Abstract: As modern family composition shifts—for many, away from a heteronormative nuclear family—so, too, must the health care that families receive. Lesbian women and their families face particular difficulties with maternity care in the United States and internationally, because many care providers lack an understanding of this population's specific health care needs. In this article, I examine the challenges faced by lesbian women during the transition period to new motherhood and recommend improvements that can be made by individual providers and the health care system as a whole to better provide culturally competent health care for this population. https://doi.org/10.1016/j.nwh.2017.12.003

Keywords: assisted reproductive technology | cultural competence | lesbian health care | lesbian motherhood | LGBTQ
Despite advances in equality for the lesbian/gay/bisexual/transgender/queer (LGBTQ) population, lesbian women face unique challenges in accessing health care, including social, political, and economic barriers. Documented social and political barriers to care include fear of or experiences of homophobia, discrimination, and stigmatization (Chapman et al., 2012; Hayman, Wilkes, Halcomb, & Jackson, 2013; Sabin, Riskind, & Nosek, 2015). Homophobic or heterosexist attitudes, heteronormative assumptions, and lack of knowledge regarding health needs for this population also pose significant barriers, which may affect lesbian women’s experiences and interactions with their maternity care providers (Chapman et al., 2012; Marques, Nogueira, & de Oliveira, 2015).

Currently, most health care communication still tends toward heterosexist language that may marginalize same-sex couples and their families. Negative experiences with providers and the health system have discouraged lesbian women from obtaining necessary health care, including preventive care (Bjorkman & Malterud, 2009; Marques et al., 2015; Rondahl, Bruhner, & Lindhe, 2009; Sabin et al., 2015). Economic barriers to lesbian couples who seek motherhood vary and depend on the cost of interventions needed to achieve pregnancy, such as use of donor sperm, intrauterine insemination, and in vitro fertilization (Bernard, 2014; Goldberg & Scheib, 2015; Hayman, Wilkes, Halcomb, & Jackson, 2015). Insurance coverage for these interventions can vary greatly. Additionally, the emotional cost and lack of community and family support compared with their heterosexual counterparts can impede lesbian women on their journeys to becoming mothers (Wojnar & Katzenmeyer, 2014).

**THEORY**

Mercer’s classic model of becoming a mother explains the process of beginning motherhood as a period of significant transition (Mercer, 2004). The process—now termed maternal role attainment—to better account for the constantly evolving nature of motherhood—consists of repeated instances of adaptation as the demands of a woman shift. It also involves a reformation of a woman’s identity, as relationships to others and to oneself change (Mercer, 2004). This is especially true of lesbian women, because the transition to motherhood may involve many struggles, such as lack of acceptance from families, feelings of isolation from support groups, social stigma, and issues related to seeking care as a sexual minority.

Although *family* is usually a biological unit, the social constructionist approach recognizes *family* as a unit that is created through active choice and is presented as such socially and legally. This approach lends more weight to the lesbian family because it recognizes that family is significantly more than a biological unit and should be recognized as valid and functional, despite differences in structure. Queer theory further builds up the lesbian family structure by challenging traditional heteronormative views of family. Together, the two approaches “highlight the active role of individuals in drawing from cultural and societal ideologies (e.g., assumptions regarding family and biology) to attach meanings to their lives” (Goldberg & Scheib, 2015, p. 727).

As Goldberg and Scheib (2015) note, queer theory suggests that lesbian women may be less attached to biological motherhood than heterosexual women, because their assumptions regarding family are much broader and their disparate sexual identities often involve a socialization in which achieving motherhood is not integral. Feminist theories as a whole have “dealt with lesbian motherhood as a form of resistance to heteronormative parenthood, but also as an assimilation of the lesbian to traditional notions of femininity” (Malquist & Nelson, 2014, p. 69). However, this generalization does not negate the real desires of many lesbian women to have biological families and the experiences of pregnancy and birth in the creation of their families (Goldberg & Scheib, 2015). Although there has been an increase in studies that focus on the LGBTQ population, the lesbian community remains fairly invisible in research, especially compared with the gay male population. Scientific studies with lesbian women usually comprise convenience samples, which greatly limit generalizability (Marques et al., 2015). Much of current maternal research has focused primarily on labor and birth experiences rather than the process of becoming a mother as a whole (Chapman et al., 2012).

For this article, I sought to review studies in which researchers focused on the experiences of lesbian women throughout the process of becoming mothers and to focus particularly on the women receiving pregnancy-related health care, instead of on their supporting partners or providers, to establish a consistent perspective. The health care needs of any subpopulation...
of people are as unique as the individuals themselves. With regard to lesbian women and their partners, the process of becoming a mother is a complex journey. I also highlight ideas for changes to the health care system needed to best support and care for lesbian women as they plan for motherhood, experience pregnancy, and become parents.

METHODS
The purpose of this review was to explore how self-identifying lesbian women (single and coupled) experienced the health care system during the prenatal, labor and birth, and postpartum periods and how the findings could be applied to nursing practice. Articles were sought whose authors specifically performed qualitative studies in which they examined women’s experiences during this period of health care delivery. The review was limited to research published between 2009 and 2016, as the technology of assisted reproductive treatment and the provision of health care to the LGBTQ population have steadily progressed.

The studies were narrowed to include those with a focus on the perspective of the woman receiving care and not the partner or the health care provider. The sample of relevant studies was identified by searching primarily health science and sociological databases: CINAHL (headings used), British Nursing Index, PubMed, the online archive for the Journal of Obstetric, Gynecologic, & Neonatal Nursing, Cochrane Library, Joanna Briggs Institute, and PsycINFO. Search terms included lesbian, mother, mothering, lesbian motherhood, lesbian parent, lesbian parenting, LGBT cultural competence, and assisted reproductive technology. No articles were retrieved from the Cochrane Library or Joanna Briggs Institute. Ten articles were identified that met the search criteria; ultimately, only qualitative data were assessed in this review. The articles used are summarized in Table 1.

Each study report was systematically reviewed with an examination of the focus of the article, methods, findings, and discussion. Selective themes within the 10 studies were identified based on the common threads and are summarized comprehensively in this review. The identified themes include the following: Making the Decision to Become a Parent, Access to Care, and Stigmas in the Health System.

FINDINGS
Making the Decision to Become a Parent
For a lesbian woman or couple, the decision to become a parent may not be an easy one. However, many lesbian women in the studies included in this review reported a strong maternal desire and need to start a family with their partner. Although adoption is a very real option for individuals in nontraditional families and was referenced numerous times throughout the literature, this review focused on the experience of same-sex female couples who pursued biological motherhood for one partner. For the purpose of this article, biological motherhood will refer to the experience of pregnancy and birth for one partner via use of donor insemination.

Historically, many lesbian women have assumed that their sexuality would exclude them from motherhood, despite any biological desires for children. These women believed that the nature of their relationships meant that parenthood was not a feasible option. This assumption has been exacerbated by the view of some in the lesbian community that motherhood is “extraneous to authentic lesbian culture” (Hayman et al., 2015, p. 402). Participants in one study struggled with a distancing by the lesbian community, sometimes due to the perception that lesbian couples seeking motherhood were “trying to emulate heterosexual families” (Wojnar & Katzenmeyer, 2014, p. 55). Some participants in this study struggled with lack of support from their families, but others felt they received significant validation from their families for their relationships and their pregnancies (Wojnar & Katzenmeyer, 2014). Despite setbacks, the women in the studies by Hayman et al. (2015) and Wojnar and Katzenmeyer (2014) were committed to parenthood.

Because there are no so-called happy accidents in lesbian motherhood, assisted reproductive technology has opened up the possibility of pregnancy and motherhood to same-sex female couples (Hayman et al., 2015). The costs of assisted reproductive technology can range from hundreds to many...
### TABLE 1

#### Relevant Studies

<table>
<thead>
<tr>
<th>AUTHOR(S), DATE, COUNTRY</th>
<th>FOCUS</th>
<th>STATED METHOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapman, Wardrop, Zappia, Watkins, &amp; Shields (2012), Australia</td>
<td>Same-sex female couples discussing their process of becoming parents</td>
<td>Qualitative, descriptive, exploratory study; interviews, open-ended, semistructured format</td>
</tr>
<tr>
<td>Goldberg &amp; Scheib (2015), United States</td>
<td>Narratives of female-partnered and single mothers regarding donor insemination versus adoption</td>
<td>Qualitative; interviews, open-ended, semistructured format</td>
</tr>
<tr>
<td>Hayman, Wilkes, Halcomb, &amp; Jackson (2013), Australia</td>
<td>The experiences of Australian lesbian mothers with homophobia from health care services and providers</td>
<td>Qualitative phenomenological; semistructured interviews (&quot;story-sharing method&quot;), demographic data sheet, participant journaling</td>
</tr>
<tr>
<td>Hayman, Wilkes, Halcomb, &amp; Jackson (2015), Australia</td>
<td>A sample of same-sex female couples discussing their journeys to motherhood, especially regarding planning pregnancy, donor insemination, and methods of conception</td>
<td>Qualitative; interviews, open-ended, semistructured format</td>
</tr>
<tr>
<td>Lee, Taylor, &amp; Raitt (2011), United Kingdom</td>
<td>The experiences of lesbian mothers throughout their maternity care in the United Kingdom</td>
<td>Qualitative, modified hermeneutic phenomenology; unstructured interviews</td>
</tr>
<tr>
<td>Malmquist &amp; Nelson (2014), Sweden</td>
<td>The experiences of lesbian mothers in Norwegian fertility clinics and maternal and child health care settings</td>
<td>Qualitative; interviews, open-ended, semistructured format</td>
</tr>
<tr>
<td>Marques, Nogueira, &amp; de Oliveira (2015), Portugal</td>
<td>Self-identified lesbian women in Portugal describing their experiences with health care professionals</td>
<td>Qualitative; interviews, open-ended, semistructured format</td>
</tr>
<tr>
<td>Röndahl, Bruhner, &amp; Lindhe (2009), Sweden</td>
<td>Lesbian women discussing the heteronormativity experienced in various aspects of antenatal, childbirth, and postnatal care</td>
<td>Qualitative phenomenological; interviews, open-ended, semistructured format</td>
</tr>
<tr>
<td>Sabin, Riskind, &amp; Nosek (2015), United States</td>
<td>The implicit and explicit attitudes by health care providers toward lesbian and gay individuals</td>
<td>Qualitative phenomenological; interviews, open-ended, semistructured format; survey</td>
</tr>
<tr>
<td>Wojnar &amp; Katzenmeyer (2013), United States</td>
<td>Experiences of preconception, pregnancy, and new motherhood for lesbian nonbiological mothers</td>
<td>Qualitative, descriptive study; interviews, semistructured format</td>
</tr>
<tr>
<td>DESCRIPTOR OF SAMPLE</td>
<td>MAIN FINDINGS</td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>--------------</td>
<td></td>
</tr>
<tr>
<td>Eight females in same-sex relationships (four couples) in Australia</td>
<td>Researchers found that despite the fact that access to assisted reproductive technology by same-sex couples is legal, these couples still face homophobia in interactions with health care professionals. The study encourages anti-discriminatory measures to be put in place to prevent negative interactions between gay and lesbian individuals and their care providers.</td>
<td></td>
</tr>
<tr>
<td>50 participants total (36 female-partnered women and 14 single women)</td>
<td>The researchers recognized a variety of main themes in the participants’ responses, including Desire to have gestation and delivery of their own child, Issues of genetic relatedness to children, and Issues of cost.</td>
<td></td>
</tr>
<tr>
<td>15 self-identified Australian lesbian couples</td>
<td>The researchers recognized main types of homophobia in interactions with health care services, including Exclusion in Care, Heterosexual Assumption, Inappropriate Questioning, and Refusal of Services. The study participants identified two ways—screening and crusading—through which they avoided homophobia in later encounters.</td>
<td></td>
</tr>
<tr>
<td>15 same-sex female Australian couples (30 women)</td>
<td>The researchers found that the journey to motherhood for same-sex female couples is “multilayered and complex” due to the challenges of becoming pregnant and coping with standards of heteronormativity. Participants completed vaginal insemination at home, intrauterine insemination, and/or in vitro fertilization, each chosen for a variety of reasons.</td>
<td></td>
</tr>
<tr>
<td>8 self-described lesbian women in the United Kingdom who had experienced pregnancy</td>
<td>The participants in the study reported positive and negative experiences with health care providers. The researchers noted that participants seemed to distance their sexuality from the negative experiences to subconsciously protect themselves (i.e., by rationalization or humor).</td>
<td></td>
</tr>
<tr>
<td>96 interviewees (51 couples) throughout Sweden, self-identifying as lesbian, with children born between 2003 and 2009 in which a child was adopted by a second female parent</td>
<td>The researchers discovered two approaches to heteronormativity found in recollections of interactions with the health care services: one focusing on heteronormativity as problematic and the other focusing on the “just great” attitude of the interviewees, in which problematic heteronormative behavior was discussed as an exception rather than normal.</td>
<td></td>
</tr>
<tr>
<td>30 self-identified lesbians in Portugal, ages 21 to 63 years</td>
<td>The researchers identified a variety of themes in the participants’ interactions with health care, including Their own avoidance of disclosure of sexual identity, The assumption by health care professionals that the participants were heterosexual, The absence of care specific to their sexual practices, and Satisfaction as a result of quality of relationships with providers.</td>
<td></td>
</tr>
<tr>
<td>10 self-identified lesbian mothers from three different cities in central Sweden who had contact with several care facilities</td>
<td>The findings showed that the interviewed women found that heteronormative language was present in verbal and written communication with health care providers and the care system.</td>
<td></td>
</tr>
<tr>
<td>Participants included 2,338 medical doctors, 5,379 nurses, 8,531 mental health providers, 2,735 treatment providers, and 214,110 nonproviders in the United States</td>
<td>Implicit preferences existed across the board for heterosexuals before gay and lesbian individuals. Nurses, in particular, held the strongest implicit preferences. The authors recommended that further studies be completed to examine how these attitudes affect care.</td>
<td></td>
</tr>
<tr>
<td>24 lesbian nonbiological mothers whose partners had birthed children within the past 2 years</td>
<td>The researchers recognized a variety of main themes in the participants’ responses, including Feeling “different”, Lack of financial security regarding insemination, sperm donation, etc.; Desire for active participation in pregnancy; Lack of support from families and the lesbian community; Feeling incomplete as a mother during the initial period of attachment and bonding; Unique role of nonbiological motherhood; and Postpartum blues.</td>
<td></td>
</tr>
</tbody>
</table>
thousands of dollars and depend on the interventions needed for pregnancy to occur. Insurance coverage for fertility treatments varies widely, even for heterosexual couples; however, I found limited academic research on this issue (American Pregnancy Association, 2016; Bernard, 2014). Thus, these “choice mothers” must be economically stable (even prosperous) to fund the expensive process to start their families (Goldberg & Scheib, 2015, p. 726). The decision as to which partner would seek pregnancy proved difficult for many couples, with many choices being made based on age, health, ability, and desire to carry a child (Hayman et al., 2015).

Many women noted that their desires for pregnancy, birth, and breastfeeding were more relevant to them than their desires to have biologically related children: “I wanted to go through the physical process of being pregnant and give birth. . . . that was one thing in my life I knew I didn’t want to miss out on” (Goldberg & Scheib, 2015, p. 732). Other women expressed the desire for a genetic link to their children as their primary reason for pursuing biological motherhood instead of considering adoption (Goldberg & Scheib, 2015). Adoption or fostering of children was likewise seen as complicated because of legal concerns (Wojnar & Katzenmeyer, 2014).

Chapman et al. (2012) noted that “for prospective lesbian parents, gaining the knowledge and understanding preparatory to having children is complicated by punitive legal systems, hostile social attitudes, and the sense of lack of existing bodies of knowledge and support” (p. 1880). These researchers observed participants’ deep-seated desires to be mothers, along with anxiety while deciding to start a family. Women in several studies reported difficulties when making this life-changing choice, particularly because of a lack of role models and uncertainty regarding the experiences of their future children (Chapman et al., 2012; Wojnar & Katzenmeyer, 2014). Participants expressed fears of financial insecurity, especially because the process of conception was determined to be “an unpleasant and expensive rollercoaster ride” (Wojnar & Katzenmeyer, 2014, p. 54).

Access to Care
Finding a provider. The issue of finding a provider to deliver service throughout the insemination, pregnancy, birth, and immediate postpartum period was often approached with trepidation. Röndahl et al. (2009) reported that participants expressed fear that communication with doctors, nurses, or midwives might be uncomfortable after the women disclosed their sexual identities. Some participants actively looked for known lesbian-friendly care providers (Malmquist & Nelson, 2014). Other participants, despite their initial fears of identity disclosure, reported that the care they received was kind, considerate, and personalized (Röndahl et al., 2009). Overall, experiences with providers was described by Malmquist and Nelson (2014) as a “contradictory and multifaceted picture in the sense that studies report exposure to prejudicial and condescending attitudes as well as respectful care from competent health care providers” (p. 57).

In all studies reviewed, researchers reported that lesbian women seeking maternity care experienced some amount of heteronormativity or homophobia in their health care encounters. One issue that arose in multiple studies, particularly those in Australia, was finding a provider for referral to a fertility specialist (Chapman et al., 2012; Hayman et al., 2013). Chapman et al. (2012) reported that couples living in isolated or rural areas had more difficulty finding appropriate care that was accepting and supportive of their sexuality. In the United States and Australia, a documented diagnosis of infertility is often required for specialist referral. This diagnosis is complicated for lesbian women because they are not making monthly attempts to achieve pregnancy with a male partner. One couple reported that because their provider had trouble figuring out how to define them as infertile for a referral, she instead took it upon herself to interrogate one member of the couple on her ability to financially support a family. “I suppose she [gynecologist] was probably thinking that she was trying to do the right thing and make sure we’d thought about it but . . . it wasn’t her business and I don’t think she would ever have asked a straight couple that” (Chapman et al., 2012, p. 1881).
Finding a donor. Sperm donors for insemination can be an anonymous (sperm bank) or known (friend or family member). Chapman et al. (2012) reported that some participants chose anonymous donors, because they feared that a known donor might eventually seek custody or a parental involvement in the child’s life. Others sought donors who would be available for multiple inseminations so that future children could be biologically related (Chapman et al., 2012). Some wanted the donor to act as an uncle for their child or be available later in life as a contact (Hayman et al., 2015). Multiple couples decided to use a sample from a brother of the partner not undergoing pregnancy to establish a genetic link to the nonpregnant partner (Hayman et al., 2015). One couple discussed the option of co-parenting with a gay male couple, in which one male would provide the sperm. They ultimately decided to inseminate via donor sperm, because they felt shared parenthood would be a threat to the nonbiological mother (Wojnar & Katzenmeyer, 2014). The decision often involved extensive research, including discussing the issue among friends who had already made similar decisions, researching options online, and meeting with multiple providers (Chapman et al., 2012; Goldberg & Scheib, 2015; Wojnar & Katzenmeyer, 2014).

An issue that arose frequently was a child’s biological link to one mother but not the other. Nonbiological mothers reported dealing with tension regarding the genetic, biological, and emotional link that their partners might have with their children. One participant reported going “back and forth between emphasizing the significance of her biological bond to her children and acknowledging the role of choice and social ties in parent–child relationships” (Goldberg & Scheib, 2015, p. 733). For some couples, both women pursued pregnancy at different times to mitigate these feelings. Situations in which one partner could not achieve pregnancy were reported to become sources of tension in relationships. Some couples pursued egg retrieval from the fertile partner and surrogacy to achieve pregnancy (Goldberg & Scheib, 2015). Although couples said they knew a genetic relationship was not the most important component of parenthood, it was recognized by many as an important emotional link (Goldberg & Scheib, 2015; Wojnar & Katzenmeyer, 2014).

Insemination. All studies included a variety of insemination methods, such as vaginal insemination, intrauterine insemination (IUI), or in vitro fertilization (IVF; Hayman et al., 2015). Hayman et al. (2015) reported that vaginal insemination performed at home was the method of choice for 12 of the 18 study participants. Of these women, 50% became pregnant. The other 6 participants chose IUI, an in-office procedure, as their first preference. No participants selected IVF as their primary choice. Overall, participants expressed frustration by the waiting period, multiple visits and months to achieve pregnancy, and the costs involved with IUI and IVF as the methods of conception (Hayman et al., 2015).

Stigmas in the Health System

Homophobia in care. In all studies reviewed, researchers reported that lesbian women seeking maternity care experienced some amount of heteronormativity or homophobia in their health care encounters. Hayman et al. (2013) recognized four types of homophobia—overt and covert—experienced by their participants, including “exclusion, heterosexual assumption, inappropriate questioning, and refusal of services” (p. 122).

One form of exclusion was the incidence of heteronormative exclusion, in which nonbiological or co-mothers were excluded from care because of their gender and assumptions about family makeup (Malmquist & Nelson, 2014, p. 62). Examples of this include health care providers asking about the father, referring to the biological mother’s partner as her sister or friend as opposed to mother or co-parent, and banning the nonbiological mother from the recovery room (despite male partners being permitted as support persons for new mothers). These situations led to feelings of delegitimization as a parent for the nonbiological mother (Chapman et al., 2012; Hayman et al., 2013).

In many hospitals and health care centers, heterosexual assumptions were present on medical forms, which had spaces only for “father” and not for any other type of partner/parent. Participants reported that this lack of cultural competence in person and on paper made them feel “embarrassed,” “self-conscious,” or “uncomfortable” (Hayman et al., 2013, p. 123). This was especially emotional for the nonbiological mothers, who often felt as though they had to fight to be seen as real parents (Wojnar & Katzenmeyer, 2014). These heteronormative assumptions made participants feel as though they had to “come out” to every person they made contact with in the health care system (Chapman et al., 2012). However, in many cases, the individuals who provided actual care were respectful and understanding, despite heteronormative systems (Malmquist & Nelson, 2014). Röndahl et al. (2009) described ways that care settings could be accommodating, for example, rewriting forms to be more applicable to different family structures to provide sensitive care.

Multiple studies referenced health care providers asking questions that were perceived as overly inquisitive about sexual orientation, because they were ultimately unrelated to care. Although these inquiries were deemed not intentionally harmful and seemed to be honest curiosity rather than malice, participants reported feeling uncomfortable because of the questioning (Hayman et al., 2013). Röndahl et al. (2009) noted that providers who had previously provided maternity care to lesbian mothers or were well educated on LGBTQ issues often treated women more neutrally and provided a sense of security to the participants. However, the authors noted that even when participants had positive experiences in their care, they believed there was an “over-focus on their sexual orientation” (Röndahl et al., 2009, p. 2342).
Finally, some women experienced homophobia in the form of refusal of services. One couple reported rejection by two hospitals on the grounds that “it was unethical for them to assist a single woman because they don’t recognize same-sex couples as being a valid couple” (Hayman et al., 2013, p. 123). Another participant reported that her midwives were unhelpful with breastfeeding education or postpartum care (such as cleaning of the perineum), because the midwives were “unwilling to engage in intimate areas of [the participant’s] body because of her sexual orientation” (Lee, Taylor, & Raitt, 2011, p. 986).

Coping with stigmas. Strategies to cope with stigmas related to care were identified. The first was to assess the level of homophobia before deciding to seek care from a particular provider or health care system. This could involve a phone call to the provider to ask about how they felt about having women in same-sex relationships as patients or getting referred by friends to providers known to be experienced in caring for same-sex couples.

Some couples used a method called “crusading” that involved them increasing visibility for same-sex parents by being up-front and honest about their sexuality and expressing to their health care providers that they would seek service elsewhere if they experienced any homophobic attitudes or practices (Hayman et al., 2013, p. 124). However, some participants were less successful in coping. After her maternity experience, one participant expressed that she did not view herself as having the same right to a child or to proper care that heterosexual women had (Lee et al., 2011).

The vague nature of stigmas. Because of the often covert nature of homophobia, many participants were able to only vaguely discuss their experiences with stigma. Lee et al. (2011) found that participants rarely described explicitly homophobic events and instead discussed covert or perceived incidences. Röndahl et al. (2009) noted that participants described experiences they perceived as negative, although they were unsure if the negativity was due to a clash of personalities or true stigma or homophobia. Lee et al. (2011) also postulated that rationalization of negative events could have been used as a protective coping mechanism for some of the participants who attempted to explain the errors of the providers. The authors theorized that this psychological technique was an aspect of dissonance theory, in that participants were attempting to “[change] the meaning of the negative encounter” after the encounter occurred (Lee et al., 2011, p. 986). Malmquist and Nelson (2014) observed what they called a “just great” repertoire, in which participants diminished experiences that may have been homophobic and instead allowed their overall interactions with health care providers to be expressed positively. Other participants realized that although no overtly homophobic incidents occurred, they were not offered services (educational classes) because of the staff’s discomfort and inability to fully comprehend their sexual identity (Röndahl et al., 2009).
Multiple authors noted the need to increase culturally competent care. Lee et al. (2011) recognized that pregnancy is a period in which affirmation of life is sought and a trusting relationship with a provider is crucial. Malmquist and Nelson (2014) discussed the difference between care that is competent versus care that is tailored to individuals. Many participants expressed desires for maternity care that is equal to what heterosexual couples would expect but also tailored to their specific needs (Malmquist & Nelson, 2014). Ultimately, provided care needs to be woman centered, regardless of the woman involved (Lee et al., 2011).

It is important for nurses and other clinicians to promote open and welcoming environments, to use and foster health language that is inclusive for all types of families, and to ensure that all families have the opportunity to thrive.

DISCUSSION
Overall, these studies show the complex nature of lesbian women’s experiences of becoming a mother. Despite many changes in the political and social spheres, lesbians must “continuously defend and justify their positions as parents” (Malmquist & Nelson, 2014, p. 70). Study participants described taking great care in deciding to become mothers and began to recognize barriers and facilitators to achieving motherhood.

Many women were able to overcome obstacles to reach the final goal of motherhood. The process of choosing donor sperm was explained as difficult for the same-sex couple, and fears persisted regarding the legal system, donor rights, and social influences. Nonbiological mothers, specifically, expressed fears related to connectedness with children because of the lack of shared genetics. Together, these issues put additional stress on the developing families.

Finding sensitive, nonjudgmental, and culturally competent care was a challenge for many women. Most women expressed that they wanted a focus on woman-centered care. However, many women experienced instances of stigma, overt and hidden as well as real and perceived. The episodes of homophobia were found to fall within four categories: Exclusion From Care, Assumptions of Heterosexuality, Inappropriate Questioning, and The Refusal of Services (Hayman et al., 2013). These instances made the process of obtaining care uncomfortable, awkward, and potentially dangerous, because infections were missed, care was lacking in thoroughness, and emotional support was absent. These issues were present for biological and nonbiological mothers, the latter of whom experienced separate issues due to their parental identities. Lesbian women developed different methods of coping with the homophobia, and some were more successful than others.

LIMITATIONS
This review was limited by the availability of existing research on this topic. As shown in this review, research on the experience of lesbian women becoming mothers has been done in only a select few countries (including Norway, Sweden, the United Kingdom, Australia, Portugal, and the United States). Findings may not be generalizable to other areas of the world, even other countries that are similar in terms of liberal policies, social justice, and economic developmental status. Only work published in English was reviewed, although many studies were conducted in other languages (including Norwegian, Swedish, and Portuguese). Additionally, because of the invisible nature of the population, study samples were found primarily by using snowball methods or word of mouth. Accordingly, the samples are not random and not generalizable.

This review was also limited to qualitative studies. Sample sizes were small and collected primarily by interview. However, the findings provided enough data to illuminate the experiences of lesbians becoming mothers and uncovered clear barriers that should be explored in future research.

IMPLICATIONS FOR PRACTICE AND RESEARCH
Every person deserves individual, respectful, and culturally competent care. Practices and health systems can take steps to promote such care. The women in these studies had all experienced the health care system at a time when they were in vulnerable positions (i.e., during pregnancy and new motherhood). Future research is needed to understand health needs and disparities related to lesbian women, motherhood, and barriers to care. Not only will this information be helpful in understanding this particular population, it will also form a basis for creating a health care system that is culturally competent for every population type.

It is clear that health care providers and staff must continue to develop skills and reflect on cultural assumptions as they work toward caring for all minority and cultural groups positively. Examination and revision of intake and other paperwork and forms is one easy way to quickly make important changes that will lead to inclusivity. Using gender-neutral terms such as parent (instead of mother or father) or partner (instead of husband or wife) can help reduce stigmas.
Participants in the study by Röndahl et al. (2009) expressed that although they did not expect specialized lesbian-centric care, they did desire care that was “open-minded and sensitive to prospective parents’ vulnerability” (p. 2341). One new mother recommended that health care providers seek education about LGBTQ health, but not from the woman who is actively undergoing care:

By all means—acquire the knowledge, but not through the patients. I can come and talk about it later, but not when I’m there to have a baby. I’ll come and talk about it as a lesbian or a parent, but not when I’m a patient. (Röndahl et al., 2009, p. 2341)

This woman expressed that she wanted her care providers to learn to be more culturally competent, but she did not want her birth experience to solely be the providers’ educational opportunity (Röndahl et al., 2009).

CONCLUSION

It is important for nurses and other clinicians to promote open and welcoming environments, to use and foster health language that is inclusive for all types of families, and to ensure that all families have the opportunity to thrive. Nurses can reach out to lesbian community resources and create opportunities for dialog, learning, and health interventions that are needed to promote optimal transitions to motherhood for all women. NWH

REFERENCES


