-139).⁹ Expanding a focus on normativity, Ahmed's work in *Queer phenomenology: Orientations, objects, others*, highlights the significance of *orientation* in sexual orientation, thinking sexuality as something we enact by desiring and becoming pulled toward other bodies, even when our social and familial environments make it seem like those bodies are not within reach (Ahmed, 2006a: 94).¹⁰ Ahmed's phenomenological project moves us beyond "straight" interpretations of bodies and spaces, aiding our

understanding of lesbian and queer embodiment within the context of heteronormative and often homophobic birthing practices.

Method: Data collection and analysis

Following required approval from the required Health Research Ethics Board, lesbian birthing couples were recruited through local lesbian and health organizations; perinatal nurses were recruited from a large Birth Unit in a tertiary care facility in eastern Canada. 12 participants, 5 nurses; 3 birth mothers; 4 non-birthing mothers (co-mothers), participated in phenomenological interviews with the Principal Investigator; each interview lasting 45-90 minutes in duration. Because phenomenological research attends to increasing understanding of the phenomenon under investigation, rather than making generalizations, determining predictions or causal relationships, yielding rich and rigorous interpretive descriptions that have transferability (fittingness) in other contexts, situations, and settings, purposeful sampling with small samples is commensurate with a qualitative (phenomenological) design (Morse and Field 1995; Sandelowski 1995).

Lesbian couples in the study described their relationships with perinatal nurses in the context of birthing environments, with each member of the couple interviewed separately; perinatal nurses described their experiences of working in relationship with lesbian birthing couples, and at times became aware of the heteronormative assumptions inherent in their practices throughout the dialogical interview process. To protect the anonymity of participants, pseudonyms were used. All interviews were audiotaped and transcribed verbatim. Lesbian participants in the study ranged in age from 30s-40s; had 1-2 children households, and varied in donor experiences (i.e. donor known or unknown), and conception locations (i.e. clinic, medical

facility, or at home). Minimal ethnic diversity was represented, and all lesbian participants were university educated. The nurse participants ranged in age from 20s to 50s. They had varying degrees of clinical experiences and education, including diploma preparation, baccalaureate, masters, and midwifery certification. There was minimal ethnic diversity within the sample although some nurses had worked extensively in countries outside North America.

Our feminist and phenomenological frameworks were helpful in allowing us to respond to the characteristics and group profile of the participants—overall, a minimally diverse group on axes of race and class—in large part by understanding the sample to instructively complement other analyses of how lesbians’ possibilities for conception, births, childcare and supportive parenting environments are still dramatically bettered by more privileged class and educational backgrounds (Gabb 2004; Taylor 2008, 2009). Young helps show how anti-oppressive research can combat the selective privileging of certain perspectives both by highlighting underrepresented experiences (e.g., those of lesbian mothers in general) and by explicitly confronting the issues of why some experiences (e.g., supportive birthing spaces) can still be out of reach for members of some groups (e.g., racialized or undereducated lesbian mothers). Participants in our study were privileged, for example, not only along axes of class and race but via their specific professional knowledge of the health care system.¹¹ Likewise, research into the racial dynamics of responses to queerness (e.g., Ahmed 2004, 2006a; Calhoun 2002) can be supported by more analyses of racial representation in contexts of lesbian birthing and parenting.

The entire research team was involved in the phenomenological analysis process, albeit at different entry points. A feminist and queer phenomenological understanding of lesbian/nursing relationships in birthing contexts was developed as we read transcripts, reflected on and highlighted themes, and considered the conceptual links between queer orientations, perinatal

nursing, and lesbian birthing experiences. Integration of the phenomenological existentials—corporeality, temporality, spatiality, and relationality—further directed our analysis (Merleau-Ponty, 1962: 20; van Manen, 1998: 101). Discussions of the methodologies involved in analyses of queer parenting (e.g., Gabb 2004, Ryan-Flood 2009) highlight our phenomenological framework as distinct from many other perspectives in social science and family studies.¹²

In considering how a phenomenological analysis relates to more standard empirical frameworks in nursing contexts, we understand the phenomenological approach to offer the possibility of foregrounding the embodied and spatial experiences of those interviewed – and we take the interpretation of both kinds of experience to be crucial to our project of investigating lesbian births and birthing spaces. Allowing phenomenological questions to shape our theoretical account thus prioritized situational experience as an object of study, which impacted our conclusions by drawing our attention to specific participant responses. Likewise, we undertook feminist analyses to ensure sensitivity to the importance of relationality and to the interactions of power and privilege which impact relationships between lesbian parents and nurses in birthing contexts. Together, phenomenological and feminist analyses take the social positioning and life-experiences of the researchers and participants to be relevant to the process and results of interviews, acknowledging the complexities of relations among and between researchers and those interviewed. Relationality is evident even more specifically, for example, insofar as some participants were asked to describe their own experiences in the knowledge that their birthing or non-birthing partners would also be asked in separate interviews. Our combined feminist and phenomenological approach allowed for the collection of rich data in this case: many participants explicitly anticipated their partners' responses while distinguishing their own experiences of the same events, allowing for further analyses of expectation and the complex

ways in which disruption can be jointly negotiated in birthing spaces. Such responses highlight the relational (in feminist analysis) and experiential (in phenomenological analysis) emphases that are crucial parts of the research process. We took the refusal of both frameworks to draw lines between analysis and activism to be part of their strength.

In what follows, we attend phenomenologically to the themes of *expectation* and *disruption*. What participants—mothers and nurses—expected the birth experience to be like was a common theme in the interviews and allowed us to consider what was taken-for-granted and what was disrupted. Specifically, we attended to the complexities of the taken-for-grantedness of heteronormativity, and the ways it became disrupted upon the entrance of queer (lesbian) bodies into the birthing space—a space of heteronormativity that positions the straight couple as a social gift, and one that, insofar as it typically reproduces itself, becomes socially binding (Ahmed, 2006a: 65; 2006b: 543). Heteronormativity works to reify sexual norms by enforcing the expectation that processes of birth and parenthood are grounded in heterosexual relationships. The success of heteronormativity relies on the shaping of expectations: we come to expect that we will all enact heterosexuality, and such expectations make heterosexuality a comfortable orientation.

Expectation, disruptions, and spaces

Expectations direct our attention as we anticipate what may happen to us in a particular space. They may be self-conscious, but are more often lived implicitly, as bodily habits, attentional salience, or emotional anticipation (Campbell, 1999: 216). When expectations are widely shared, as is often the case with heteronormative expectations about birth, they shape the taken-for-grantedness of our environments and embodied space (Babbitt, 2001: 53). In the

research study, expectations of the birthing space as a medicalized space often suggested heteronormative privileging would be absent, even in the presence of queer bodies. When Sarah, a lesbian, first-time mother states, “I expected to be treated like any other woman going to have a baby; it was basically a medical procedure,” she calls upon the legitimate expectation of any woman giving birth to be treated with respect and competence by health care providers. Lisa, who is both a lesbian mother and a Registered Nurse, often expressed comfort with the birthing space, insofar as she was part of the health care community and knew what to expect and do. Both Sarah and Lisa formed generally positive expectations about the events and actions that would be involved in their birthing experiences.

Less positive expectations were revealed when mothers expressed gratitude for quality treatment against a background of fearful anticipation about being out of place or vulnerable to punishment. Non-birthing partners were often grateful simply to be acknowledged as partners. One couple, not knowing their nurse was lesbian, was overly thankful for her easygoing manner that removed their burden of explanation; they were spared the difficulty of perpetual outing (Rickards & Wuest, 2006: 530). As Anne, a labour nurse, states, “I think they were kind of shocked, but in a good way, like pleasantly surprised, that there was no problem with them explaining their relationship, and I know afterwards, that they thanked me for being so easygoing.” This positive experience uncovers the exclusory space that often makes lesbian birthing couples fearful of how they will be attended—couples’ expectations of poor treatment from doctors and nurses is symptomatic of the harms of heteronormativity in birthing contexts. Even Sarah, generally optimistic about the kind of treatment she and her partner would receive, highlights their luck in being met positively: “It hasn’t been as horrible as I expected it could be...overall it’s been, touch wood, a good experience. I’ve been very fortunate.” In contrast to

the experiences of couples who anticipate good quality care, the expectation of difficulty can impact not only the birthing experiences themselves (where anxiety can make a risky event riskier), but also how couples will approach health care throughout the pregnancy and after, for both themselves and their child(ren).

We often feel most comfortable in our embodiments when they align with the expectations of our communities, such that we can easily embody shared norms (e.g., heteronormativity). As Ahmed explains, “Normativity is comfortable for those who can inhabit it. The word ‘comfort’ suggests well-being and satisfaction, but it also suggests an ease and an easiness. To follow the rules of heterosexuality is to be at ease in a world that reflects back the couple form one inhabits as an ideal” (Ahmed, 2004: 147). Disruption of such comfort involves a complex combination of factors that may make it difficult to act in once familiar environments. Thus Ahmed writes, “[t]o be comfortable in this space is not to disturb the order of things, [Whereas] to make things queer is certainly to disturb the order of things” (2006b: 565).

It is not always clear who or what will be the subjects or objects of disruption, and it is difficult to determine how disruption will impact individuals affectively and corporeally—sometimes disruption makes us feel fearful or weak (Ahmed, 2004: 154); at other times, stubborn or strong (Ahmed, 2004: 165). Disruption is further complex insofar as our intent to disrupt spaces and/or practices for political means may be contravened; disruption is often non-intentional, its impact indeterminate, and our reactions surprising. In such circumstances, we may no longer know how to move our bodies, how to communicate with those around us, or how to interpret our experiences (Ahmed, 2006a: 158). We can be disrupted when we enter into spaces which challenge the norms we embody, and we can disrupt spaces when we embody non-normative stances within them.

In birthing contexts, queer bodies enter both deeply relational and historically-constituted spaces such that actions and understandings that had seemed natural or easy come to seem questionable or difficult—birthing spaces can be disrupted by the presence of lesbian mothers. While the maintenance of social expectations can allow for shared comfort in community understandings, to enter a space as a queer body is to disturb, to disorient, and to disrupt. Disruption of the order of things (Ahmed, 2006b: 543) manifests itself as lesbian bodies enter the heteronormative birthing space; the anticipation of such disruption is anticipated by mothers with fear and worry. Janet, a co-mother, and partner to Lisa says,

With the male...oh, well, come right in!...I think for lesbians and gay couples... if they're not told...they would hang back. Like are they [health care providers] going to yell at me; are they going to demand something, instead of, you know the nurses, or hospital staff...

For Janet, there is an understanding of expectation likely based on previous, hurtful experiences as a lesbian woman, confronting expectations that she would act in such a way as to only enter spaces when allowed by privileged others, and only to the extent that she did not disrupt the norms at work. As Ahmed understands such situations, “The availability of comfort for some bodies [e.g., heterosexual ones] may depend on the labour of others, and the burden of concealment” (Ahmed, 2004: 148-149). Janet’s experience exemplifies Ahmed’s claim: inasmuch as heteronormative privileging prevails, queer bodies are concealed in the background, unlike “straightness” that greets you at the door: front and center; loud and clear.

To disturb the order of a space is to make it uncomfortable by making the people within it uncomfortable in their habits of embodiment and expectation. Nurses note how lesbian couples disrupted their habits, sometimes making them unsure of what to say or how to react to

their presence. Marcia, a perinatal nurse, describes a time when she entered a birthing room where a lesbian couple was lying together on a hospital bed:

You see heterosexual partners do that...and you say, oh you guys are so cute...with [the lesbian couple] I just said, oh you guys are resting are you? Even though I may have come off very nonchalant...inside I was like, this is a difference. This is different, and I believe they feel that energy ...even though I'm not used to seeing two girls cuddle on a stretcher together...whether I'm awkward or not, they're picking up on that, but they're always knowing that I'm trying to get used to it.

Marcia recognizes how the presence of the lesbian mothers disrupted her habits of expectation, affirmation, and embodied response – she finds herself surprised to see their bodies together, reluctant to affirm them as naturally as she would a heterosexual couple, aware of her awkwardness and a desire to act casually and create comfort. The disruption makes Marcia concerned about the norms governing her language, emotions, and embodiment, and she highlights a struggle to find better ways of caring for couples. The richness and complexity of this situation is contrasted by other nurses' descriptions of trying to prevent disruption by, for example, letting all care providers know in advance that they will be encountering a lesbian couple. Liv explains:

We try to prevent any awkward situations...[by noting] 'this is a lesbian couple' ...Anything that kind of veers outside of [the norm]...we just do kind of the heads up...so that when the nurse goes in to provide care she is not creating any awkward moments and situations...I would just like to remove questions that might be uncomfortable for [mothers], or that may feel insensitive to them...cause we do tend to assume.

While such practices are meant to facilitate the comfort of lesbian couples in birthing environments; they actually allow the norm of the heterosexual couple to remain the default, the presence of lesbians is explicitly noted as an exception.

Mothers describe how dangerous it can be to disrupt spaces, highlighting concern about whether their well-being would be threatened by making birthing spaces uncomfortable for health care providers. As Janet states, “we had been expecting the worst, and somebody maybe wouldn’t know us and wouldn’t be comfortable... and see us as a couple in the situation.” Similarly, Lisa says, “we did spend time worrying if it would be uncomfortable for anyone.” To avoid disrupting the habits of attention in the heteronormative space, and to ensure her own safety, Lisa secured the “on-call” schedule of physicians and nurses, hoping to coordinate her own birth with the safest possible hospital conditions. She says

I knew how to maneuver away from the doctors and the nurses that I knew had problems...I have seen it firsthand. The doctors mistreating them [lesbians] physically when they are frustrated, angry, don’t like them...any of those things and I was really afraid of that...I have the whole obstetrical schedule on my fridge...So, if I was feeling contractions I would go and see who was on that day, who was on call cause my doctor didn’t deliver babies. I had to see whoever was on call the day I went into labour...I was constantly sitting in fear of getting an obstetrician who was someone I wasn’t comfortable with.

Lisa’s words demonstrate how deeply heteronormativity can impact embodiment—to such an extent that we might want to control the very timing of births or contractions.

The disruption of birthing spaces that happens when lesbian mothers enter them can allow for a disruption of heteronormative expectations about birthing, about what kinds of bodies

have children together, what kind of bodily support might best help mothers, and what kind of gender dynamics will play into the first hours of parenting.¹³ As Zita explains, the presence of queer bodies like those of pregnant lesbians and gay and lesbian co-parents “scramble the categories of heterosexual sex/gender ontology and open the possibility of playing against the edge of meaning with the body” (Zita1998:55).

When we are comfortable or made comfortable, our presence needs no explanation because we are expected. When, however, we disturb the order of things, we are called upon to explain our very being.¹⁴ The oppression of various groups is often evident in the special explanatory burden that signals their deviance from the norms that govern social spaces.¹⁵ Some of the most poignant and disturbing moments of the phenomenological interviews concerned “the burden of explanation” on lesbian couples. Anne forgets to explain that the woman she has been caring for is part of a lesbian couple when she delivers her to postpartum. Anne says,

And when we went into the room, the birth mother went into the bathroom, and her partner was sitting holding the baby in the rocking chair...and the postpartum nurse came in, and kind of looked around and said, who are you? The patient’s partner said, ‘I’m the mom,’ and she [the nurse] said, ‘no you’re not,’ and it was really terrible. She said, ‘no, where’s the baby’s real mom.’

Anne here takes responsibility for failing to clarify a relationship that disrupted the straight tendencies that enable the postpartum nurse to act. In the postpartum nurse’s reaction, motherhood is denied by the health care provider herself. The nurse’s denial of the non-birthing mother’s legitimate status as mother is, in part, a denial of the legitimacy of her embodiment (i.e., she does not have the right kind of body at that moment for her to be ‘the real mom’) and her capacities for self-identification (i.e., she does not have the power to identify herself as

‘mother’ against the nurse’s habitual understandings). The postpartum nurse is thus unable to treat the lesbian couple with even minimal respect and dignity. Both the fact that mothers are required to explain themselves and the actual explanations given by mothers are disruptive moments where assumptions and expectations of parental and birthing roles are called into question.¹⁶ In a birthing context where heteronormativity is still expected by nurses, physicians, and parents (queer and otherwise), the affective difficulty of preparing to give birth can be substantial—queer bodies disrupt birthing spaces, and this can be anticipated and enacted with fear, anxiety, and discomfort.

From disruption to queer: The challenge of shifting birthing spaces

The entrance of lesbian bodies into birthing spaces disrupted the heteronormative habits of attention. Lesbian couples become disrupted in their expectations about and experiences of care; nurses were disrupted in the taken-for-grantedness of their heteronormativity. As Marcia describes shifts in her care practices and responses to birthing couples, “I felt awkward a little bit, but I worked really hard – like, I felt I tried harder to make [lesbian couples] feel comfortable...always in the back of my head I was wondering, am I saying the wrong words, do I say partner, do I say girlfriend...in developing the relationship, it’s very different because you feel like you’re going to say something wrong.”

Although these disruptions were pervasive, the transformative or refigurative potential of some disruptive moments was also revealed in the context of the research—in some descriptions, we can understand the birthing space to have been *queered*. Birthing spaces became queered perhaps most notably: when dominant understandings of sameness and difference in practices of treatment are questioned; when embodiments of care are more closely attended to; when the

language of parenting shifts to reflect new roles; when gendered norms of parenting are playfully challenged; and when imperatives of ease or comfort are recognized as keeping heteronormativity powerfully in place.

Recall Anne. She embodied a birthing space oriented towards queer. As a nurse who is also lesbian, she jettisoned the taken-for-grantedness of heteronormative birthing practices when caring for lesbian couples:

I think my perspective is probably very different from a lot of nurses' perspectives...I probably would be more sensitive than some nurses because of my lifestyle and my sexual orientation...But it still can be uncomfortable, because everyone identifies differently, and I don't want to use a label or something that maybe I would say that they don't identify with.

Anne's words are reminiscent of what is needed to embody queer spaces. That Anne is herself lesbian yet able to recognize difference in sameness is an important starting point and a quality that sets her apart from many of her nursing colleagues who negate difference because of fear or misunderstanding. Rather than recognize that difference may need acknowledgment and respect, nurses in the study often equated the recognition of difference with diminished care. The assumption that the best treatment would not distinguish between the needs of queer and non-queer couples is based on a privileging of sameness over difference.

The necessity of recognizing difference is evaded when nurses assume that the treatment they provide lesbian mothers should be identical with that given to heterosexual parents. Liv, a perinatal nurse, responds to the question of how she might go about treating a lesbian couple in the birthing context by saying, "I'm not sure I do that much different...I sort of feel that I have to treat them just like any other couple...Maybe that's good, maybe that's

bad, maybe I should be doing things differently, or maybe [lesbian couples] prefer ... just being treated exactly like you would like another couple.” Nurses’ narratives often reflected the view that differences were not relevant when caring for lesbian experience. Joyce, a nurse participant says, “...in some places it would never be acknowledged that people were heterosexual or homosexual, in as much as, for fear of being out there...but I can honestly not tell you that I do anything different...I don’t feel I approach anybody any differently.” Marcia accentuates the sameness of lesbian mothers and heterosexual parents, emphasizing how “they love each other just as much as you love your husband, and they have relationship problems just like you do, and they want a baby just as bad as you do.” The affirmation of care practices blind to difference is also found in some mothers’ accounts. Sarah expresses appreciation for her obstetrician’s efficiency, explaining that, “she [was] a great doctor from start to finish, and kept tabs on me just like every other pregnant woman...it’s her job just to make sure the baby is healthy, and everything goes well in labour and delivery...it was just another baby for her...she delivered one a day, pretty much.”

The presumed need to treat all couples the same is one way in which difference goes problematically unrecognized. One way in which nurses might better approach the birthing experiences of queer couples differently is by attending particularly closely to the needs and feelings of the non-birthing mother. Jen, a non-birthing mother, highlights her experience of feeling less supported and heard than she needed while her partner was receiving interventions and giving birth, and suggests that “When your partner’s in labour, she has to be the focus...people need to take care of the partner, so that the partner can take care of the woman who’s laboring.”

Another way in which approaches to treatment could attend to differences among birthing couples reflects how some birthing couples more than others might benefit from greater attention to community development as a component of birth-context caregiving. This point is highlighted by Chloe's (non-birthing mother) description of how another lesbian couple was brought into the same recovery room as she and her partner:

We didn't know them, but we could hear them talking on the phone and we were like...that's two women over there!... Nobody said boo. Although it would have been nice if the nurses had said there are two women next door too, but any how we were all in to our own thing so much at that point...We now know who they are...for support.

Without generalizing to all birthmothers' experiences, one way nurses could approach difference in the treatment of lesbian couples is by helping to foster possibilities for community development, becoming alert to the potential for queer families to feel particularly isolated and to the importance of support networks for all new parents. In their descriptions of the extent to which they might treat some mothers or couples differently than others, nurses tend to highlight how different treatment is motivated by the difference and uniqueness of every person's needs and every couple's experiences. As Anne explains, "There are ways that every couple is the same when they're having a baby, and like every human being, there are differences...if you don't tailor your practice for your individual patient, then you're doing them a bit of a disservice." Her words highlight a pervasive, problematic tendency to understand the requirements of acknowledging diversity as best met by sustained focus on the individual. Such thinking understands diversity as chiefly connected to individuality. While failing to tailor practice towards individual patients can threaten to neglect their diversity, diversity must be recognized on a group-level as well:¹⁷ by virtue of the systematic harms of

heterosexism, lesbian mothers as a group may need particular kinds of care that heterosexual mothers tend not to need.

The need to engage difference is further ignored when lesbian or lesbian-friendly nurses are consistently assigned to lesbian couples. Although the intent of such practices is to provide safe and optimal care, this practice makes it such that nurses uncomfortable with lesbian experience continue to refrain from caring for lesbian clients, reinforcing systemic homophobia. As Joyce points out about her nursing colleagues, “I still think there are people extremely uncomfortable with [lesbian experience], and don’t want to be involved.” When lesbian birthing mothers recognized and received recognition from lesbian nurses, this sometimes reinforced rather than disturbed heteronormative space. Birthing spaces might become queered in part by recognition of the need for treatment more attentive to difference, responsive to the particular needs of lesbian parents, and further by giving non-lesbian nurses more opportunities to engage with queer mothers.

Queering birthing spaces also requires that nurses and other participants in birth become more attuned to the ways problematic social norms can appear in their embodied behavior. For example, mothers speak of how empowered and cared for they can feel as a result of receiving eye contact from nurses. Janet describes nurses as sometimes “being inclusive in conversations, you know, and not just looking at the patient, but looking at the partner.” Mothers also note how silenced and insignificant they can feel when not acknowledged by such contact. As Chloe describes one nurse, “...She was trying to take vitals and stuff [of the infant] and...she would not look at ya”, and as Jen describes her experience as a non-birthing mother in the birthing room: “it’s like I was invisible.” Anne’s earlier description of the nurse who came in and looked around for the ‘real mom’ further exemplifies

a dismissive gaze. As Chloe highlights, even the way people in positions of relative power (e.g., nurses) respond to the presence or coming-out of mothers with a particular kind of *blinking* can be noted as a sign of significant discomfort or disapproval. A queering of birthing spaces might include a higher sensitivity to the power and potential for both harm and care held by the embodied gestures of nurses and other health care providers.

Almack (2005) considers the complex issues around surname choices for children born to lesbian parents; our research showed the need to further understand also the more intimate practices of naming within families and between parents and nurses. When asked how they referred to non-birthing mothers, nurses provided a variety of responses—even the question itself was in some interviews disruptive, bringing up an issue that nurses had not yet considered. In some cases both the birthing and non-birthing partners were regularly referred to by nurses as ‘mom’, in other cases not, and in some cases the non-birthing mother was not referred to by role or name at all. It seems that a commitment on the part of nurses to ask mothers how they are planning to be named could be an important part of a queered birthing space by making it explicit that birthing and parenting roles are up for redefinition and re-identification. Such practices could not only acknowledge the agency of partners to identify themselves, but undermine the development of new rigid patterns of expectations about the roles of birthing and non-birthing parents in the lives of children (e.g., even settling into using ‘mom’ and ‘mom’ might encourage such patterns by maintaining the heteronormative assumption of there existing two fixed, gendered parental roles). Joanne, a birthing mother, describes how, after their first birthing experience, she and her partner

both decided that we wanted to use some version of mommy or mama because...it matters to us...[and for] the non-birthing mother this was extra important...sort of like a

claim that you want to have that sort of acknowledgment...that's how you see yourself, and that's what your role is in this child's life.

Securing this kind of agency for mothers would ensure them a certain degree of power that they have historically been denied, when situations have left them to try and shape their birthing experiences only through indirect means (e.g., as when Lisa wanted to control which on-call doctor she would see). To give queer parents the opportunity to identify themselves is to start with the expectation that their self-identifications are meaningful, legitimate, trustworthy, and thus important to the event of their child's birth. It is possible that the more positive sense of 'giving opportunities for self-identification' might sometimes blur with the requirement that mothers 'explain themselves' in practice, particularly given the pervasiveness of heteronormativity. As Joanne describes her family's response to her as a non-birthing mother, "Even to this day, my parents will say, what do they call you again?" Even so, it might be possible to queer birthing spaces in one sense by taking the self-identifications of their most important participants to be valuable and instructive.

In addition to the potential queering of birthing spaces by establishing treatment sensitive to difference, by focusing on nurses' embodiments of care, and by reworking assumptions about birthing roles, in part, through language, such spaces might also be made queer by the playfulness that queer subjects can bring to them. Chloe laughs as she recounts an anecdote from shortly after her partner gave birth:

"One funny story... [I was] walking down the hall with the baby and there was a man walking down the hall as well, and I had a friend with me and she said...how did it go you know? I said...oh it was easy...It didn't hurt at all!...And look...I am back in my

jeans already!... And buddy was looking ‘cause I had the baby you know. He said... ‘oh my god!’”

There is a subversion to this playfulness—of course the man would expect the baby’s mother to have a particular kind of body so soon after birth, not one easily walking around or wearing jeans. Chloe’s intention is presumably not to disrupt the man’s expectations; even so, such play can highlight gendered norms around birthing and parenting as contingent and open to new enactments, and it can do so in non-threatening, accessible, even enjoyable ways. Playful subversions can queer birthing spaces by allowing lesbian mothers to show dominant expectations as open to questioning and revision, while doing so in a language and tone that expresses rather than conceals the excitement and joy they might be feeling about their births, families, and futures. As Ahmed states, “The hope of queer is that the reshaping of bodies through the enjoyment of what or who has been barred can ‘impress’ differently upon the surfaces of social space, creating the possibility of social forms that are not constrained by the form of the heterosexual couple” (Ahmed, 2004: 165).

Finally, our study revealed the potential interplay of comfort and discomfort in queered birthing spaces as important to shifting such places. Mothers and nurses alike highlighted the need to ensure the comfort of birthing and non-birthing parents during the processes of giving birth; there are important respects in which queered birthing spaces need to ensure the comfort of all parents within them. Mothers should feel confident in the care they will receive from dedicated and competent health care providers, secure in the knowledge that their well-being is a priority, and trusting of the nurses providing care. What complicates emphases on the importance of *comfort* in queered birthing spaces is our claim that creating birthing spaces that

better reflect the needs of lesbian mothers in particular might require that people within those spaces face fruitful *discomfort*.¹⁸

Conclusions

To queer the birthing space, a profound shift is required. Researchers have argued that the ability for lesbians to recognize themselves in a space through a more generous visual and textual representation of lesbian lives is important (Barbara, Quandt & Anderson, 2001: 45; Stevens, 1995: 25; Wilton & Kaufmann, 2001: 203). However our study suggests that this strategy will not be effective unless expectations of and relations within the very space(s) where birthing occurs are disrupted and re-worked to embody orientations that reside outside heteronormativity. We have suggested that expectations can be disrupted when lesbians enter birthing spaces and nurses are called to notice, anticipate, or respond to their distinct needs for support and care. Such disruptions are thus interactive rather than unilateral: the entrance of a lesbian mother or parenting couple is not sufficient to queer the space. Following the disruptive entrance and uptake of lesbian bodies, birthing spaces can be queered—where ‘queering’ is an ongoing process, not one that will come to a conclusion—when all participants become able to experience and enact births differently as a result of shifts in expectations and new understandings of care.

Our discussion of disruption means to initiate discussion of complexities around who or what can queer a birthing space. To view disruption as dependent on the presence of an *explicitly identified* lesbian birthing mother or non-birthing mother would not align with our analysis of interactive disruption, and would risk neglecting the experiences of single lesbian mothers, or problematically reducing queer births to only those where mothers explicitly identify

as lesbian to their caregivers. To clarify the possible impact of queering birth spaces, we might try to imagine a case in which a queer woman who neither explicitly identifies as queer nor enters a birthing space with a queer co-parent might nonetheless receive care within it that makes possibilities for queer parenting more accessible, both in the birthing space and elsewhere. The potential difficulty of such imaginings may help again expose how deeply heteronormativity characterizes such spaces.

Ahmed highlights the promise of disrupting spaces in the following way:

The closer that queer subjects get to the spaces defined by heteronormativity the more *potential* there is for a reworking of the heteronormative, partly as the proximity ‘shows’ how the spaces extend some bodies rather than others...What happens when bodies fail to ‘sink into’ spaces, a failure that we can describe as a ‘queering’ of space? When does this potential for ‘queering’ get translated into a transformation of the scripts of compulsory heterosexuality? (Ahmed, 2004: 152, original emphasis)

Making heteronormative birthing spaces more accessible to queer parents allows for potential for the reworking of the space itself—the realization of this potential depends in large part on the willingness of those who work within birthing spaces to have their expectations disrupted and their practices re-worked. That nurses in the study were committed to providing open and respectful care for lesbian birthing couples suggests that re-alignment is possible, albeit slowly and with cooperative efforts. Reworking birthing spaces will also depend on the continued strength and courage of the queer parents who enter them. We see bodies failing to ‘sink into’ spaces when mothers and nurses resist old terminology in favour of creating new ways of identifying themselves and their relationships, build alliances and community even when the health care framework makes that difficult, and playfully and courageously challenge gendered

norms of childbirth and parenting even when doing so generates discomfort. Mothers describe the need to be recognized in embodied ways by those who work within the birthing spaces, and they open paths for analyzing how the best kind of care would not aim to treat all bodies or births the same.

Notes

¹ Terminology around motherhood is challenged by the couples we interviewed, and our language in this paper is meant to reflect the nuances of mothers' roles. We use 'non-birthing mother' and 'co-mother' interchangeably here, aiming also to represent the experiences of some mothers who did not give birth in the most recent cases, but were birthing mothers in previous pregnancies (as was the case for some of the women interviewed). In section four, we consider how this challenging of language can allow in part for queering birthing spaces.

² **Many nuanced accounts focus on individuals' access to and experiences of conception, and/or the ongoing interactions of lesbian-parent families within the home (Almack 2005; Gabb 2004; Taylor 2008, 2009).**

³ **This is a distinct contribution to the literature insofar as many accounts focus on relationships between lesbian parents, between parents and children, or between lesbian-parent families and their communities (Gabb 1999, 2008; Ryan-Flood 2009; Weeks et al 2001).**

⁴ **We are a diversely oriented research team, from the disciplines of nursing, medical education, philosophy, and gender and women's studies.**

⁵ **Future connections between this project and the most recent work of Diprose are particularly promising: although this is beyond the scope of this project, it would be interesting to develop connections between the complexities of lesbian birthing experiences in connection to affect, and in particular to the emotions associated with *giving* (Diprose 2002, 95-106).**

⁶ Beginning with Beauvoir's early writing in *The second sex*, we are introduced to her phenomenological interpretation(s) of woman's recovery of lived experience (Allen 1989: 71). **The final chapter of Weiss 1999 on "Bodily Imperatives: Towards an Embodied Ethics" stresses the need to develop corporeal emphases in clarifying ethical action, showing the importance of discussing ethical bodies and embodied practices of responsibility. We understand the work of Beauvoir and Young to have importantly initiated and sustained such projects, while also carving out paths for showing the potential of phenomenological research to be inherently ethical.**

⁷ *The second sex* thus remains a substantive resource for understanding social critique and female experience (Young 2005: 98).

⁸ **For reflection on how practices of birthing are not exempt from the hierarchies foundational to birthing environments, see Goldberg 2002: 446; 2005, 401.**

⁹ **By including provocative examples, such as the male lesbian and lesbian femfire, Zita challenges us, both theoretically and experientially, to move beyond the social constructs of heteronormative bodies.**

¹⁰ **Further recent phenomenological approaches to queerness can be found in Fryer 2008 and Salamon 2004, 2009, with Salamon's work highlighting phenomenology of trans identities and experiences in particular. Salamon's analyses might be drawn into further conversation with our research projects particularly as issues surrounding trans pregnancies and births become more pressing in years to come.**

¹¹ **Young provides a background to this understanding of the intersections between social privilege and professional situation in "Affirmative Action and the Myth of Merit" (Young 1990a, 192-225).**

¹² **Gabb's perspective into 'radical research' aimed at lesbian family structure is particularly instructive: while experiential accounts are canvassed (Gabb 2004, 17), explicitly phenomenological frameworks do not seem available.**

¹³ Nurses and lesbian mothers might be disrupted when heteronormativity is challenged in birthing spaces, even if they already subvert heteronormativity in other areas of their lives.

¹⁴ One of the ways the taken-for-granted expectations of others become explicit discomforts for those who are marginalized is through the burden of explanation (Babbitt, 2001: 53).

¹⁵ Calhoun (2002: 75) suggests that for those who are lesbian and gay, there is a special burden precisely because their marginalization consists in their “displacement.” In the United States, where Calhoun (2002: 45) writes, it is acceptable to be queer, only if one does not embody queer subjectivity in public space.

¹⁶ If we think that disrupting birthing spaces can allow for disrupting heteronormative expectations, that one way expectations can be disrupted is by unexpected explanation, and that these moments of disruptive explanation have the potential to be fruitful, we will need to consider how they can be highlighted as valuable without putting more burdens of explanation onto mothers.

¹⁷ **We thank an anonymous referee for bringing this interesting point to our attention.**

¹⁸ **Such discomfort may be felt more by the bodies more involved in enacting (or, even unconsciously, enforcing) heteronormativity. Even so, such discomfort might also be felt by queer parents within the spaces. One concrete way that this might happen is in pairing lesbian couples with non-lesbian nurses in birthing rooms. Although queer mothers sometimes noted how comforting it was to experience personal connection with lesbian nurses, birthing spaces might be queered in part by establishing more open, personal, and caring connections between non-queer nurses and lesbian mothers. Perinatal health providers, including nurses, who do not necessarily identify as lesbian or queer, may benefit directly from understanding lesbian birthing in the context of heteronormativity (Goldberg, Ryan and Sawchyn, 2009). The disruption that plays an important role in challenging heteronormativity and queering birthing spaces can involve and require the discomfort of some people within those spaces. See, for example, Boler 1999: 175-203 on the pedagogical promise of discomfort.**

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