A Qualitative Exploration of Maternity and Neonatal Experiences of Lesbian, Bisexual, and Queer+ Parents

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Thesis Portfolio Abstract

Background: The 21st century has seen significant positive legislative changes for LGBTQ+ people; however, challenges still exist. Research indicates that the challenges LGBTQ+ parents face in healthcare are partly due to the heteronormative and cisnormative assumptions and views that services and healthcare professionals may hold. This thesis aims to explore the maternity and neonatal experiences of lesbian, bisexual, and queer+ parents.

Methods: A qualitive systematic review of the literature on lesbian and bisexual mothers' experiences of maternity care, was carried out by searching five databases. A qualitative empirical study was conducted which explored the experiences of lesbian and queer+ parents who had experience of their baby being admitted to a neonatal unit in the United Kingdom. The study used semi-structured interviews, and reflexive thematic analysis was used to analyse the findings.

Results: The systematic review synthesised the findings from 10 studies, producing four topic areas: "heteronormativity", "acceptance and inclusion", "finding your own path", and "knowledge and power of professionals". Twelve parents participated in the empirical research which produced two meta-themes. The first meta-theme, the "experience of lesbian and queer+ parents in a neonatal unit", included four themes: "real and perceived threats", "adapting to a heteronormative world", "positive experiences", and "actions speak louder than words". The second meta-theme, the "experience as parents in a neonatal unit", included two themes: "safety and care", and "loss".

Conclusions: The findings from both the systematic review and empirical study are discussed and critically evaluated throughout this thesis portfolio. Recommendations for clinical practice are provided.

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Chapter 1: Introduction to the Thesis Portfolio

Introduction

There has been significant cultural change in the understanding and recognition of sexual and gender diversity worldwide in the 21st century (Hammack & Wignall, 2023). However, although positive changes in the equality of law and policies have been made, the rise in visibility of LGBTQ+ (lesbian, gay, bisexual, transgender, queer, and other included identities) people has not always resulted in the reduction in vulnerability for some (Russell & Fish, 2019). Findings by Redman (2018) suggest that although the legalisation of same-sex marriage did have an effect on public attitudes towards same-sex relationships, it served to strengthen the pre-existing attitudes of those that were already supportive. The legalisation had little to no effect on those that were already unsupportive of same-sex relationships. Therefore, although positive legislative changes have taken place, the societal context that LGBTQ+ people experience may not feel like it is changing, and there are other factors that impact a person's views outside of the legislation that exists, with legislation being just one piece of a much larger puzzle of societal acceptance. Furthermore, in recent years there has been an increase in hate crimes towards LGBTQ+ people worldwide, suggesting that legislative equality has not necessarily led to greater acceptance (Home Office, 2024; Human Rights Campaign, 2024; ILGA-Europe, 2023). Further suggesting that even with legislative changes, societal attitudes have not necessarily improved. Therefore, it is important for research to explore the current experiences of LGBTQ+ people to understand their reality and life experiences.

Alongside broader societal attitudes, LGBTQ+ people may also experience negative attitudes and stigma when accessing healthcare services (Clark et al., 2023; Pickern, 2024). These experiences can lead not only to adverse health outcomes but also erode the trust that LGBTQ+ people have in healthcare professionals (Guest & Weinstein, 2020). This trust is crucial in ensuring that people feel safe within healthcare services. Within maternity and

neonatal services, trust is crucial due to the impact it not only has on the parent's experiences of care but also the quality of care of both parent and child (Brødsgaard et al., 2019; Shields et al., 2012; Wells & Lang, 2016). Therefore, it is important that maternity and neonatal healthcare providers are aware of how to provide environments that foster a trusting relationship between healthcare providers and LGBTQ+ people.

The literature about parents' maternity and neonatal experiences often focuses on cisgender heterosexual parents and literature about LGBTQ+ parents has often centred on lesbian and gay parents (Goldberg, 2023). However, recent research has examined bisexual parents' experiences and found that bisexual parents that are single or are in different-gender relationships experience stigma from both heterosexual and LGBTQ+ communities (Goldberg, 2023; Manley & Ross, 2020). Furthermore, findings that a parent's bisexual sexual identity may decrease when in the context of a long-term relationship with a partner, suggest that the experience of bisexual parents may differ in a variety of ways from that of other parents within the LGBTQ+ community. Therefore, it is important for research of LGBTQ+ parents and of parents in different-gender relationships to be inclusive of bisexual parents.

Throughout this introduction, the author has posited that more research needs to be undertaken with members of the LGBTQ+ community. It is important that not only more research is undertaken, but that this research is sensitive to the needs of the LGBTQ+ community. Historically, research has been used to justify the oppression of the LGBTQ+ community and therefore, it is important that researchers are aware of their unconscious biases when developing research (Hammack et al., 2013; Hammack & Wignall, 2023; Lewis & Reynolds, 2021). Veldhuis et al. (2024) developed a guide with considerations of how to write manuscripts that serve the LGBTQ+ community. This guide acknowledges the importance of researchers considering their 'outsider' or 'insider' perspectives on the

community and using reflexivity to consider the identities of the researchers. The authors have reflected on their identities throughout the research and these reflections are woven into the discussions of both the systematic review and empirical paper, and the discussion chapter.

The Thesis Portfolio

The focus of this thesis portfolio is the experience of lesbian, bisexual, and queer+ parents during their maternity and neonatal journeys. The systematic review provides an updated synthesis of the literature about the maternity experience of lesbian and bisexual mothers, with recommendations for healthcare providers and healthcare professionals provided. The empirical research paper explores the experience of lesbian and queer+ parents whose baby was admitted to a neonatal unit in the United Kingdom. Chapter three serves to bridge the systematic review and empirical paper together by summarising the findings of the systematic review and providing a rationale for the links between them. Chapter five offers extended details into the chosen methodology and data analysis for the empirical research paper. Chapter six offers further results which were not included in the empirical research paper. Chapter seven connects the findings from both the systematic review and empirical research project, critically evaluating and discussing the findings, the strengths and limitations of them, and offers clinical and theoretical implications.

Please note, tables and figures have been included in-text throughout both Chapters 2 and 4 to allow a better flow of understanding. However, when submitted for publication, these will be moved to the end of each manuscript as stated in each journal's guidelines. Where appropriate, material from the author's DClinPsy thesis proposal have been reused throughout this thesis portfolio.

Definition of Terms

Throughout the thesis portfolio, the term LGBTQ+ has been used to describe those that identify as lesbian, gay, bisexual, transgender, queer, and other sexual or gender minorities. The authors recognise that terms such as SOGD (sexual orientation and gender diversity) and SOGM (sexual orientation and gender minority) are sometimes preferred by members of the LGBTQ+ community as they feel these are more inclusive of the diversity of identities and do not focus solely on identity labels (Veldhuis et al., 2024). Alternatively, some people view terms like SOGD and SOGM as reductive due to the focus on identities being about sex rather than the person as a whole (Veldhuis et al., 2024). Participants within the empirical project often referred to themselves as being part of the LGBTQ+ community and this is the term that has been used within the majority of the research included within the systematic review, hence, the use of this throughout the thesis portfolio.

Although, the focus of this thesis portfolio is the experience of lesbian, bisexual, and queer+ parents during their maternity and neonatal journeys, much of the academic literature within these areas focus on the experience of LGBTQ+ parents. Where literature has focused on the experience of a specific identity, such as lesbian mothers, this has been stated. The author is aware that there are a variety of experiences that LGBTQ+ parents have, and these may differ depending on one's sexual orientation and gender.

The terms 'same-sex' and 'same-gender' to define relationships have been used throughout this portfolio. 'Same-sex relationship' has been used within the systematic review due to this being the term that has been used within the articles included and within similar research in the journal. Furthermore, although the systematic review is not specifically looking at fertility experiences, there is an expectation that parents in same-sex relationships were unable to conceive a child biologically without the need for assistive methods. The

authors acknowledge that this upholds a binary view of sex, and in doing so gender. However, this is in-line with current literature within the journal and with the expectations of the parents' journeys to pregnancy. Within the other chapters of the portfolio, both 'same-sex relationship' and 'same-gender relationship' have been used with differing contexts, for example, in terms of the legalisation of marriage the term 'same-sex' is specifically defined by law, however, when discussing the experience of LGBTQ+ people in relationships and without a legal definition, 'same-gender' has been used.

The terms 'heterocentricity' and 'heterocentric' have been used in this thesis portfolio. Heterocentricity refers to the centring of heterosexuality in society, such that those that do not identify as heterosexual, or within the gender binary of male or female, become outliers (Swan & Habibi, 2015). Heteronormativity upholds heterocentricity by imposing the belief that all people fall into two separate and opposing genders and assumes that romantic relationships consist of heterosexual partners (Dollar, 2017).

Chapter 2: Systematic Review

Written for publication in *Midwifery* (see guidelines in Appendix A)

A Narrative Synthesis of Lesbian and Bisexual Mothers' Experiences of Maternity Care

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Abstract

Aims: To explore and synthesise qualitative research about the experience of maternity care for lesbian and bisexual mothers. To provide recommendations to healthcare providers on how to support lesbian and bisexual mothers during their maternity experience.

Background: The past 14 years has seen significant legal changes for same-sex parents worldwide. Previous reviews of lesbian mothers' experiences of maternity care identified that they experience covert and overt homophobia during their maternity care journey; that curiosity and knowledge of lesbian and bisexual life is important for healthcare professionals, and disclosure of sexual orientation can feel risky.

Method: Five databases were searched for studies published from May 2011 to December 2024. Qualitative research studies published in English that explored the maternity care experience of lesbian and/or bisexual mothers were included. Stenfors criteria for quality bias assessment was used, 10 studies were included. Findings were synthesised using a narrative synthesis approach.

Findings: Four categories were identified, these were: 'heteronormativity', 'acceptance and inclusion', 'finding your own path', and 'knowledge and power of professionals'. The findings are discussed in the context of current research and compared to the findings of the previous systematic review.

Key recommendations: Recommendations for maternity healthcare providers and healthcare professionals have been provided and include: an increased awareness of how heteronormative views and assumptions can present in services, education on how to challenge and reduce heteronormativity for healthcare professionals, explicit acceptance to be offered, and for professionals to be more aware of the power they may hold.

Key words: lesbian, bisexual, mothers, maternity care, narrative synthesis

Introduction

Recently, attention within the media has been drawn to reports of maternity care for mothers, such as the National Review of Maternity Services in England and a review of midwifery care in the United States (Care Quality Commission, 2024; Combellick et al., 2023). Factors impacting care were related to systemic issues and the need to change the culture of care to improve disparities that exist within maternity services. A recent article looking at the competencies for basic midwifery practice identified the 'care needs of marginalized and vulnerable populations' as an essential piece of knowledge for midwives (Butler et al., 2018, p. 173). However, recent reviews of perspectives of both LGBTQ+ (lesbian, gay, bisexual, transgender, queer, and other included identities) people and nurses and midwives caring for LGBTQ+ people, found that experiences varied when accessing midwifery care and there appear to be gaps in the development of cultural competence related to the healthcare needs of LGBTQ+ people (McCann et al., 2021; Permezel et al., 2023; Stewart and O'Reilly, 2017). Therefore, clear recommendations for maternity healthcare professionals and maternity healthcare providers in supporting LGBTQ+ parents are needed.

Dahl et al. (2013) used a meta-ethnographic approach to review lesbian women's experiences with healthcare providers in the birthing context. The review identified that experiences of covert homophobia can be subtle and hard to interpret, with overt homophobia often expressed through comments, gazes, and stereotypes. Mother's felt that healthcare professionals needed to know more about lesbian life, but that curiosity should be carefully considered to ensure that mothers feel safe. Disclosure of sexual orientation was viewed as an important but risky action, unless the mothers were in control of how they shared this. Making co-mothers feel visible and legitimate parents was important, alongside being accepted as a couple and family unit. The review provides a useful synthesis of the research that was available up to May 2011. However, although small recommendations about ways to

improve lesbian mothers' experiences are discussed, clear recommendations for maternity healthcare providers are not provided. Additionally, since 2011, 27 countries have legalised same-sex marriage (Pew Research Center, 2024) and alongside this there has been a rise in visibility of LGBTQ+ people (Hammack and Wignall, 2023). Therefore, the experiences identified in Dahl et al.'s (2013) may differ in recent research.

Individuals and groups within the LGBTQ+ community may have different needs and requirements from healthcare professionals, such that recommendations which are broadly applied to providers of healthcare for the LGBTQ+ community may not always identify the specific needs of lesbian and bisexual mothers. Furthermore, the experiences of bisexual parents have often been ignored within parenting literature, even when a bisexual parent is in a same-sex relationship, and therefore, we might be missing the nuances of the biphobia that bisexual parents may experience from both heterosexual and LGBTQ+ communities (Bartelt et al., 2017; Todd et al., 2016). Therefore, the current review included all parents in same-sex female relationships, which includes both lesbian and bisexual mothers.

The decision to complete a modified update of Dahl et al.'s (2013) review was to provide an updated synthesis of the research on the maternity care experiences of lesbian and bisexual women, which is relevant to the current laws and policies in place. Meta-ethnography is particularly suited to the development of theoretical understandings of a phenomenon (Sattar et al., 2021); however, the current synthesis does not aim to develop a theory, which has already been well explored in Dahl et al.'s (2013) review, but to synthesise current research to develop recommendations for care.

The aim of the current review is to build on the findings of Dahl's et al.'s (2013) paper by reviewing research literature on lesbian mothers' experiences of healthcare in the birthing context but also to include the experience of all mothers in same-sex relationships and

throughout their maternity care experience. Therefore, the first aim of the current review was to explore and synthesise qualitative research about the experience of maternity care for lesbian and bisexual mothers. The second aim was to use the synthesis to provide recommendations to healthcare providers on how to support lesbian and bisexual mothers during their maternity experience. A statement of significance, see Table 1, provides a summary of the problem identified, what is already known, and what this paper adds.

Table 1

Statement of Significance

Problem	An updated review of lesbian and bisexual mothers' experiences of maternity care is needed to understand current experiences and provide recommendations to maternity healthcare providers on supporting lesbian and bisexual mothers.
What is already known?	Lesbian mothers experience covert and overt homophobia during their maternity care journey. Curiosity and knowledge of lesbian life is important for healthcare professionals and disclosure of sexual orientation can feel risky.
What this paper adds?	Clear recommendations for maternity healthcare providers and healthcare professionals are provided. The paper also gives a more up to date representation of experiences. Disclosure of sexual orientation was viewed by the mothers as a chance for further acceptance.

Method

Before starting the review, a study protocol was developed and registered with the University of York Centre for Reviews and Dissemination (PROSPERO; registration number CRD42024489670) and followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Appendix B; Page et al., 2021).

Search Strategy

Initially, the search strategy and inclusion and exclusion criteria of Dahl et al.'s (2013) review were considered and additions to include all mothers in same-sex relationships were added (detailed in Table 2). To ensure there was no overlap with the previous review, a systematic search of literature published after May 2011 was conducted. An initial search was completed in August 2024 and a further search to check for any new literature was completed in December 2024. The electronic databases searched were APA PsycInfo, CINAHL Ultimate, Medline Ultimate, Ovid Embase, and Web of science. Reference lists of papers that were assessed for eligibility at full text were also reviewed.

Table 2

Search Terms Used

Key concept	Search terms used
Lesbian or bisexual female	lesbian OR female homosexual OR same-sex female OR bisexual female
Mother	comother OR co-mother OR mother OR parent
Maternity care	maternal health services OR prenatal care OR postnatal care OR perinatal care OR childbirth OR delivery
Methodology	Qualitative OR mixed methods

Ethical Considerations

The current study is a systematic review of published literature. The review required no recruitment or primary data collection and therefore, no specific ethical approval was required.

Eligibility Criteria and Study Selection

Articles were included if they met the following criteria: (1) they were qualitative or mixed-method empirical studies looking at the maternity care experience of lesbian and bisexual mothers (2) they were published after May 2011, and (3) they were published in a peer-reviewed journal. Articles were excluded if they: (1) only used a quantitative methodology, (2) were not an empirical research study in a peer-reviewed journal, (3) were a review paper, (4) the findings for lesbian and bisexual mothers were not presented separately from the findings of other LGBTQ+ parents, (5) the focus of the article was only on the experience of fertility services, (6) the focus was not on the wider maternity service experience, for example, where the focus was on a specific aspect of maternity care such as bereavement care.

Records were independently screened by the first author (AH) against the inclusion and exclusion criteria and, if a record was excluded, a reason for this was noted. Each exclusion and inclusion decision were then independently checked by a second reviewer (EN or BB); any disagreements were discussed and a decision made.

Quality Assessment

There is a lack of consensus on the most appropriate critical appraisal tool for qualitative syntheses and some researchers argue that checklist tools can result in the application of quantitative understandings to judge qualitative research (Barbour, 2001; Hannes et al., 2010; Majid and Vanstone, 2018). Therefore, in line with moving away from a checklist approach,

studies were quality assessed using Stenfors et al. (2020) key criteria in evaluating the trustworthiness of qualitative research by AH; this was then reviewed by a second researcher (EN or BB). The key criteria consider the credibility, dependability, confirmability, transferability, and reflexivity of the research (see Appendix C). This approach allowed the research to be assessed within their theoretical and philosophical contexts and to consider how the findings can be applied (Stenfors et al., 2020). Rather than using a 'yes' or 'no' approach to whether the research met the criteria, written text was used to review how the research met the criteria and if there were any limitations.

Data Extraction and Synthesis

Data extraction and narrative synthesis was conducted following guidance from Popay et al. (2006). Data was extracted on study characteristics (author, date, country, data collection method, sample size, analysis method) and participant characteristics (age, ethnicity, age of children at time of research, birth or non-birth parent). The findings of the included studies were reviewed and any that were relevant to the current review's aims were extracted into a table. Popay's framework is traditionally used in systematic reviews aiming to synthesise evidence on the effects of interventions or the factors shaping the implementation of interventions, however it can be used for other types of review questions. Popay's framework consists of four key components: 1) formulating a theory about how an intervention works, why, and for whom, 2) creating a preliminary synthesis of findings of included studies, 3) exploring relationships within and between the data, and 4) assessing the strength of the synthesis (Popay et al., 2006). The focus of the current review is not an intervention, and therefore, the theory formulation was developed using the findings from Dahl et al.'s (2013) review. As this review does not focus on an intervention, theory formulation was based on Dahl et al.'s (2013) findings. Relevant findings were reviewed alongside study characteristics and the bias assessment to identify influencing factors. Themes were then grouped to explore

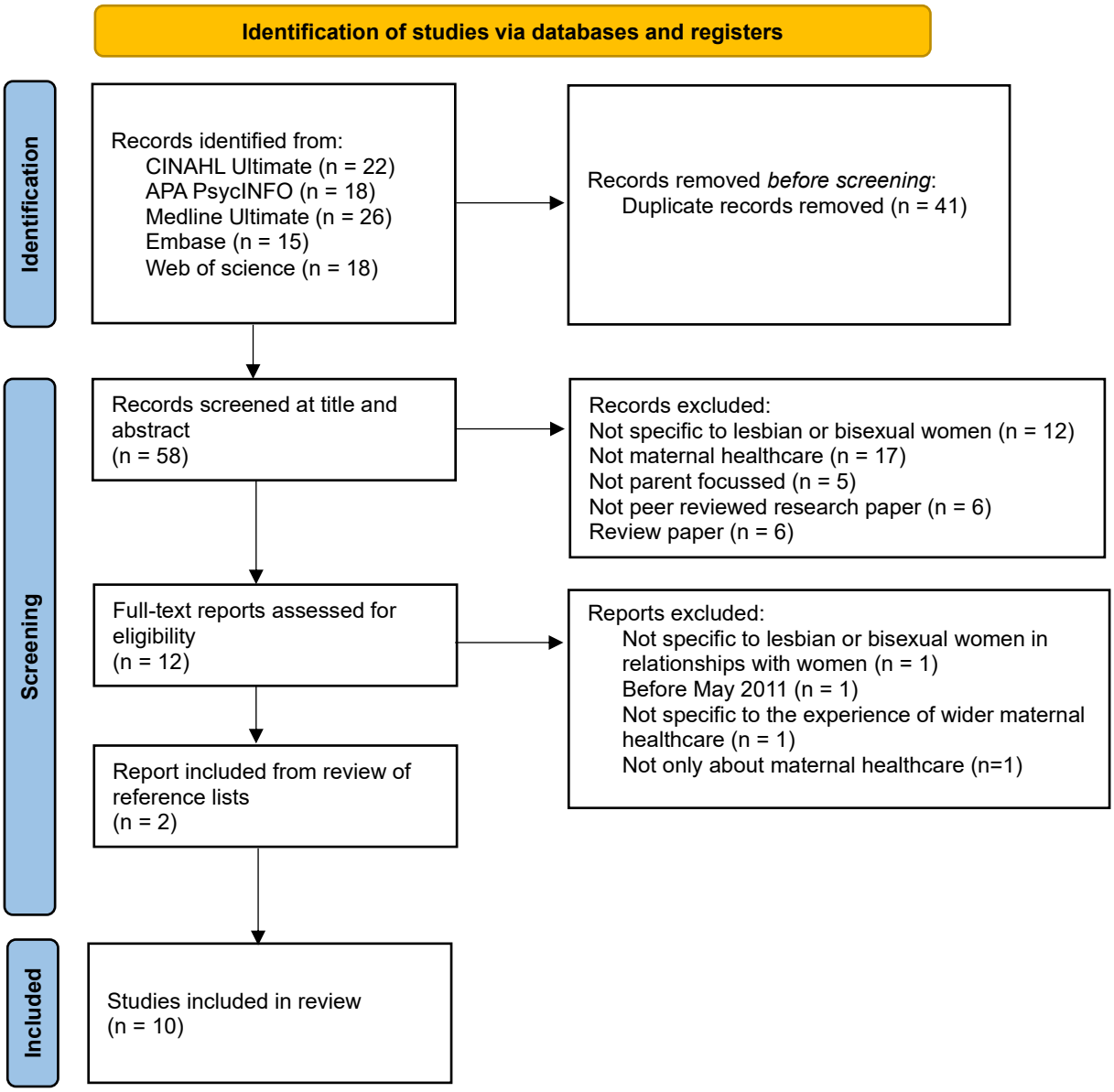
relationships within and between studies. To assess synthesis strength, findings were compared with those of Dahl et al. (2013) and discussed in the final section.

Results

The initial search in August 2024 yielded 94 records and the search in December 2024 yielded an additional five records which had been published since (see Figure 1). After removing 41 duplicates, the title and abstract of 58 papers were screened against the inclusion and exclusion criteria. This reduced the number of papers to 12, which were then subjected to full-text screening. The reference list of the 12 papers was also searched which added an additional two papers to the full-text screening. Ten papers met the inclusion criteria for the systematic review.

Figure 1

PRISMA flow diagram updated from the December 2024 search



Study and Participant Characteristics

As shown in Table 3, most studies were conducted in regions which hold similar political, societal, and medical beliefs (Western Europe, North America, Australasia) and relied on interviews for data collection. Ril et al. (2024) used asynchronous methods via WhatsApp, allowing participants to respond when they were available. Hayman et al. (2013) combined story-sharing with semi-structured interviews and journalling, which included text, music,

photos, and drawings. Qualitative analysis methods used varied: four studies used thematic analysis, two used a phenomenological approach, and one used grounded theory. Dos Santos et al. (2024) applied Geertz's interpretative theory of culture to explore meaning through cultural diversity. Malmquist and Nelson (2014) used critical discursive psychology to analyse rhetorical language patterns. O'Neill et al. (2013) used a general inductive approach, coding transcripts into nine categories and refining them into themes.

Few studies reported all their participant's characteristics (see Table 4). Only three studies specified the ethnicity of all their participants. Six of the studies recruited both birth mothers and non-birth mothers and the other four recruited only non-birth mothers. There was a variety of age ranges of participants and age of their children.

Table 3

Study characteristics

Author (date)	Country	Data collection method	Sample size	Analysis Method
Cherguit et al. (2013)	United Kingdom	Semi-structured interviews	10	Interpretative phenomenological analysis (IPA)
Dahl and Malterud (2015)	Norway	Interviews	11	Thematic analysis
Dos Santos et al. (2024)	Brazil	Interviews	10	Geertz's Interpretative Theory of Culture was used as a theoretical framework for data interpretation
Engström et al. (2018)	Sweden	Semi-structured interviews	20	Grounded theory
Hayman et al. (2013)	Australia	Story sharing method, including semi-structured interviews and journaling	15	Thematic analysis

Malmquist and Nelson (2014)	Sweden	Semi-structured interviews	98 interviewees, 51 interviews	Critical discursive psychology
McKelvey (2014)	United States of America	Interviews	10	Resissman's thematic analysis
O'Neill et al. (2013)	New Zealand	Semi-structured interviews	8	General inductive approach
Ril et al. (2024)	Brazil	Asynchronous online interviews and asynchronous online focus group	9	Thematic content analysis
Wojnar and Katzenmeyer (2014)	Pacific Northwest	Semi-structured interviews	24	Colaizzi's (1978) phenomenological approach

Table 4

Participant Characteristics

Author (date)	Age Range (years)	Ethnicity	Age of Children	Birth or non-birth mother
Cherguit et al. (2013)	33 – 51	7 white 1 Welsh 1 British 1 Anglo Indian	0.5 to 6 years	Non-birth mothers
Dahl and Malterud (2015)	30 – 52	N/R	N/R	Non-birth mothers
Dos Santos et al. (2024)	30 – 39	N/R	N/R	Both birth mother and non-birth mother
Engström et al. (2018)	25 – 42	N/R	1 to 3 years	12 birth mothers 8 non-birth mothers
Hayman et al. (2013)	28 – 58	N/R	2 months to 10 years	Both birth mother and non-birth mother

Malmquist and Nelson (2014)	Mean age 36 years	Majority of interviewees were born in Sweden, a few had migrated from other European countries	0 to 10 years	Both birth mother and non-birth mother
McKelvey (2014)	30 – 61	9 white 1 African American	20 months to 14 years	Non-birth mothers
O'Neill et al. (2013)	Early 30s to late 40s	European descent	9 months to 12 years	Both birth mother and non-birth mother
Ril et al. (2024)	N/R	N/R	N/R	Both birth mother and non-birth mother
Wojnar and Katzenmeyer (2014)	28 - 48	20 white 2 African American 2 mixed ethnicity	<2 years old	Non-birth mothers

N/R – Not reported

Quality Appraisal

As detailed in Table 5, areas of strengths and weaknesses in relation to Stenfors et al.'s (2020) key criteria have been noted. All studies were deemed acceptable for inclusion as they demonstrated credibility, clearly described their methods and analysis, and presented their findings with quotes. Ril et al. (2024) did not separate their findings from the discussion section, limiting differentiation of their findings from other studies they discussed, but was deemed acceptable as they clearly differentiated the quotes they used in describing their findings. While not all papers showed strong reflexivity regarding the researcher's role, it was acknowledged that this is not a primary focus in all qualitative methods.

Table 5

Summary of Quality Assessment of Included Studies

Author (date)	Credibility	Dependability	Confirmability	Transferability	Reflexivity
Cherguit et al. (2013)	There is good alignment between the aim and the results. The authors have described the process in less detail, but this may be due to IPA being a more well-known approach. There is less discussion for why the specific	There is mention of the guidelines used to develop the research questions but little information about the questions used which would limit a researcher being able to replicate the design.	There are detailed descriptions of the findings and quotes are provided for each point made.	Current context of the National Health Service in the United Kingdom, with a clear outline of what is already known about the topic and what the study adds has been provided. There is recognition in the limitations that due to	There is no mention of reflexivity during the research process.

	method and data analysis were used.			the change in legislation in the United Kingdom this might have affected some participant's experiences.	
Dahl and Malterud (2015)	Strong alignment. There is discussion of how the design and data collection links to the analysis approach.	There are clear descriptions of how the analysis was completed. There is mention of the initial guiding question for interviews.	There are detailed descriptions of the findings and quotes are provided for each point made.	Demographics have been provided which add context, no ethnicity data was provided which limits contextual understandings. The findings are linked to current research within the area.	There are reflections about the healthcare backgrounds of the authors, but further reflections of other intersectional identities or how this was considered during the research are not provided.

Dos Santos et al. (2024)	Strong alignment. There is a clear justification for the design of the study and discussion of how the findings link to relevant research in the findings section.	There are clear descriptions of how the analysis was completed and the frameworks used for this. There is mention of the initial guiding question for interviews.	There are detailed descriptions of the findings and quotes are provided for each point made.	Discussions of the current political climate in Brazil helps to develop a context for the research. There is discussion of the framework used during analysis and how this shaped the findings. Sociodemographic characteristics were reported for participants which allowed for the context of the participants to be developed.	There is mention of the researcher's reflective notes being used to aid analysis but no further information about how.

Engström et al. (2018)	Strong alignment. Clear information about the steps taken within the Grounded theory approach. Discussion of the reasons for decisions about data collection and analysis methods have been provided.	There is detailed information about the procedure and structure of the interviews.	There are detailed descriptions of the findings and quotes are provided for each point made.	Demographics have been provided which add context, no ethnicity data was provided which might limit contextual understandings. The study discusses the current legislative situation in Sweden to give further context.	There is no mention of reflexivity during the research process.
Hayman et al. (2013)	The research paper is looking at specific findings within the wider findings of the research. Therefore,	Information about the use of the story-sharing method and how this was used in interviews provided. Specific	Quotes have been provided throughout the findings, however, there is not always a quote or journalling	Demographics have been provided which add context, no ethnicity data was provided which might	There is mention of the use of reflection and journalling from the researcher, but this is not explored further.

	discussion of the data collection methods is broader than the specific findings discussed but there is alignment between the overall aim and data collection and analysis method.	information about the journalling aspect of data collection has been provided.	evidence for every point made.	limit contextual understandings. There is not as much information about current political and legislative climate of the country where the research took place.	
Malmquist and Nelson (2014)	Strong alignment. Discussion of why the specific analysis was used and how this links to the aims of the research.	There is mention of the narrative interview approach but little information about the questions used which would limit a	There are detailed descriptions of the findings and quotes are provided for each point made.	Demographics have been provided which add context, no ethnicity data was provided which might limit contextual understandings. The	There is no mention of reflexivity during the research process.

		researcher being able to replicate the design.		findings are linked to current research within the area.	
McKelvey (2014)	Strong alignment. Discussion of why the specific analysis was used and how this links to the aims of the research.	There is a good explanation of the analysis method and interview process.	There are detailed descriptions of the findings and quotes are provided for each point made.	Demographics have been provided which add context. The study discusses the current legislative situation in the United States of America to give further context.	There is mention of the use of reflective processes but no clear reflections within the paper itself.
O'Neill et al. (2013)	Strong alignment. Discussion of why the specific analysis was used and how this links to the aims of the	There is detailed information about the procedure and structure of the interviews. There is detailed	There are detailed descriptions of the findings and quotes are provided for each point made.	Demographics have been provided which add context, no ethnicity data was provided which limits	There is clear information about how reflexivity was used during the research process, specific to the

	research and relevant theory guiding the research.	information about the data analysis.		contextual understandings. The findings are linked to current research within the area.	identity of the first author.
Ril et al. (2024)	Strong alignment. There were considerations of how the theory links with the findings, such as considering how cisheteronormativity is upheld within healthcare services and politics and how this leads to their findings	The authors provided details for how decisions were made and how the analysis was completed, such as reasons why they used an asynchronous method of data collection.	The authors have embedded quotes throughout the results section but did not separate their findings from the discussion, which at times has made it difficult to identify if they are original findings or	The authors have discussed the context of the policies and legal bills within the country where the research took place. Sociodemographic characteristics were reported for participants which allowed for the context	There is little mention of the researcher's role within the research and of how reflexivity was embedded and supported in the research process. There are reflections about the methods used and how these supported participants'

	of institutional violence towards lesbian and bisexual mothers.		findings of another research study.	of the participants to be developed.	engagement with the research.
Wojnar and Katzenmeyer (2014)	Strong alignment. The authors considered the reason for the research and gap in research knowledge. The approach allowed for reflexivity and considering whether the findings were reflective of experts in the area's experiences.	There is detailed information about the procedure and structure of the interviews.	Quotes from the research are embedded within the article and a quote explaining each point is provided for each subtheme.	There are links to the research within the discussion to consider the context the research was performed in. Findings were discussed with experts in the area to improve the contextualisation of the research. Ethnicity data was provided	Discussion of how field notes were used to consider misinterpretation of data, and prolonged engagement with participants to reduce researcher bias. There is mention of the use of a self-reflective diary but not specific

	which furthers contextualisation.	reflections made by researchers.

Narrative Synthesis of Results

From the final set of 10 studies, four topic areas were identified as important factors in the maternity care experience of lesbian and bisexual mothers and the main findings within them have been displayed in Table 6.

Table 6

Topic Areas and Main Findings of the Review

Topic Areas	Main findings	Study
Heteronormativity	Experiencing heteronormative views and assumptions, being treated and viewed differently, expectations of how we will be treated, protecting myself and my partner, not being recognised as a mother or a couple, downplaying negative experiences	Cherguit et al. (2013), Dahl and Malterud (2015), dos Santos et al. (2024), Engström et al. (2018), Hayman et al. (2013), Malmquist and Nelson (2014), McKelvey (2014), O'Neill et al. (2013), Ril et al. (2024), Wojnar and Katzenmeyer (2014)
Acceptance and inclusion	Being treated equally, being shown explicit acceptance	Cherguit et al. (2013), Dahl and Malterud (2015), Malmquist and Nelson (2014), McKelvey (2014), O'Neill et al. (2013)
Finding your own path	Recognising others that have gone before us, feeling we are the first people to do this, finding your own way to be a mother	Cherguit et al. (2013), Dahl and Malterud (2015), O'Neill et al. (2013)

Knowledge and power of professionals	Having to explain to health professionals, being open about our sexual orientation, choosing or being forced to be 'out', the power of healthcare professionals	Cherguit et al. (2013), Engström et al. (2018), Hayman et al. (2013), O'Neill et al. (2013), Ril et al. (2024)

Heteronormativity

All the studies found that heteronormativity within maternity care services impacted the experience of lesbian and bisexual mothers. Heteronormative views and assumptions were seen as barriers to having a good experience with healthcare professionals. As discussed in Ril et al. (2024), societal views of motherhood alongside a lack of inclusive language impacted the legitimacy mothers felt they had.

> *There was no way to get a SUS [Brazil's Unified Health System, Sistema Único de Saúde] card with the names of two mothers…I don't know exactly how it is in the system, if the name is in the place for "Father" or if both are in the place for "Mother", but we're both there* (Interview 2; Ril et al., 2024, p. 5)

A lack of inclusive language was identified in many of the studies, and this represented heterocentricity being embedded throughout the maternity care systems, such as the lack of recognition of lesbian families in the literature provided (Cherguit et al., 2013). Dahl and Malterud (2015) also found that mothers wanted to be asked what they preferred to be called.

In five of the studies, mothers described being treated and viewed differently (Cherguit et al., 2013; Hayman et al., 2013; O'Neill et al., 2013; Ril et al., 2024; Wojnar and Katzenmeyer, 2014). Wojnar and Katzenmeyer (2014) found that mothers felt both different and isolated at

points during their maternity journey and felt pressure to be “perfect” (p. 54), so they were not judged by healthcare professionals.

> *Because we were different...I felt I had to be perfect...I dressed neatly and I was really supportive to my partner. I was afraid a nurse or a doctor would come into the room and judge that same-sex couples who decided to have babies are not good to each other or that I don’t know how to be a supportive partner in labor or postpartum period* (Wojnar and Katzenmeyer, 2014, p. 54)

Ril et al. (2024) described institutional violence that occurred because mothers were treated differently, such that one co-mother was unable to be present at her baby’s birth due to too many other professionals wanting to be there. Ril et al. (2024) suggested that the pregnant lesbian mother was seen as an experiment for the group to analyse out of curiosity.

> *On the day of the birth, the students wanted to watch, as if it were different…they claimed there weren’t enough clothes in the surgical centre for me to wear, because they had two obstetricians, the nurse, the anaesthesiologist, and four residents in to watch. [...]* (Interview 5; Ril et al., 2024, p. 7).

In four of the studies, participants described the expectation that they would have a negative experience with healthcare professionals (Cherguit et al., 2013; Dahl and Malterud, 2015; Engström et al., 2018; Malmquist and Nelson, 2014). Cherguit et al. (2013) identified that when mothers had a positive experience, they were still concerned there might be underlying prejudice and discrimination that is not being presented.

> *There was again no negativity there at all, certainly not to us um face to face* (Susan; Cherguit et al., 2013, p. 1273)

Mothers in the studies described having low expectations to protect themselves from being hurt by discrimination and were surprised when they did not experience negativity (Engström et al., 2018).

> *When you get something that says "Parents", instead of "Mom and Dad", you feel happy* (Engström et al., 2018, p. 1447)

When mothers did have good interactions with healthcare professionals, this was seen as having an eroding effect on the negative expectations they had of maternity care (Cherguit et al., 2013).

> *Well legally we had to be treated, but in reality how would we be treated? I was quite nervous about that. I came away feeling a lot better with how lovely they were* (Amy; Cherguit et al., 2013, p. 1272)

Dahl and Malterud (2015) identified that the personal self-confidence of mothers and their lived experiences of being a lesbian or bisexual woman impacted their expectations of how they would be treated by healthcare professionals.

> *My lesbian identity influences the encounters. However, it is difficult to know if the awkwardness you sometimes feel is inherent in yourself or within the person you are communicating with.* (C-M 6; Dahl and Malterud, 2015, p. 170)

Mothers took specific precautions to protect them from negative experiences, such as choosing a maternity provider that was known to be LGBTQ+ friendly or 'screening' services to see if they were accepting of lesbian and bisexual mothers before visiting them (dos Santos et al., 2024; Hayman et al., 2013; O'Neill et al., 2013).

> *It was already a recommendation from someone, and from someone very close to the doctor, so we [...] didn't have this barrier [...] of talking about the topic [double*

> *motherhood], or suddenly encountering some prejudice and not being well received* (Coral, 39, MN; dos Santos et al., 2024, p. 7)

Mothers experienced their partnership being devalued and co-mothers experienced not being recognised as an equal mother (Dahl and Malterud, 2015; dos Santos et al., 2024; Hayman et al., 2013; Malmquist and Nelson, 2014; McKelvey, 2014; O'Neill et al., 2013; Ril et al., 2024; Wojnar and Katzenmeyer, 2014). Dahl and Malterud (2015) found that co-mothers felt left out of the conversations about their baby and did not feel valued as a co-mother.

> *'Who's the biological mother?' he asked. When my wife said 'It's me', he turned to her. That made me feel I was not equally important…* (C-M 7; Dahl and Malterud, 2015, p. 170)

O'Neill et al. (2013) identified that devaluing the couple could be done through asking inappropriate questions and suggestions by healthcare professionals which led mothers to need to defend and justify their roles.

> *At the hospital people were fine but abrupt. You know, they were kind of like, 'OK, what are you doing with a baby?* (Laura; O'Neill et al., 2013, p. 217)

Malmquist and Nelson (2014) identified that many of the mothers downplayed their bad experiences and presented themselves as having a 'just great' experience. The mothers described their experiences positively even when they experienced discrimination, such as the quote below where Sandra initially states the staff had been "really good" (p. 65) but then goes on to discuss being excluded from a birth diploma and then adds that the staff told her in a "nice way" (p. 65).

> *Sandra: [...] well the staff there were really good, I think, we were treated well. [Inaudible] and then they came in with this diploma, and explained that I couldn't be*

> *on it, uh, because I wasn't a legal guardian or something…but they, they said, they said it in a nice way anyway* (Malmquist and Nelson, 2014, p. 65)

Acceptance and inclusion

Five studies identified moments of explicit acceptance and inclusion (Cherguit et al., 2013; Dahl and Malterud, 2015; Malmquist and Nelson, 2014; McKelvey, 2014; O'Neill et al., 2013). Mothers wanted to be treated equally and for both birth and non-birth mothers to be treated as a family unit. When both mothers were recognised, this served to create safety and trust in the healthcare professionals supporting them.

> *They just treated me like Jes's partner you know talking to me as much as they talked to her and treating me like an equal part* (Maya; Cherguit et al., 2013, p. 1272)

Explicit acknowledgement of the 'lesbian family unit' and acknowledging the co-mother's presence was valued by both mothers (Cherguit et al., 2013).

> *One sweet woman said something like 'oh that's really good, two women bringing up a baby'* (Ruksana; Cherguit et al., 2013, p. 1272)

Factors that supported the mothers in feeling accepted and included were not referring to the "daddy" (O'Neill et al., 2013, p. 216) and including co-mothers in the care of baby (Cherguit et al., 2013; McKelvey, 2014). Additionally, a warm approach from healthcare professionals along with non-verbal cues such as eye contact and a friendly smile helped mothers to feel visible and accepted without focussing too much on their sexual orientation (Dahl and Malterud, 2015; O'Neill et al., 2013). The language healthcare professionals used was also a factor in whether the mothers felt accepted. For example, mothers in Dahl and Malterud's (2015) study, acknowledged that phrases such as "both of you" (p. 170) created an inclusive atmosphere. Even when healthcare professionals did seem to struggle to find the right words,

if their overall attitude was perceived as inclusive, mothers felt accepted (Dahl and Malterud, 2015).

Finding your own path

Cherguit et al. (2013) identified that mothers felt like they were in "unchartered territory" (p. 1274) within maternity healthcare services and that they were "paving the way to visibility" (p. 1274). Mothers did not appear to know other families like theirs and did not see themselves represented in maternity spaces, and feeling like they were the first to charter this territory contributed to their own sense of invisibility and self-consciousness.

> *Being two women together we were very open about attending the clinic, because again we thought 'well you just don't know if there's anybody else thinking about doing this [trail blazing]* (Amy; Cherguit et al., 2013, p. 1274)

O'Neill et al. (2013) identified how some mothers recognised that "safe" (p. 216) responses they experienced from healthcare professionals had been influenced by the path already taken by other mothers. One mother described wanting to acknowledge the mothers that came before her and had resulted in change and acceptance of their identity as parents.

> *And I think it's really changing, the world actually. And I think we need to acknowledge people who have come before us* (Alex; O'Neill et al., 2013, p. 216)

In addition to the family unit's experiences of walking what sometimes felt was an untrodden path, co-mothers in Dahl and Malterud's (2015) study discussed finding their own identity. The co-mothers described not knowing what it was like to be a co-mother and that they had to find other ways to be a mother to their children differently than if they had given birth to the child themselves. Deciding what they wanted to be called was part of this journey, some of the co-mothers described 'co-mother' as being cold or a legal concept whereas others felt it was a better word than 'partner' as it implied motherhood.

> *So, co mother is…can be useful of course, but in many contexts it comes out unnatural, I think. Because a mom is a mom, and that's it* (C-M 4; Dahl and Malterud, 2015, p. 171)

Knowledge and power of professionals

The knowledge and power that healthcare professionals held was identified within five of the studies (Cherguit et al., 2013; Engström et al., 2018; Hayman et al., 2013; O'Neill et al., 2013; Ril et al., 2024). Mothers in Ril et al.'s (2024) study felt they were expected to explain how their pregnancy occurred and that professionals did not always appear to understand how they could have become pregnant.

> *[...] we always had to tell the story, right? Of what was involved, that there were two mothers, and that the ovule was mine, everything was mine* (interview 2; Ril et al., 2024, p. 7)

The lack of knowledge from healthcare professionals served to make mothers feel left out and their experiences of becoming pregnant to be un-recognised (Engström et al., 2018).

> *They had very little knowledge of IVF and artificial insemination…it was probably the worst…you feel a little left out when they do not know what you went through* (Engström et al., 2018, p. 1448)

Mothers felt that the more open they were, the more acceptance they would see and therefore, the more knowledge healthcare professionals would have for future generations (Cherguit et al., 2013; Hayman et al., 2013).

> *As consumers and as women we just have to keep voicing our needs and make sure that we don't go back; we keep going forward and empowering ourselves in the system* (Hayman et al., 2013, p. 124)

The mothers in O'Neill et al.'s (2013) study described feeling unable to challenge healthcare professionals due to the power that the healthcare professionals held in caring for them and their baby. Mothers relied on healthcare professionals for clear and honest information and when this was not given, feared the consequences of voicing their concerns.

> *But it was just because [nurses] had so much power over our lives that really mattered…* (Laura; O'Neill et al., 2013, p. 218)

Some mothers decided to "go with the full disclosure" (p. 218) of their sexual orientation which was viewed as a way of reclaiming their personal power within what felt like a disempowering maternity care system (O'Neill et al., 2013).

Discussion

The first aim of the review was to synthesise current research about the experience of maternity care for lesbian and bisexual mothers. The review identified four topic areas of importance from the 10 studies identified: 'heteronormativity', 'acceptance and inclusion', 'finding your own path', and 'knowledge and power of professionals'. The second aim of the review was to provide recommendations for healthcare professionals and providers of maternity care, which are detailed below.

As reported by both the Care Quality Commission (Care Quality Commission, 2024) and Combellick et al. (2023), the culture of care was often viewed as heteronormative by mothers (Cherguit et al., 2013; Dahl and Malterud, 2015; dos Santos et al., 2024; Engström et al., 2018; Hayman et al., 2013; Malmquist and Nelson, 2014; McKelvey, 2014; O'Neill et al., 2013; Ril et al., 2024; Wojnar and Katzenmeyer, 2014). Similar to the findings of McCann et al. (2021), Permezel et al. (2023), and Stewart and O'Reilly (2017), the lack of healthcare professionals' development of cultural competence and knowledge of lesbian and bisexual mother's experience, led to mothers feeling unseen and left out (Engström et al., 2018).

Many of the findings from Dahl et al. (2013) were mirrored within the current review, such as overt homophobia being expressed through inappropriate questions and suggestions (O'Neill et al., 2013). Furthering the original findings, homophobia and heteronormativity led to mothers feeling devalued as a family unit and as a mother (Dahl and Malterud, 2015; dos Santos et al., 2024; Hayman et al., 2013; Malmquist and Nelson, 2014; McKelvey, 2014; O'Neill et al., 2013; Ril et al., 2024; Wojnar and Katzenmeyer, 2014). Similar to Dahl et al.'s (2013) findings that curiosity should be carefully considered, mothers in Ril et al.'s (2024) study experienced curiosity as that of the medical team putting their own interests first and therefore, this was a barrier to co-mothers being able to attend the birth of their child. It may be that there is a difference between the curiosity of the mother's individual experience, and medical curiosity which may feel more intrusive. Disclosure of sexual orientation was viewed as risky within Dahl et al.'s (2013) review, whereas in the current review was seen as a pathway to gaining more acceptance and helping further acceptance for future generations (Cherguit et al., 2013; Hayman et al., 2013). It may be that due to the changes in the legal systems that have happened since Dahl et al.'s (2013) review, that mothers felt more empowered as the risks may feel lower. However, further research specifically reviewing this change may help further this hypothesis.

The existing research evidence is limited and employs a variety of qualitative methods from both culturally and systemically varied populations. Future research should aim to understand the impact of the legal changes and consider identity intersectionality. Future research should also report participant characteristics to support contextual understanding.**Limitations**

The majority of studies within the review recruited participants from Western societies, and therefore, the synthesis lacks studies from non-Western societies where experiences may differ. Additionally, only three studies explicitly recorded the ethnicity of their participants (Cherguit et al., 2013; McKelvey, 2014; Wojnar and Katzenmeyer, 2014) and two others

described participants as mostly Swedish or European (Malmquist and Nelson, 2014; O'Neill et al., 2013). Therefore, a lack of ethnicity data, and the confirmed ethnicity being majority white, limits our findings' generalisability to mothers not represented by the studies. The intersectionality of ethnicity, alongside sexual orientation, may be an additional factor in the experience that is not able to be represented within the current review. Furthermore, although all articles were published after significant legal and policy changes, the reported ages of children suggest that some participant's maternity journey was prior to these changes, and therefore, we may not be seeing the full extent of experiences following the legal changes.

The research group consisted of three people all with similar professional backgrounds within the United Kingdom's National Health Service (clinical psychologist and trainee clinical psychologist) but different specialist areas, sexual orientations, and gender identities. This provided a variety of perspectives within the group and is a strength of the research, but it is possible that a research group with different professional backgrounds or only lesbian and bisexual researchers would have viewed the data differently.

Recommendations

The following recommendations have been made to help foster inclusive environments for lesbian and bisexual mothers. Please note, as detailed further in the limitations section, these recommendations have been developed from a small sample of studies from a broad population with a limited pool of data due to missing information.

- For increased awareness of how heteronormative views and assumptions can present within maternity healthcare services.
- For maternity healthcare professionals to access training on how they can challenge and reduce heteronormative views and assumptions within themselves and the wider

healthcare systems, such as providing literature which is inclusive of lesbian and bisexual family units.

- For lesbian and bisexual mothers to be asked what they would like to be called, and their chosen names to be used throughout their care without the need for further questions.
- To offer explicit acceptance to lesbian and bisexual mothers and recognise both mothers as parents within the family unit, this can be done through staff having a positive attitude toward mothers and using language which demonstrates this, such as "both of you".
- For professionals to be aware of the power they may hold in interactions with lesbian and bisexual mothers, and how this may disempower mothers in advocating and challenging non-inclusive care.

Conclusion

The review has identified important aspects of lesbian and bisexual mothers' experiences of maternity healthcare services in the current context of same-sex marriage and parentage legality. Recommendations for maternity healthcare providers and professionals are provided; these aim to help develop more inclusive environments for lesbian and bisexual mothers.

Declarations of interest

AH and BB declare no potential competing interest. EN is employed by a healthcare trust and works as part of a Clinical Psychology Team in a neonatal unit.

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Chapter 3: Bridging chapter

Bridging Chapter

The systematic review identified four key topic areas from the 10 studies identified. These were “heteronormativity”, “acceptance and inclusion”, “finding your own path”, and “knowledge and power of professionals”. Recommendations made by the systematic review include increased awareness of how heteronormative views and assumptions can be presented, for further education to be provided to maternity healthcare professionals on how they can challenge and reduce heteronormative views and assumptions, for the language used by services to reflect what lesbian and bisexual mothers wish to be called, for explicit acceptance to be offered, and for professionals to be aware of the power they hold in their interactions with mothers. Mothers expressed wanting to be viewed as equal mothers within the family unit; there was little consideration of how a birthing mother’s needs may differ from a non-birthing mother. This may reflect them not only experiencing a lack of equality but also that this can be indicative of heteronormative views and assumptions. It may be that equitable care, aimed at providing the care based on each mother’s individual needs whilst still acknowledging both mothers, could provide the equality that the mothers are seeking.

LGBTQ+ parents may be more likely to have a baby admitted to a neonatal unit due to the diverse pathways they have to parenthood. LGBTQ+ parents are more likely to use assistive reproductive technology (ART) compared to cisgender heteronormative people as ART has enabled LGBTQ+ parents to overcome biological barriers to pregnancy (Raja et al., 2022; Topper & Bauermeister, 2022). ART has been linked to a greater risk of baby needing additional support from a neonatal unit (Pontesilli et al., 2021; Qin et al., 2016; Scala et al., 2018). However, as detailed in additional research, although there appears to be a link between ART, additional parental characteristics are likely to impact whether a baby is more likely to need admission to a neonatal unit (Liao et al., 2024; Pontesilli et al., 2021).

Therefore, it is crucial that not only should researchers consider the maternity care experience of LGBTQ+ parents, but also their experience of neonatal care.

The majority of LGBTQ+ parents whose baby is admitted to a neonatal unit, will have had some interactions with maternity healthcare professionals during their perinatal journey. Therefore, understanding the maternity experience of parents, in the case of the current systematic review specifically lesbian and bisexual mothers, may help us to consider how their maternity experience shaped their neonatal experience. Recommendations of how to improve lesbian and bisexual mother's experiences of maternity care may support their maternity care experience but may not always be appropriate or suitable to a neonatal setting. Therefore, further insight into LGBTQ+ parents' experiences of neonatal care will support with the development of recommendations to help ensure that LGBTQ+ parents are appropriately supported throughout their perinatal journey.

Chapter 4: Empirical Research Paper

Written for publication in the *Journal of Reproductive and Infant Psychology* (see guidelines in Appendix D)

"Oh, who's the mum?": A Thematic Analysis of the Neonatal Experience of Lesbian and Queer+ Parents

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“Oh, who’s the mum?”: A Thematic Analysis of the Neonatal Experience of Lesbian and Queer+ Parents

Objective: The aim of the current research was to explore how LGBTQ+ parents experience neonatal units in the United Kingdom and how they feel their own sexual orientation and/or gender identity impacted this experience.

Background: Admission of a baby to a neonatal unit for any reason can have negative psychological consequences for the parents, and parents whose baby was born prematurely experience increased rates of mental health difficulties. LGBTQ+ parents are more likely to experience discrimination and feel invalidated by care they receive. Receiving family-centred care can help parents feel respected and affirmed. However, much of the research of parents’ experiences has focused on cisgender parents who are in heterosexual relationships and there is little guidance for professionals supporting LGBTQ+ parents on neonatal units.

Method: 12 parents identifying as lesbian and queer+ were interviewed about their experience of their baby being admitted to a neonatal unit. Interviews were recorded, transcribed, and analysed using thematic analysis.

Results: The findings were separated into two meta-themes and the themes identified within the meta-theme, ‘experience as lesbian and queer+ parents in a neonatal unit’ are presented. Four themes were discussed: ‘real and perceived threats’, ‘adapting to a heteronormative world’, ‘positive experiences’, and ‘actions speak louder than words’.

Conclusion: The current research contributes to an important gap in the literature. Recommendations for clinical practice have been made, including the use of inclusive language, and proactive actions.

Keywords: neonatal, LGBTQ+, parent, qualitative, thematic analysis

Introduction

Every year 1 in 11 babies are cared for in neonatal units in the United Kingdom (UK), for a variety of reasons such as prematurity, sepsis, or respiratory difficulties (Cleveland, 2008; National Neonatal Audit Programme, 2023). There are three types of neonatal units in the UK: special care baby units, local neonatal units, and neonatal intensive care units (Bliss, 2023). For the purposes of this research, the term neonatal unit will include all three types.

An admission to a neonatal unit can negatively affect parents' mental health, with increased rates of psychological difficulties, and their bond with their baby, (Bry & Wigert, 2019; Busse et al., 2013; Grunberg et al., 2019; Malouf et al., 2022). Obeidat et al. (2009) identified that the neonatal unit environment can be traumatic, as parents may witness distressing treatments and face repeated risks to their baby's health.

Recently, a review by Yinger et al. (2024) into the experience of family centred care for LGBTQ+ parents in neonatal units examined the experiences of stigma, discrimination, resilience, and family-centred care. Most of the studies included in the review were not specific to the LGBTQ+ community and out of 150 overall participants across the studies, only 12 to 14 participants were LGBTQ+. Experiences of discrimination were identified in all the studies; however, it was recognised that some studies were completed prior to same-sex marriage becoming legal and therefore, discrimination and fears of parental rights may differ currently. The review identified that family-centred care, even if not explicitly explored, was important in supporting parents to feel respected and affirmed. Due to such a limited number of LGBTQ+ participants within the studies, and many of the studies not being specifically LGBTQ+ focussed, Yinger et al. (2024) recognised the need for further research to take place to understand the experience of LGBTQ+ parents in neonatal units.

In addition to the challenges faced by parents with a baby in neonatal care, research identified that lesbian mothers often feel pressured to repeatedly ‘come out’ to ensure both

mothers are acknowledged in medical decisions (McManus et al., 2006). A more recent meta-ethnography found that disclosing sexual orientation can feel both important and risky, with a sense of control over the process needed to feel safe (Dahl et al., 2013). In neonatal units, where parents have limited control, the need to 'come out' may be particularly present and negative experiences with disclosure may affect how safe a parent feels leaving their baby in staff care.

Regardless of their sexual orientation and/or gender identity, LGBTQ+ parents are more likely to experience stigma, and research shows this experience continues into healthcare settings (Mccrone, 2018). LGBTQ+ parents accessing healthcare for their children face assumptions of heterosexuality, heteronormative language, and a lack of recognition in administrative systems; there is also a desire for greater professional awareness of LGBTQ+ parenthood (Coulter-Thompson, 2023; Haugland et al., 2023; Kelsall-Knight, 2021). Additionally, LGBTQ+ parents can feel invalidated as a family unit which can be distressing for parents. There are different factors which impact how validated a parent feels which include: negative experiences connected to heteronormative and cisnormative assumptions about the parents' relationship status, parental labels they choose, and preferred pronouns (Klittmark et al., 2023). The needs of the LGBTQ+ community will differ depending on their gender identity and sexual orientation, for example, in female same-sex couples, it is important to be recognised as a family of two equal mothers and the use of 'partner' or 'parent' does not always allow for this recognition (Klittmark et al., 2023). Furthermore, non-birthing mothers experience feeling between the roles of 'mother' and 'father' and they report a need for them to build their own identity as a parent (McKelvey, 2014). Qualitative research which is not specific to LGBTQ+ parents and does not specifically focus on their LGBTQ+ identity may therefore miss the subtleties of their experience, such as their

experience of being the ‘other mother’ (McKelvey, 2014) and therefore impact the usefulness of recommendations that may be made to neonatal services.

Alongside limited research on LGBTQ+ parents' experiences, there is a lack of National Health Service (NHS) maternity and neonatal policies that address their need for tailored support. For example, NHS England’s resource pack for implementing better births does not mention LGBTQ+ parents (NHS England, 2017). This lack of inclusion, combined with limited research, may leave staff unsure about the specific support LGBTQ+ parents need and how to tailor their approach to LBTQ+ parents.

The studies detailed above acknowledge the challenges parents face when their baby is admitted to a neonatal unit, however, the research primarily includes cisgender and heterosexual parents. The challenges identified in the literature discussed will likely be experienced by parents who are part of the LGBTQ+ community, however there may be additional challenges specific to this group of parents that have not previously been identified. To date, there is no empirical research that has aimed to specifically consider the experiences of LGBTQ+ parents in neonatal units. The aim of the current research was to explore how LGBTQ+ parents experience neonatal units and how they feel their own sexual orientation and/or gender identity impacted this experience.

Method

Participants

As can be seen in Table 1, 12 parents whose baby had been admitted to a UK neonatal unit ranging from 10 days to 35 days (M= 19, SD = 8.77) were recruited. Of the 12 participants, there were four couples, with each parent interviewed separately regardless of whether their partner was also involved in the study. Parents were interviewed separately to ensure that each parent had the opportunity to share their own story; their experience could be fully explored, and that there was homogeneity of interview types, such that there was not a

mixture of couple and individual interviews. In keeping with the ontological and epistemological approach, each parent's experience is believed to be unique to them and therefore, interviewing parents allowed for each parent to reflect on their own experience (Blake et al., 2021). To be eligible for the study, participants had to be over 18 years old, fluent in English, a parent (birthing or non-birthing parent), identify as part of the LGBTQ+ community, and had a baby admitted to a UK neonatal unit for over seven days (within the last 10 years, but not more recently than 6 months).

Table 1. Participant Demographics.

Demographics	**Proportion n**
Who	
Birthing parent	7
Non-birthing parent	5
Age ranges	
25 – 31	3
32 – 38	3
39 – 45	6
Ethnicity	
White British	11
White Any Other Background	1
Sexual Orientation	
Queer	4
Bisexual	2
Lesbian	5
Pansexual	1

Gender Identity	
Woman	11
Non-binary	1
Gestation at time of birth	
28+1 to 32+0 weeks	1
32+1 to 39+0 weeks	11
Was baby a singleton?	
Yes	10
No	2

The decision to only include parent's whose stay was over seven days was to support the richness of the data not only about their stay but also their interactions with staff and other parents, and a shorter stay may have meant parents did not have the opportunity for these interactions to take place. The project recruited to all parents within the LGBTQ+ community to begin to develop a baseline that further research could build on. Using 10 years as a cut-off was due to the last major legal milestone for the LGBTQ+ in England being in 2013, when the Marriage (Same Sex Couples) Act was introduced (Marriage (Same Sex Couples) Act, 2013). This law altered the experience of LGBTQ+ parents (Teo et al., 2022) and is therefore, likely to have impacted upon any neonatal unit experiences. Although we aimed to recruit participants from all identities within the LGBTQ+ community, the majority of participants identified as female (n=11), and lesbian (n=5) or queer (n=4).

The study excluded parents who had experienced a bereavement during their stay on a neonatal unit, as their experience would be somewhat different from a parent with a surviving baby. To ensure a minimum level of homogeneity, the unique experience of bereavement was unlikely to allow for this.

Prior to recruiting, the lead researcher (AH) met with two parents with experience of being an LGBTQ+ parent and having a baby admitted to a neonatal unit, to consider how recruitment would be undertaken and to collaboratively develop the semi-structured interview guide.

Procedure

Participants were recruited using posters (see Appendix E) on both social media and through LGBTQ+ and premature baby charities, such as BLISS and LGBT Mummies. Potential participants made contact with the lead researcher (AH) who provided them with a detailed participant information sheet (see Appendix F) to review before arranging the interview. It was made clear to participants that they could withdraw from the interview at any time up to two weeks after the interview date without consequences (although no participants did withdraw). Prior to the interview, participants were provided with an electronic consent form to sign (see Appendix G). Alongside the consent form, participants provided their demographic information (Appendix H, detailed in Table 1). A debrief letter (Appendix I) was also provided to participants following the interview which signposted to places parents could access support regarding the information discussed, and information on who to contact for further information or complaints about the study.

Interviews were conducted online and recorded using Microsoft Teams. Microsoft Teams automated transcription was used and then reviewed by the lead researcher (AH). All interviews were conducted by the lead researcher (AH) and semi-structured interviews allowed for the flexibility to focus on topics that were meaningful to participants (see Appendix J; Kallio et al., 2016). The Information Power model was used throughout the research process to consider when the data collected held adequate information power (Malterud et al., 2016). The Information Power Model indicates that the more information a sample holds, the smaller the sample size is needed. The study had a broad aim, but

participants had highly specific characteristics; despite a limited theoretical background, interviews collected high quality information, and cross-case analysis was used to support recommendation development. Therefore, there it was decided once 12 participants were reached that the data collected held adequate information power.

Ethical Considerations

Ethical approval was gained from University of East Anglia Faculty of Medicine and Health Sciences Research Ethics Subcommittee on 12th January 2024 (ETH2324-0061; Appendix K) and a further amendment to include contacting additional charities to support with recruitment was approved on 26th April 2024 (ETH2324-2289*; see Appendix L). Due to the sensitive nature of the topics that would be discussed in the interviews participants were offered breaks or a pause during the interview and signposted to places they could receive support for some of the distressing topics parents might discuss.

Theoretical and Analytic Approach

A relativist ontological stance was employed (Moon & Blackman, 2014). In keeping with a relativist stance, the researcher took a subjectivist epistemological approach, assuming that meaning is developed by how an individual engages with and understands their world (Creswell & Creswell, 2017; Crotty, 1998). How this world is understood is based upon an individual's cultural, historical and social perspectives (Moon & Blackman, 2014). These approaches are in line with the research as gender roles and heteronormative assumptions are often developed by how a person understands their world and is developed through societal, cultural, and historical perspectives.

Reflexive Thematic Analysis (Braun & Clarke, 2006, 2019) was used as it allowed for the consideration of the researcher's subjectivity within the data analysis, aligned with the epistemological approach of the research. The analysis involved six stages: familiarisation with the data, generating initial codes, colleting initial codes into potential themes, reviewing

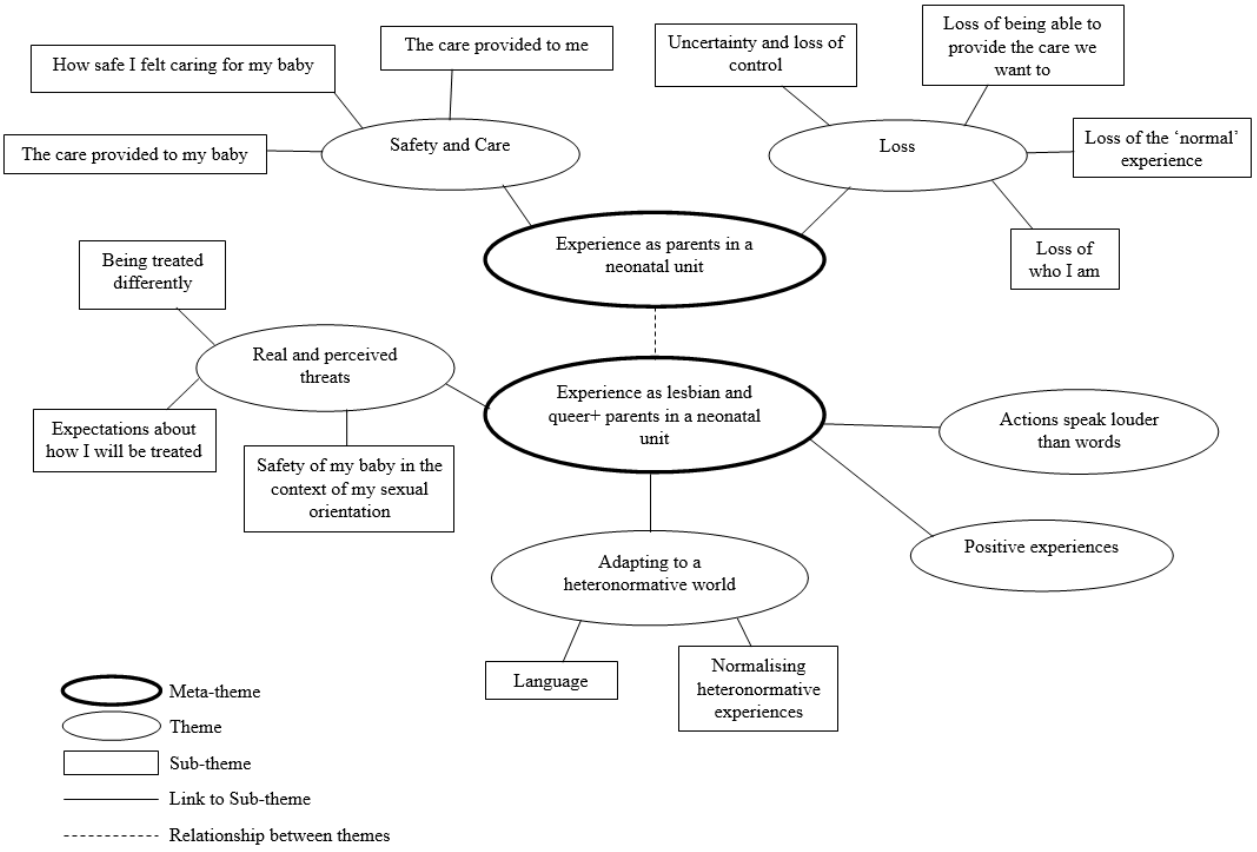
the themes, generating a thematic ‘map’ of the data, and writing up. The research team met to review the themes developed by the lead researcher. NVivo 14 was used to support with the organisation of codes and themes.

The lead researcher kept a reflective diary to explore ways in which their own lived experiences and perspectives might influence analysis. For example, the lead researcher is a member of the LGBTQ+ community and their own experience within services and in how they are perceived by society was reflected upon and discussed within the research team.

Results

As detailed in Figure 1, the findings have been separated into two meta-themes, ‘experiences as parents in a neonatal unit’ and ‘experience as lesbian and queer+ parents in a neonatal unit’. The following results section discusses only those themes identified within the ‘experience as lesbian and queer+ parents in a neonatal unit’ meta-theme. Four themes within this meta-theme were identified: ‘real and perceived threats’, ‘adapting to a heteronormative world’, ‘positive experiences’, and ‘actions speak louder than words’.

Figure 1. Thematic map.



Real and perceived threats

As the parents discussed their experiences within the neonatal units it became clear that they experienced real threats to how safe they felt, such as being treated differently, but also perceived threats to them and their baby's safety.

Being treated differently

Parents noticed times where they were treated differently due to their gender and sexual orientation, and this impacted their feelings of trust towards staff. Experiences of being treated differently negatively impacted their expectations of how they would be treated in different situations. Many of these experiences were seen as an additional challenge on top of the already difficult experience of having a baby admitted to a neonatal unit.

> P1: Nurses were obviously fine with me being bare-chested…but seemed to take a bit of issue with P1_Wife being so. When they wanted to take baby's temperature or count respirations they would sort of 'oh' and 'ah'…in case there was a flash of breast from the non-feeding parent.
>
> P4: She went like 'are you two sisters' and we were like 'no' and she was like 'you, you could be twins'…why that's your assumption with two people like sitting day and night around a baby…I'm having to deal with having to explain to someone that she's not my sister while this is going on, really sucked.

Parents described feeling like they were being treated differently but there not always being 'hard evidence' (P1) of this. They did not always experience overt homophobia, but all parents described experiencing assumptions made about who their baby's parents were. Participant 5 described these microaggressions as something you experienced every day as 'less of a uh, incident and more of just like a little pinprick'. Being treated differently wasn't always seen as a negative, with Participant 3 experiencing positive discrimination where her and her wife were able to both stay on the ward due to it being a 'mum's only' ward. Parents also developed ways to protect themselves from being treated differently such as being 'confident and…outspoken' (P2) to ensure staff knew about their identity and to emphasise their parentage so it wasn't questioned.

Expectations about how I will be treated

Alongside actually being treated differently, many of the parents expressed an expectation or fear that they would be treated differently, perceiving threats to their safety as lesbian and queer+ parents on the neonatal unit. Parents feared that they or their partner would be turned away or not recognised as an equal parent by staff. They would repeatedly 'out' themselves to staff by always calling themselves the 'other mother' to present their parentage on entrance to the unit.

> P1: Whether they would trust P1_wife's answers to anything…are they gonna see P1_wife as an equal parent to me…I don't have anything explicit that said that they didn't…it's just a feeling…like you're not quite safe enough.

> P2: From the first time that I went on to the ward and every single time since then… I would say it's baby's other mummy.

Even parents who did not have negative experiences expected this and were relieved when they didn't have a negative experience.

> P3: I imagine you probably hear a lot of negative ones.

Parents acknowledged their lived experience as a lesbian or queer+ person impacted how they expected to be treated within the neonatal units. Non-birthing parents expressed fears they would be seen as 'less than' which came from their own feeling of contributing less to the conception of their baby.

> P8: You already feel less than like you contributed less, like you're gonna mean less, and, and you're gonna have to work 10 times harder…just to be mum.

Safety of my baby in the context of my sexual orientation

Parents experienced real and perceived threats as not only affecting their safety but also their baby's safety. On experiencing a lack of inclusivity in the language of many hospital forms, such as only offering heteronormative choices/headings, and not feeling respected as a parent, they began to fear for the safety of their child.

> P8: When you feel like actually who you are…in that position isn't respected and isn't, isn't actually taken into consideration…you're just teetering on this edge of going do they respect me enough to look after my, my child.

Adapting to a heteronormative world

Many of the real and perceived threats that parent's experienced were due to heteronormative assumptions and being part of the LGBTQ+ community within a heteronormative society. Parents attempted to adapt to the neonatal environment both internally, by normalising and rationalising experiences, and externally, by recognising heteronormative language and adapting their own language to 'fit' heteronormative standards.

Language

Parents experienced language as not being inclusive of families that did not fit within a heteronormative viewpoint. Parents wanted to be called by their chosen names and felt validated when staff used these names. As well as feeling validated, witnessing staff use their chosen names helped their trust in staff to provide personalised care to their baby.

> P10: At HOSPITAL_A they seemed to pay attention, so we refer to ourselves as mama F and mama G and…quite a few of the nurses picked up on that…if they were speaking to BABY through the night.

> P5: …Staff who would be like, you know, but how are the mums today and you know that would be really validating in that moment.

Alongside the experience of heteronormative assumptions, parents also appeared to use their language to challenge these assumptions by referring to themselves as the 'other mother' (P4). The term 'other mother' was used by both birthing and non-birthing parents, seemingly to challenge the heteronormative assumptions that they perceived staff would have. However, there was a devaluing nature to this phrase as it did not recognise them as an equal parent but the 'other' or secondary parent.

> P4: I can remember us both talking about how we both felt like that we were constantly saying I'm the other mother.

Both birthing and non-birthing parents described frustrations that most of the documentation did not allow for both parents to be called ‘mother’. When signing documents for the hospital, birthing parents could sign for ‘mother’, but non-birthing parents were often classed as ‘fathers’. Parents described these experiences as being a further frustration on top of all the worries they already had about their baby.

> P10: The things like the forms and stuff like that…it mustn't be nice for P10_PARTNER to have to cross dad off.

> P8: Repeatedly over and over every single form that I’m filling out is mother's name and father's name… then you almost feel like you're being bashed every time like you're filling out a form.

During their maternity and neonatal experience, Participant 1 described feeling very uncomfortable with always being referred to as ‘mummy’ and that the experience of gendered care and gendered assumptions led them to realise they were non-binary. Experiencing gendered care created a sense of being less than other people and feeling it was ‘dehumanising’.

> P1: Find it really like dehumanising and actually my experience going through maternity care and then the neonatal care is what led me to realise I’m nonbinary, because everything was so mummies this and ladies that.

Normalising heteronormative experiences

When talking about experiencing heteronormative assumptions many of the parents would normalise this experience by rationalising it or saying it isn't only something they experienced in the neonatal unit but something that happens in lots of different settings. By rationalising the heteronormative assumptions as not being specific to the neonatal unit,

parents protected the neonatal staff and seemed to forgive them for upholding the heteronormative assumptions that exists within society.

> P6: There was obviously like regularly there was “oh, who's the mum?” but that's I think you get that anyway [as] a gay parent you don't just get it in in terms of care you get it anywhere.

Parents even blamed themselves for how they perceived situations by explaining that maybe it was their hormones or their internalised homophobia that impacted how safe they felt. By internalising the blame, parents presented themselves as the problem; this felt like a possible protective measure as the alternative to them being to blame was that society, which they do not have as much power to change, saw them as being outside of the norm.

> P11: I suppose my unconscious bias and my internalised [homophobia] probably…had more of an effect on me than actually anything else that happened.

Parents themselves rationalised why they might not have experienced homophobia by describing how they might fit into the views and assumptions that a heteronormative world has of lesbian and queer+ relationships.

> P3: …It also helps that my, my wife does dress a little bit more masculine than, than feminine so…we're very obviously a gay couple.

Positive experiences

Some parents described very positive experiences of their baby’s admission to the neonatal unit and felt that they did not experience any negative responses to their sexual orientation. Emphasis was often given to it being a positive experience only on the neonatal unit, suggesting that their experiences elsewhere in healthcare services weren't always as positive.

> P3: We had a really, really more than positive experience of our sexuality there.

Through discussing positive experiences, parents would often point out the challenges that the NHS is experiencing, almost to emphasise the effort staff put into providing great care.

> P5: Such an amazing unit I'm sure doing its best with the resources they have.

Actions speak louder than words

Parents that experienced heteronormative language and assumptions described frustration when words did not lead to action. Some parents experienced a lack of acknowledgement of heteronormative language as representing a limited chance of services becoming more inclusive.

> P10: I think it would have been quite nice to just acknowledge like…we haven't had that happen before…we'll see what we can kind of do um to change things up.

Parents perceived a lack of action as blaming and shaming them for choosing to be parents and the fault being placed on them as lesbian and queer+ parents rather than the fault of heteronormative assumptions.

> P2: There were two toilets…one of which had a sign on it saying um for use of mum's only and I was just like cool I'm a mum so I used [the] toilet several times and I got told off for doing so…they didn't then change the poster…it felt to me like once they'd spoken to me they then didn't feel the need to do the poster because they…found the culprit which was me.

When positive action was seen, it helped soften the impact of the parents' experiences of heteronormative experiences. Although, many of these positive actions still represented the presence of a heteronormative assumption, such as staff crossing out father and putting the parent's name.

> P4: What was good about that was as soon as someone picked up, they're like “oh my god we're so sorry” and they kind of got the, the card that was in his little incubator nest thing and they kind of like crossed out father and put mother and put P4_Partner's name on.

When proactive actions were taken to ensure inclusivity for parents, parents appreciated it, and this helped them to feel validated as parents. These proactive actions provided safety for parents as it represented a correcting of the system itself rather than the parent being the problem.

> P12: Felt really good 'cause it…felt like they took care to communicate about the fact that we're two moms it felt good you know…it felt really nice to not have to have that conversation when everything else was going on.

Discussion

The current research identified four themes specific to the experience of lesbian and queer+ parents in the neonatal unit environment. Parents were acutely aware of both real threats and their perception of threats that could occur. They were consciously and unconsciously adapting themselves to fit in a heteronormative system. Some parents had very positive experiences of the neonatal units, however, their expectation that other parents might not have the same experience, reflected their fear of being discriminated against. The parents perceived proactive and reactive actions that staff took to make the environment more inclusive as positive and validating of their identities, and it was actions, rather than words, which made the most difference.

Although Yinger et al. (2024) suggested that experiences of discrimination may not be as present due to same-sex marriage being legalised, many of the parents within the present study still feared they or their partner would be turned away or not recognised as equal. Whether this perceived threat developed into a real threat did not change the worries that parents had, and when parents did not have a bad experience there was often surprise in

not being discriminated against. It is understandable that parents who had experienced homophobia throughout their lives, as many LGBTQ+ people do (McManus et al., 2006), had an increased fear of being treated differently.

Similar to the participants in Obeidat et al.'s (2009) study, the parents experienced lots of fear about their baby's safety and perceived them to be at risk of harm if safe care was not provided. In addition to this fear, parents had the added fear of how their sexual orientation impacted their baby's safety. Furthering the findings by Dahl et al. (2013) and McManus et al. (2006), of the lack of control parents may have when coming out and in the care of their baby, when parents experienced a lack of inclusivity relating to their sexual orientation, they began to fear for the safety of their child. The impact of not feeling safe as a lesbian and queer+ parent affected how much trust parents could place in staff, and this added to the distress parents experienced when leaving their baby in the care of staff.

The use of language served to both validate and invalidate parents. As identified in the review by Yinger et al. (2024), care that is centred on the family, such as using the language that parents use to describe themselves, made parents feel validated in their identity. When parents perceived their chosen names as being used even if they were not present, it helped them to feel that their baby was safe and that they were respected as parents. Similar to Klittmark et al.'s (2023) findings, when parents experienced heteronormative assumptions, whether these were through professionals asking them who was the mum or in documentation, they felt invalidated as parents.

Similar to the research by McKelvey (2014), some of the non-birthing parents appeared to not connect completely with the term 'mother' but also not connect with the term 'father'. Non-birthing parents felt they needed to work harder to be seen as an equal parent and during their neonatal experience began to build their own identity. Non-birthing parents being the first to visit baby on the neonatal unit, and being treated as an equal parent by staff,

helped them to feel validated and accepted as a parent. In some couples, both parents would call themselves the 'other' mother, which suggested a need to consistently 'come out' to ensure professionals viewed them both equally. There was a focus on equal parentage, which may suggest that in a neonatal setting, where the focus of care is on baby, both parents prioritise being equal in decision making and information sharing. Parents that recognised they were othering themselves, reflected on how doing this helped them develop their own identity as a parent (Klittmark et al., 2023), such as deciding what they wanted to be called.

Parents perceived actions either proactively to make an environment more inclusive, or reactively to repair the 'damage' caused by a lack of inclusivity as important in them feeling safe as parents and feeling their baby was safe. Similar to the findings by Klittmark et al. (2023), a lack of proactive action felt blaming for parents and invalidated them as not only a parent but also as a family.

Limitations and implications for future research

All participants identified as white and therefore, the experience of parents of other ethnicities may differ from that presented. Future research should aim to recruit parents of all ethnicities and consider how the intersectionality of gender, sexual orientation, and ethnicity may impact experiences. Furthermore, although recruitment was aimed at LGBTQ+ parents, no male or transgender parents contacted the researcher with interest in the study. Future research should aim to recruit parents from other LGBTQ+ identities which may provide specific recommendations for these parents. Additionally, although there was a 10-year limit on a parent's neonatal experience due to this being when the most recent significant legal changes happened, there is the possibility that parents were not able to recall all the details of their experience.

Recommendations for clinical practice

As identified above, there is a lack of guidance on how to support and adapt care for LGBTQ+ parents in neonatal services. The researchers recognise that these recommendations have been developed through research with only lesbian and queer+ parents, and therefore, specific guidance for LGBTQ+ parents not represented by this study is still needed. In keeping with the epistemological and ontological stance, these recommendations should act to support a person-focused approach which recognises that each parent's experience may differ. The following recommendations are made to help foster inclusive environments for parents:

- The use of language to be inclusive and to consider the impact of a lack of inclusivity on LGBTQ+ parents. This might include having documentation that is universal for all parents or provides more open-ended choices (like parent's preferred names). If it is not possible to change the documentation, recognising that it might not represent a parent, can foster safety.
- Parents to be asked what they would like to be called and proactive actions to be taken to ensure their chosen names are used without the need to ask again.
- Proactive actions to ensure inclusivity were appreciated by parents, but reactive actions also served to help foster safety.

Declaration of Interest Statement

AH and BB declare no potential competing interest. EN is employed by a healthcare trust and works as part of a Clinical Psychology Team in a neonatal unit. The Doctorate in Clinical Psychology at the University of East Anglia supported this study.

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Chapter 5: Extended Methodology

Extended Methodology

The following additional chapter aims to supplement the methods section of the empirical paper. The rationale for methodology, quality of analysis, and ethical considerations will be discussed in further detail.

Rationale for Methodology

Rationale for a Qualitative Framework

The aim of the current research was to explore how LGBTQ+ parents experience neonatal units and how they feel their own sexual orientation and/or gender identity impacted this experience. As discussed within the introduction of the empirical paper, there is no published literature exploring only the experience of LGBTQ+ parents. Qualitative research allows participants to talk about their experience and can sometimes lead to learning more than what the research set out to discover (Hammarberg et al., 2016), therefore, with such little research existing within the topic area, using qualitative methodology allowed for participants to emphasise the areas that were important to them.

LGBTQ+ parents experience stigma not only in medical settings but throughout their interactions with society (Mccrone, 2018). Although the empirical research project did not specifically focus on the parents' experiences of stigma, structural and institutional stigma can be perpetuated through policies, legislation and systems that exist, such as maternity and neonatal services using heteronormative language within their literature or only having the option of 'mother and father' on documentation (Bos et al., 2013; Stutterheim & Ratcliffe, 2021). Stutterheim and Ratcliffe (2021) considered how qualitative research can support in understanding and addressing stigma. They claimed that because stigmatisation is complex, qualitative research can capture the rich and contextualised diversity of how stigma is experienced and allows for social context to be considered. Additionally, qualitative research

allows for meaningful engagement with communities, and it gives voices to those that may be unheard or silenced as well as ensuring future research questions and study designs are informed by the lived experiences of people with a stigmatised identity (Hayre & Muller, 2019; Hennink et al., 2010). Through using a qualitative framework to explore the experience of LGBTQ+ parents, the research allowed LGBTQ+ parents to have a voice and for their lived experience to help develop recommendations that they themselves identified. A qualitative methodology also allows for social context to be considered and reflected upon by the author and research team.

Ontology and Epistemology

The author's ontological stance is relativist, where reality is mentally constructed by each individual person (Moon & Blackman, 2014). Therefore, reality is a subjective experience and rather than two people just experiencing the world differently, it is that their worlds are different (Bayley, 1995; Stajduhar et al., 2001). This ontological stance fits with the research, as realities for each person can change because they are affected by the person's cultural and historical experiences (Crotty, 1998). Therefore, the reality of one LGBTQ+ parent will differ from another LGBTQ+ parent based on their own lived experiences. By exploring each parent's experience, we can develop a tentative understanding of these experiences whilst still considering the subjective nature of each parent and the person-focused care that is needed to support each parent's reality.

The author's epistemological stance is subjectivist; therefore, knowledge depends on how people may perceive and understand their reality (Moon & Blackman, 2014). A subjectivist stance recognises that reality is pluralistic, where it can be expressed through different systems, and plastic, reality can be shaped to fit a purpose (Moon & Blackman, 2014). Subjectivist research is useful in identifying how a person's experience shapes their

perception of the world, for example, how a parent's experience with staff on the neonatal unit shapes the perception of their reality.

The ontological and epistemological stance were crucial throughout the research, they influenced the methodological approach taken, how the data was collected, and analysis approach. For example, through asking questions that varied between understanding experiences and understanding a parent's reality, the author was able to begin to subjectively understand how a parent had created their reality. Additionally, the decision to interview each parent individually, regardless of whether their partner was also a participant, meant the author was able to hear from each individual about their reality and how their individual experiences shaped this. Parents seemed to, quite naturally, discuss their own lived experience of being part of the LGBTQ+ community which allowed for further understanding of how their experiences have shaped their reality.

Rationale for Reflexive Thematic Analysis

Thematic analysis is a method that allows a researcher to identify, analyse, and then interpret themes within qualitative data (Clarke & Braun, 2017). Reflexive thematic analysis is the approach that Braun and Clarke developed, which emphasises that the researcher's subjectivity is crucial as an analytic resource, along with their reflections when engaging in the research process (Braun & Clarke, 2021a). Theoretical frameworks are a valuable tool in qualitative research; they draw upon existing knowledge and the researcher's epistemological position to provide a clear lens for how the study processes the data (Collins & Stockton, 2018). Reflexive thematic analysis is flexible and can be guided by different theoretical stances (Braun & Clarke, 2021a). The flexibility of reflexive thematic analysis means it can suit a critical stance (Braun et al., 2015), such as the relativist stance taken within the current research study. The reflexive thematic analysis approach highlights the researcher's role in

the production of knowledge, with the researcher actively engaging with and interpretating the data (Braun & Clarke, 2019). Through the researcher engaging with the data, the themes developed are subjected to the researcher's own theoretical assumptions. This approach fits within a relativist stance whereby individuals, including the researcher, create their own reality based on their lived experience (Patton, 2002).

Reflexive thematic analysis is also flexible to the heterogeneity of the participant characteristics, which suites the aim of the research to explore the experience of LGBTQ+ parents. The use of an alternative approach, such as interpretative phenomenological analysis would require a much more homogenous sample to allow for an in-depth analysis of each case (Smith, 1996; Smith et al., 2021).

Semi-Structured Interview Topic Guide

The topic guide was developed in collaboration with both a parent with neonatal experience and a parent who identified as part of the LGBTQ+ community. Furthermore, the research team included two staff members with experience as clinical psychologists within neonatal services (EN and BB). The decision to work in collaboration with a parent with one of each identity (having neonatal experience or being part of the LGBTQ+ community) allowed for these parents to engage in the development of the guide without excluding them from later eligible participation.

An initial topic guide was developed by the research team and then feedback from the parents was sought. Their feedback included adding in a question asking about experiences with other parents, and probing questions about accommodation and travel to the neonatal unit. Prior to involving parents in the topic guide, a payment policy was developed using the NIHR guidance (National Institute for Health and Care Research, 2022) alongside consideration of the financial limitations of the budget available. It was agreed by the

research team that parents involved in reviewing the topic guide would be paid £10 using an e-gift card that could be spent at a variety of outlets.

The Quality of Analysis

Framework for Qualitative Research

Yardley's (2000) characteristics of good qualitative research were used to ensure good validity of the research.

Sensitivity to context

The author ensured that existing theoretical and empirical literature was considered, and the context of such literature is reflected upon within the introduction. For example, considering the literature on parent's experiences of their baby being admitted to a neonatal unit alongside the relevant literature on LGBTQ+ parents' experiences of maternity care. The author showed sensitivity to context by considering the perspective and socio-cultural context of participants; by keeping a reflective diary the author was able to consider how their own characteristics impacted their engagement with the research, such as being part of the LGBTQ+ community, but not being a parent. Furthermore, the relativist and subjectivist stance of the author supported the sensitivity to context as it allowed for a reflective approach to be taken throughout the research process and these reflections to include considerations of the context of the researcher and the participants (further reflections detailed below). The author ensured the analysis showed sensitivity to the data through re-engaging with the dataset throughout the analysis and sharing reflections with the research team to allow for discussions of how the author's characteristics may have impacted their interpretations.

Commitment and rigour

To ensure commitment to the research the author continued to engage with the dataset throughout analysis, making sure to go back to the transcripts when writing the manuscript to

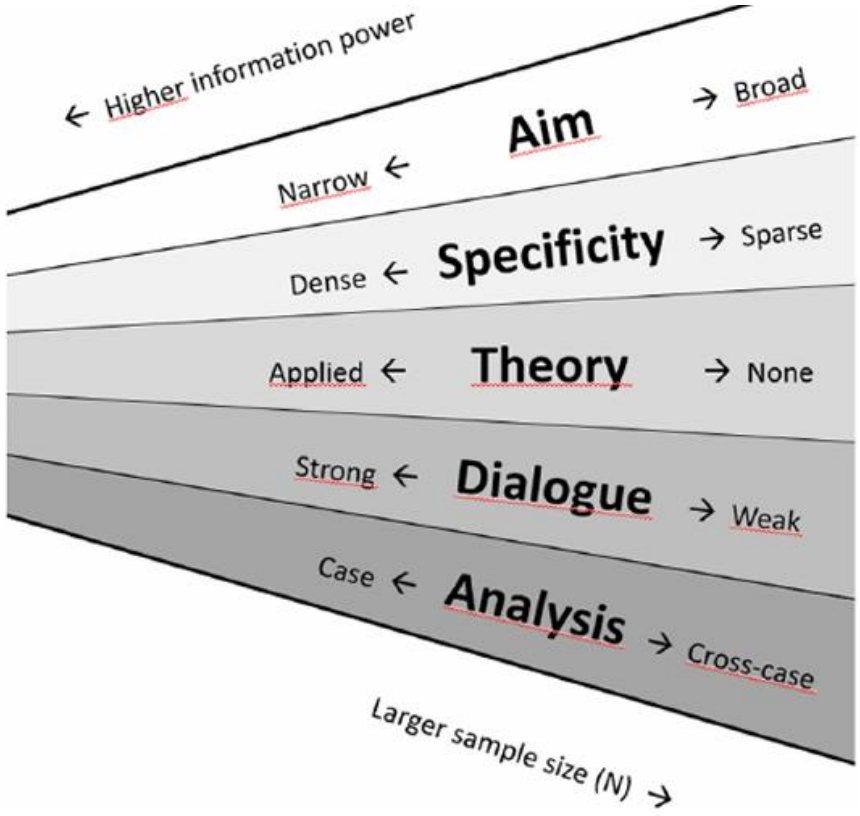
check understanding and inform how the research was presented. Furthermore, to ensure that the research recruited enough participants to be able to provide the recommendations as detailed in the aims of the manuscript, information power instead of saturation was used. Deciding when to stop recruiting using data saturation may not be useful within reflexive thematic analysis as it suggests that saturation is objective and that there is no other information that can be gained from further recruitment (Braun & Clarke, 2021b; LaDonna et al., 2021). Additionally, a relativist and subjectivist stance indicate that as each person's reality differs, each participant will be able to provide valuable insight into their own experience.

As discussed in the manuscript, information power was used to inform when recruitment would stop (Malterud et al., 2016). Information power acknowledges that the more information participants hold which are relevant to the research, the lower the number of participants is needed for the study. As detailed in Figure 1, information power considers five areas which can impact the sample size required, these are aim, specificity, theory, dialogue, and analysis. The current study had a broad aim, but the participants held characteristics that were highly specific to the research; there is not a large theoretical background to the research topic, but interviews provided large quantity and good quality levels of information, and the analysis was cross-case to support with developing recommendations. As acknowledged within the limitations, although the aim was to interview parents with a variety of LGBTQ+ identities, the study did not do this. Therefore, a decision was made to stop recruitment once the author had "heard enough" instead of "heard it all" in relation to the LGBTQ+ identities that were represented within the participants (LaDonna et al., 2021, p. 608; Morse, 2015). The author decided they had "heard enough" once there was significant repetition in the findings from each interview and it was felt that although more

interviews would likely lead to more information, that this would not significantly alter the overall findings.

Figure 1.

Information power: items and dimensions (Malterud et al., 2016, p. 1756)



Transparency and coherence

To ensure transparency and coherence, the data analysis method of Reflexive Thematic Analysis was carefully chosen to fit within the ontological and epistemological stance of the author, along with the ensuring it met the aims of the research, as detailed in the above discussions. Quotations were embedded and included throughout the results section to provide a clear and transparent analysis. Due to the word limit of the chosen submission journal, and the richness of the data, the findings were split into those specific to lesbian and queer+ parents and findings relevant to all parents. Although this has limited the transparency

within the empirical paper, an alternative journal with a larger word count, but not as closely related to the topic, might be less accessible to staff working within neonatal units. The thematic map has been included within the manuscript to present the themes that could not be discussed within the empirical research paper to help assist with the transparency.

A reflective journal was used to consider how the author's personal characteristics and lived experiences influenced the analysis and interpretation. There was limited space to discuss reflective journal content within the manuscript, however, this was acknowledged within the manuscript and further reflections are detailed below.

Impact and importance

The empirical paper has presented the impact and importance throughout the manuscript. The recommendations section allows for direct professional implications to be considered by healthcare professionals and healthcare providers. The findings have been discussed within the context of relevant literature which has allowed for the novel findings to be presented and linked to relevant literature. Throughout the research process, the author was contacted by healthcare professionals who were interested in the findings and how they can adapt their practice to meet the needs of LGBTQ+ participants and discussions of dissemination alongside publishing the empirical study are ongoing. The recommendations will support these professionals in evaluating their own practice and the practice of their service.

The Reflexive Thematic Analysis Process

Braun and Clarke's (2019) reflexive thematic analysis approach were followed, along with their six-stage guidance for thematic analysis (Braun & Clarke, 2006). The worked example of Braun and Clarke's approach was also reviewed as a helpful example of how the six stages may be presented and how one can move through the stages in a non-linear fashion

(Byrne, 2022). AH familiarised themselves with the data, they reviewed the transcripts that were automatically created by Microsoft Teams; this involved first re-listening to the recording and then checking the transcripts against the recording and making any wording changes required. The author then listened to the recording with the transcript visible a second time to ensure that all inflections, breaks, pauses, and tones had been recorded (Braun & Clarke, 2013). Any identifiable information was also removed during this process.

Once transcripts had been completed and reviewed sufficiently, these were uploaded to NVivo 14, and each was coded line by line by AH. The research aims were held in mind during this process, along with the researchers' relativist and subjectivist stance. In line with this stance the author used an inductive approach where the data was open-coded to represent the meaning identified (Braun & Clarke, 2013; Byrne, 2022). Although an inductive approach was taken, researchers make assumptions and interpretations that reflect their own experiences and personal characteristics as they actively engage with the research (Braun & Clarke, 2019). Interpretations and assumptions made by AH were recorded in their reflective diary and then discussed during supervision. Once all the transcripts had been coded, they were reviewed to consider whether any newer codes might apply, and to ensure there was consistency throughout the coding process; see Appendix M for an extract from a coded transcript.

When the codes were collated, these were discussed by the research team and often, the original transcript was reviewed to provide contextual information and allow for reflections of why AH used a specific code. For example, the code "safety of baby" was felt to encapsulate how safe parent's felt their baby was in the care of staff but also how safe they felt in caring for their baby. The codes were then merged and renamed individually by AH and discussed within supervision. Initial themes emerged from the codes and were discussed with the research team, and reflections of how AH made sense of the data was considered. As

themes emerged, AH drew out thematic maps to reflect on the relationships between the themes and visualise the 'story' the data created. Appendix N demonstrates an example of how themes were initially developed around "safety of baby" and "safety of the parents", and how through discussions in supervision, "loss" was identified as thematically unique from these. The theme "trust" was initially identified but through reviewing the transcripts and engaging with the dataset, this was absorbed into the final themes.

Supervision

Once the research supervisors for the thesis project had been confirmed, an initial meeting took place to agree upon supervision requirements. AH was provided with at least monthly supervision for the majority of the research, if this was not possible due to sickness or leave, AH was able to access support via email from the supervision team. Regular supervision, along with contact via email, ensured that all members of the research team were kept up to date with the current stage of the project. Supervision offered the opportunity to reflect on the stage of the research but also on the impact the research had personally, as well as providing space to discuss practical aspects of the research. The research supervisors offered advice and guidance within the areas of qualitative research and neonatal services. The supervisors' experiences of research, their own personal characteristics, and their work within neonatal services provided the opportunity to discuss different viewpoints of the data and during data analysis, to reformulate and reconsider codes and themes. Records of supervision meetings were completed by AH and saved in a shared document which all members of the research team had access to. A draft of each chapter of the thesis portfolio was read by both research supervisors and their feedback was used to refine the final drafts.

Reflective Journal

AH kept a reflective journal throughout the research process, from the point of writing the ethics application through to completion of analysis. An example extract from the reflective journal can be seen in Appendix O. The reflective journal assisted with the reflexivity of the research and allowed AH to consider how their own values, opinions, and assumptions impacted how they engaged with the research (Braun & Clarke, 2019, 2022). From a subjectivist stance, the subjectivity of a researcher cannot be neutralised or explained away, and the reflective journal allowed AH to use their subjective reflections as an asset with which to consider their own participation throughout the research process (Olmos-Vega et al., 2023)

Ethical Considerations

As detailed in the empirical paper, ethical approval was gained from University of East Anglia (UEA) Faculty of Medicine and Health Sciences Research Ethics Subcommittee on 12th January 2024 (ETH2324-0061, Appendix K). A further amendment to include contacting additional charities to support with recruitment, and adaptation of the poster to meet the size requirements of Instagram, was approved on 26th April 2024 (ETH2324-2289*, Appendix L) following limited recruitment from the single charity (Bliss). This was reflected upon within the researcher's reflective diary and will be discussed further within Chapter 7 of the thesis portfolio. Adapting the poster was recommended by Bliss following their approval to post and it was decided that this poster would be used when contacting the additional charities.

Informed Consent

Participants emailed AH to express interest and were given 72 hours to read the participant information sheet (PIS; Appendix F) before booking in an interview time and being sent the electronic consent form (Appendix G). Participants were given the opportunity

to ask questions about the research prior to providing consent to ensure that consent was fully informed. Participants were made aware via the PIS and electronic consent form, as well as being reminded at interview, and in the debrief sheet (Appendix I) that they could withdraw at any point up to two weeks after their interview.

Confidentiality

Participants were made aware via the PIS and reminded at the start of the interview that any information they share would be confidential, unless it was deemed that they or another person were at risk of harm. It was explained to participants that if the researcher felt that confidentiality would need to be broken, that they would be informed unless the researcher deemed this to increase the risk of harm. Fortunately, no issues where confidentiality would have needed to be broken arose.

As detailed in the empirical paper, all interviews were conducted virtually and recorded using Microsoft Teams. AH was the interviewer for all the interviews and these were conducted in a private space in their home. Some participants had their baby with them in the room and a discussion was had prior to the start of recording the interview about times that participants may need to pause to take care of their baby. Participants were reassured that the researcher was happy to pause the interview if they needed to care for their baby and that this was not an inconvenience to the researcher.

The interviews were transcribed by the Microsoft Teams' automatic transcription software. Any identifiable information from the transcripts were removed by AH once these were downloaded. Participants were informed via the debrief sheet and at the end of the interview that they could request their transcript be sent to them to review, however, no participants asked for this. It was understood that as the participants all had caring responsibilities, and that they could not be reimbursed for reviewing the transcript, that

participants may not wish to do this. Relevant identifiable information was gathered via the demographic form (Appendix H).

One participant identified as non-binary at the time of their participation but had identified as a woman during their pregnancy. It was agreed that they would report their gender identity as the one they currently identify with, and following discussions within supervision, they were contacted to check whether they consented to this being discussed within the findings. During their interview they had explained how a gendered maternity and neonatal experience had impacted how they viewed their own gender, and they did consent to this being discussed in the final empirical paper. Additional consent was deemed necessary due to the participants already sitting within a minority group and discussing this specific participant's gender experiences was felt to make the group even smaller. Further discussion with this participant also included checking how they would like to be referred to, such as 'spouse' instead of 'wife', and the pronouns they wished the researcher to use for them. It was important to include participants in the discussion of how they wish to be described and the language they want the researcher to use due to the value that language holds for members of the LGBTQ+ community (Lewis & Reynolds, 2021).

Data Storage

All data for the research were stored on a password protected UEA OneDrive. Consent forms were stored in a separate folder to minimise the risk of matching identifiable information to the study data.

All the interviews were audio and video recorded using Microsoft Teams and these, along with the automatic transcripts that Microsoft Teams develops, were saved immediately in the OneDrive folder. When Microsoft Teams creates the recordings and transcriptions these appear in the chat function of the meeting, once the recordings and transcripts were

downloaded, the chat was deleted. Once the transcript was finalised, the recording was deleted from OneDrive.

In accordance with UEA's Information Classification and Data Management Policy (2018), all information was shared between the authors via OneDrive, access was restricted to only those with authorisation by the data owner (AH). Regarding the collection, storage, processing, and disclosure of personal information, all authors complied with the regulations outlined by the General Data Protection Regulation (*Data Protection Act*, 2018). In line with UEA's Research Data Management Policy (2022), data from this research will be stored in the UEA data repository securely and destroyed 10 years after the study has ended.

Potential Burden to Participants

The PIS outlined the scope and expectations of the research to ensure participants were aware of both the possible benefits and disadvantages of taking part in the study. A potential disadvantage of taking part was that participants might experience distress when talking about their experiences; to ensure participants were supported with this they were provided with signposting for relevant support via the debrief sheet. Additionally, participants were reminded that if they did not wish to talk about a specific topic they did not have to, and that information shared was confidential.

Time taken for the interview was also identified as a potential burden, especially given the caring responsibilities that participants held. Therefore, as a token of appreciation and as a thank you for their time, each participant was offered a £10 e-gift card, which was emailed to them after the interview along with the debrief sheet. Consideration of the financial limitations of the budget available to the research team meant that payment was not able to reach the standards set by the NIHR (2022), but it was felt that in line with recent

research about the importance of paying research participants, that some payment should still be made (Grady, 2019; Head, 2009).

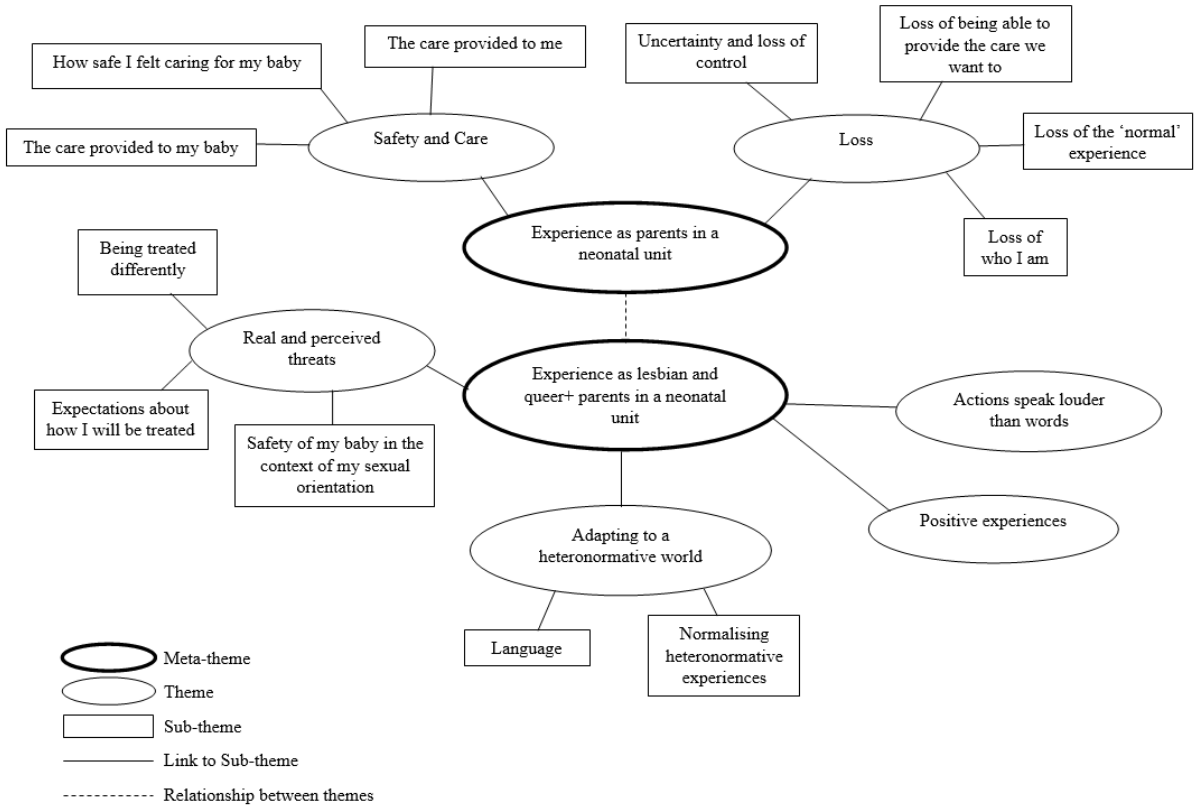
Chapter 6: Additional Results

Additional Results

As detailed in Figure 1, the findings have been separated into two meta-themes, "experiences as parents in a neonatal unit" and "experience as lesbian and queer+ parents in a neonatal unit". The meta-theme encompassing the experiences as lesbian and queer+ parents in a neonatal unit, has been presented in the empirical research paper (Chapter 4). This decision was made due to the limited word count of the journal and that findings relating to lesbian and queer+ parents are novel within the research area. The following additional results section discusses only those themes identified within the "experience as parents in a neonatal unit" meta-theme. Two themes within this meta-theme were identified: "Safety and Care", and "Loss".

Figure 1

Thematic map



Safety and Care

As parents discussed their experiences within the neonatal units, it became clear that the safety of their baby was incredibly important to them and that how safe they felt in the care provided to them, self-care, and in the care provided to them as parents, impacted how safe they felt in caring for their baby.

The care provided to my baby

How parents perceived the care that was provided to their baby, was crucial to how safe parents felt their baby was in the neonatal unit. Parents deemed care that was similar to how they would have cared for baby outside of the unit, as an important factor in this perception. Staff that went "the extra mile" (P8) to what parents expected care to be like, was a strong indicator for how safe parents felt baby was. How parents decided what "the extra mile" (P8) looked like was often informed by their experiences of other healthcare services.

> They would care for them…more like than a patient relationship, so you know they would sing to them, they would talk about how cute they were …they hadn't become like kind of dead (P9)

Interactions with staff impacted how parents felt about the care that was provided to their baby. Staff that connected and built relationships with parents were deemed as more trustworthy than staff that did not develop a connection.

> Think it impacted how we felt about how much they care, like of course I don't doubt that they don't care, you know the nurses are amazing, what they do like I, I couldn't do it, but at HOSPITAL_A you kind of felt like you had that emotional connection to them and they knew about you so you're leaving your baby with them and they know who you are, whereas HOSPITAL_B's I wouldn't even necessarily be confident if they knew our names (P10)

Parent's perceived staff that came across as "human" (P9) as more trustworthy and therefore, that their baby was safer. Parents wanted to be able to see how important their baby was to staff and when parents could see the connection that staff had with the babies, it served to build their sense of safety.

> There was actually two deaths of babies when we were on the on the ward as well, and if you could see the effect that it had on the staff and it was just like heart breaking, but also just like it was so endearing to see them affected by, by something like that rather than just thinking oh, this is just another part of the day (P9)

Parents faced further challenges during the COVID-19 pandemic when masks impacted the connections parents could make with staff and therefore, how much they trusted them.

> But also, you can't see if they are actually being more hostile, so it kind of works in both, both directions…you can't tell their intention um, so it did make that harder (P1)

How much information was shared by staff impacted how much parents felt they could trust staff to care for their baby. The sharing of information by staff also helped parents to feel involved in their baby's care.

> Feel like as much information as they were able to share about the baby, they were sharing…mean the nurses were all, I thought, really great um, in terms of just communicating you know what they're doing, what's happening, also you know just helping with some basic stuff (P12)

How safe I felt caring for my baby

How safe parents felt on the neonatal units impacted how much they trusted themselves to care for their baby. Many parents were required to complete a checklist whilst on the neonatal unit. The checklist was perceived as either a lack of trust from staff in your

ability to care for baby, or as an opportunity to provide care and to feel empowered to care for your baby alongside staff. For some parents who had older children and who felt they already had experience caring for a baby, the checklist was seen as an additional burden placed on parents. Many of the first-time parents viewed the checklist as the opportunity to be supported with learning things that they would otherwise have had to learn on their own, such as having the opportunity to ask questions to staff whilst learning how to put a nappy on their baby.

> We had to follow this like booklet to prove we could do all this stuff, like to prove we could do tube feeding…it was like nobody else has to do this stuff [why] have I got to do it (P6)

> I learned to look after my baby surrounded by nurses…I learnt it with the safety of the nurses being there, you know, so whatever I was doing they were there to help me and to show me how to do it and if I was unsure, I could ask again (P7)

The care provided to me

Both birthing and non-birthing parents reflected on the psychological impact that having a baby admitted to a neonatal unit had on them and described feeling alone during their baby's neonatal stay. Parents recognised that they wanted staff to focus on caring for their baby and that the focus of the service was primarily their baby's care, but that they themselves needed care as well.

> They're there to care for the babies, they're not there to care for the parents, but there was nobody to care for us (P1)

Non-birthing parents described often choosing to prioritise the care of their partner and baby over the care that was provided to them. They described feeling "torn" (P9) between caring for baby and caring for their partner. Non-birthing parents felt they needed to communicate to

their partner the details of care provided to baby, almost to reassure their partner that baby was safe. This process of trying to be "strong for everybody" (P9) and striving to do everything that they felt was required of them often came at the detriment of their own mental health.

> I just was felt very torn in like three directions and felt as if I had to be like advocating for the boys with the staff and yeah I think it was just like the holding it in, um, and being strong for everybody…we don't know in hindsight whether it was the best for my mental health, but at the time I felt like I felt like I was on it (P9)

Parents felt that even if support had been offered to them, it would have been difficult to access it because they wanting to spend as much time as possible with their baby. Parents perceived support not being offered as due to external factors, somewhat protecting staff from their criticisms about a lack of support.

> So we never got the thing like there was there was all these posters about like there's a there's a family liaison support work, or something like that, and they'll talk to you about your care plan and how you how you're going to leave and…we never had any of that because I think people kept thinking oh they're going to be gone before you know it (P4)

For some parents, the support they received from family and friends was a protective factor in helping them to feel cared for. It seemed that although parents wanted to feel cared for by the neonatal service, being cared about by others helped them to celebrate the positive moments in what was described as an experience of extreme "stress" (P1). Many parents felt pressure to share how their baby was doing with family and friends and had to balance wanting to spend time with their baby, with updating others about their baby's health. When the pressure to update others was taken off them, as in the example below where family set up a

communal group chat and the parents didn't need to update everyone individually, parents felt able to share the 'smaller' details and celebrate the 'smaller' milestones.

> There was like a big sort of communal online celebration at moments where things were moving forward and stuff which felt really good (P5)

Parents focussed so much on the safety of their baby, that they often needed explicit permission from staff to care for themselves. Parents feared judgement from staff about how often they visited their baby; so, when explicit permission was given to care for themselves it was perceived as recognition and validation from staff about their ability as parents.

> She was the one that would turn around and be like guys just go home and get some sleep…it was recognised very, very early on that we were there for, for a very, very long time and um yeah for them to witness that we having a particularly teary or, or, or sad time and them to be like go home and have some rest that was that was nice (P3)

Parents were not always aware of the expectations that staff had of how long they needed to stay on the unit and what they needed to do. Explicit permission from staff also provided parents with an understanding of the expectations staff had of them.

> Where they were like right you need to know go and have you, have to go and have your lunch now and it's ok you can leave him with us, but that took a while for us to it wasn't explicit at the beginning (P5)

Parents also feared judgement from staff about how well they cared for their baby and when judgements of others were made or witnessed, this served as evidence that staff might be judging them.

> There was definitely conversations that happened between nurses that about parents which were, you would think that's not appropriate (P11)

Loss

Parents described a sense of loss of the many aspects of parenting they expected to experience. The loss they experienced impacted their wellbeing and continued to impact them even after their baby had been discharged from the neonatal unit.

Uncertainty and loss of control

Parents experienced lots of uncertainty during their baby's admission to a neonatal unit. This uncertainty and loss of control often led to fears and doubts that information was being hidden from them about their baby's health.

> They're like oh, you know, that he's gonna be ready to go by the end of tomorrow I think and when that doesn't happen it actually makes you more worried because you're like, oh, like he's not perform, like he's not developing in the way that they were expecting, is there something even more sinister and wrong with him (P4)

The fear that information was being withheld led some parents to attempt to regain control through requesting lots of information or "sneaking" (P11) a look at medical information that wasn't always provided to them.

> I think it was like we were looking at the blood sugars all the time, like how, what was that blood sugar, what was that blood sugar, and we were sneaking and looking at them (P11)

The loss of control was viewed as overwhelming for many of the parents. Some of the parents struggled to recollect aspects of their experience and perceived this to be due to how overwhelming the situation was. There was also a sense that because much of the decision

making had been taken out of their hands, that they did not always remember as they didn't make the decision themselves.

> I can't remember asking anything, which is very unlike me, which makes me think was I just in shock and I wasn't actually saying much (P9)

The lack of control around discharge from the unit was perceived by some parents as evidence that they were not fit parents and that they could not provide the care that baby needed at home. The neonatal unit was perceived as somewhere that parents did not choose to go to and at times, did not have the power to leave. The neonatal unit was somewhere they needed to be but not somewhere they wanted to be.

> It's a bit like an indeterminate prison sentence, like you don't really know when your child can go home (P6)

The loss of control in caring for their baby, was often combined with uncertainties about the care provided to them as parents. Uncertainties about accommodation were often ongoing throughout their baby's admission and were viewed as another stressor on top of all the concerns parents already had about their baby.

> There's definitely like politics around that in the hospital, but really early on someone in neonatal was like try and stay in the postnatal ward as much as you can because otherwise you'll be like travelling in and we were like oh my god, we didn't even realise that we she would get discharged while the baby was still in the hospital and she was trying to breastfeed (P5)

Parents were not always provided with information about accommodation. This meant they had to figure out how to continue to have access to accommodation in the hospital, by emphasising birthing parent's postnatal needs, or how they would travel to and from the hospital if they were discharged before their baby.

Loss of being able to provide the care we want to

Parents felt unable to provide the care that they had always assumed they would be able to give their baby. At times, birthing parents prioritised being able to go see their baby over their own health needs, parents viewed this as a "maternal instinct" (P12) which they were not always able to follow.

> I literally couldn't stand up, so at that point it became the mission to stand up and to get what everything out so I, I was just kind of pestering the doctors to keep check keep checking me I want…all this out as soon as possible so I can go (P11)

Parents experienced feelings of guilt when they were not able to provide the care they wanted to give their baby. Parents had built an idea of how they would care for their baby and the things they would do to ensure their baby felt safe, such as always responding when their baby cried. When they could not provide the level of care they had always planned to, parents criticised themselves.

> That was very difficult to know that, you know, there was times overnight that we weren't there, and she was crying for us, you know, you wouldn't that's, that was really really difficult (P11)

Parents needed to balance the care that their baby needed with the care they wanted to provide to their baby. When distressing procedures were necessary for their baby's health, parents criticised themselves for not being able to protect their baby. Witnessing distressing procedures led to fears about how the "trauma" (P11) would impact their baby during their life within and outside of the neonatal unit.

> I sat in that room, and I watched two junior people tried to put a cannula in her arm for way over an hour and she screamed, and she screamed, and I didn't want to get in the way, and I just stayed back (P11)

Loss of the 'normal' experience

Parents described how they imagined being a parent would be and the experiences they would like to have shared with their baby, and the difference in the reality of what parenting looked like whilst their baby was admitted to the neonatal unit. Witnessing other parents experience the 'normal' events was distressing for parents and continued even after they were discharged from the neonatal unit.

> What I struggled with a bit more at HOSPITAL_A was you could see people leaving the hospital with their babies, not directly from NICU [neonatal intensive care unit]…but from the room that I was in when I was staying in there you were directly like looking at the path of people carrying their new babies out in their car seats the mum's still waddling (P10)

Parents appreciated when staff recognised the loss they were experiencing. Parent's had little control over how much of the 'normal' experience they could have, so when staff helped protect them from witnessing others 'normal' experience, it served to validate the parents' emotions about this loss.

> They thought it would be fairer to give me my own room…which I thought was really good because it would have been difficult for me being around mom, new moms with their babies (P7)

Losing the 'normal' experience was perceived as a barrier to parents' ability to bond with their baby. Non-birthing parents who were able to have the bonding experience earlier than their partners felt guilty, not only about being able to be with baby but that they were experiencing those first moments with their baby and their partner was not.

> I was spending all this time bonding with my son doing the skin-to-skin, P8_PARTNER hadn't got that opportunity and it felt really foreign to me because she

> had in my head like, she had carried him and she had, she had done all that and it was kind of like I just saw her, I felt bad, I felt guilty (P8)

When staff supported parents to bond with their baby and allowed for some of those shared moments to occur, it helped foster safety in parents trust of staff but also soften the guilt that parents experienced.

> The other thing we got offered which was lovely…at the start is they gave us a…cloth triangle for BABY and for me um, so like she slept with hers and I slept with mine and then we swapped them over each night, that was so lovely (P7)

Parent described an ongoing fear that not being able to bond in the 'normal' way would impact their future relationship with their child. Parents acknowledged that some education from the neonatal service about bonding and normalising those fears would have helped reduce this.

> I was a bit worried about whether she would have a negative relationship with me or she wouldn't bond properly, and I think that some psychoeducation for parents just like normalising that, would be really useful (P6)

Loss of who I am

Parents felt de-prioritised by services and that their needs were lesser than their baby's. Parents recognised that they prioritised their baby's needs above their own but when this was done by services this triggered a fear that they would not receive the care they needed.

> Who I was as a person didn't exist you just become mummy, you're just mummy how's baby, mummy how's baby um, and even like when I was experiencing

> symptoms um, it the first thing would be well let's check baby and I'm like but hang on I don't feel well (P1)

Many of the birthing parents described the care after they gave birth as worse than whilst they were pregnant. They perceived this as meaning their bodies were more important when they were pregnant than after and when care was not provided, that they meant less as a person once they had given birth.

> As soon as the baby was out, out of me, I felt like it was like a handmaid's tale, it felt like I was just a vessel and the baby was out of me, now the baby's in special care you've done your job, and I literally felt like a piece of trash (P4)

Chapter 7: Overall Discussion and Critical Evaluation

Overall Discussion and Critical Evaluation

This thesis portfolio has explored how lesbian, bisexual and queer+ parents experience maternity and neonatal services; the final chapter summarises the main findings of the empirical paper and the systematic review and provides an evaluation of the findings. Clinical implications and future research are also considered.

Summary of the Main Findings

Systematic Review

The systematic review aimed to synthesise current research about the experience of maternity care for lesbian and bisexual mothers and to provide recommendations for healthcare professionals and providers of maternity care. Ten studies using a variety of qualitative methodologies were included in the review. The review identified four topic areas of importance from the studies identified: “heteronormativity”, “acceptance and inclusion”, “finding your own path”, and “knowledge and power of professionals”.

The first topic area, “heteronormativity”, highlighted the mothers’ experiences of heteronormative views and assumptions, as well as their expectations and reality of being treated and viewed differently. The culture of care was often viewed as heteronormative by the mothers which has been reflected in both the Care Quality Commission report (2024) and Combellick et al.’s (2023) research. Mothers did not always feel recognised as a couple, and non-birthing mothers did not always feel recognised as a mother. Mothers felt the need to protect themselves and their partner, as well as downplaying negative experiences during their maternity journey.

The second topic area, “acceptance and inclusion”, recognised when mothers felt they were treated equally and the importance of being shown explicit acceptance. “Finding your own path”, the third topic area, acknowledged the parents that had paved the way for the

mothers, whilst also including the feeling that mothers had of being the first parents to walk this path. Non-birthing mothers also described how they were finding their own way to be a mother.

The final topic area, “knowledge and power of professionals”, described the mothers experience of having to explain to healthcare professionals their relationship as well as the balance between wanting to be open about their sexual orientation and whether this was a choice to voice or being forced to be ‘out’. This topic area also acknowledged the power that healthcare professionals hold during their interactions with the mothers.

Many of the findings mirrored those that were found in Dahl et al.’s (2013) review and furthered the original findings that homophobia and heteronormativity led to mothers feeling devalued not only as a family unit but also as a mother. The power that healthcare professionals hold, alongside their curiosity about the mothers as identified by Dahl et al. (2013), was identified as a barrier to care and inclusion. In contrast with Dahl et al.’s (2013) findings that disclosure of sexual orientation being viewed as risky, many of the mothers in the current review saw disclosure as a pathway to gaining more acceptance and in furthering acceptance for future generations.

Recommendations for healthcare professionals and healthcare providers included an increased awareness of how heteronormative views and assumptions can be presented within maternity services and for further training to be provided for healthcare professionals on how they can challenge and reduce heteronormative views and assumptions within themselves and the wider healthcare system. Additionally, for considerations of language use in the literature provided by maternity services and interactions with parents, such as asking mothers what they would like to be called, and to offer explicit acceptance to the mothers individually and as a family unit.

Empirical Research

The empirical research provided novel findings in an area not previously explored. Twelve parents who identify as lesbian and queer+ and whose baby(s) had been admitted to a neonatal unit were interviewed to gain further understanding of their experiences and how they perceived their sexuality and/or gender impacted this. Reflexive thematic analysis (Braun & Clarke, 2019) was used to analyse the interview, and resulted in two meta-themes, one with two themes and the other with four themes. The findings were separated so that the novel meta-theme closely linked to the parents' experiences as lesbian and queer+ parents were discussed in the empirical paper, and the second meta-theme which encapsulated broader neonatal experiences discussed in the additional results chapter.

The meta-theme of "experience as lesbian and queer+ parents in a neonatal unit" included four themes. The first theme, "real and perceived threats", was made up of three subthemes: "being treated differently", "expectations about how I will be treated", and "safety of my baby in the context of my sexual orientation". Parents were acutely aware of both real threats to their baby's safety, and their perception of threats that could occur. These included fears that their baby would be cared for differently due to their own sexual orientation. Many of the parents provided the context of their lived experience of being lesbian and queer+ and their experiences of overt and covert homophobia, similarly to that identified in McManus et al. (2006), increased the fear they had of being treated differently. Similar to findings by Dahl et al. (2013) and McManus et al. (2006), when parents experienced a lack of inclusivity, this increased their fears about the safety of their baby.

The second theme, "adapting to a heteronormative world", was made up of two subthemes: "language", and "normalising heteronormative experiences". The parents experienced language as not being inclusive of their family unit and the language often

served to further heteronormative assumptions about what family units look like. Parents described wanting to be asked what they would like to be called and that the experience of heteronormative language served as a further frustration in addition to the worries they already had about their baby. Many of the parents would normalise heteronormative encounters by explaining that they experience heteronormative assumptions in all aspects of their lives, seemingly protecting and forgiving neonatal staff. Parents at times blamed themselves for the way they perceived situations and when they experienced positive interactions would rationalise this through a heteronormative lens. As identified in the review by Yinger et al. (2024) and similar to Klittmark et al.'s (2023) findings, a lack of inclusive language served to invalidate the parents' identities.

The third and fourth themes, "positive experiences" and "actions speak louder than words", recognised the positive experiences that parents had and how the parents experienced the ways that staff could uphold heterocentricity, or challenge it. Parents were often very clear that their positive experience was specific to the neonatal unit and when acknowledging this would often point out the challenges that healthcare services within the UK are currently experiencing. The parents expressed frustration at a lack of acknowledgement for the heteronormative language that is present within neonatal services and this lack of action served to feel blaming and shaming for some of the parents; findings shared by Klittmark et al. (2023). Positive actions were seen to soften the impact of the heteronormative assumptions and parents appreciated proactive practical actions by staff.

The second meta-theme, "experience as parents in a neonatal unit", included two themes: "safety and care", and "loss". The "safety and care" theme encompassed three sub-themes called "safety of the care provided to my baby", "how safe I felt caring for my baby", and the "care provided to parents". Parents perceptions of the care provided to their baby was crucial in how safe parents felt their baby was. Similar to findings by Bry and Wigert (2019)

when the trust parents had in healthcare providers were impaired, they became more worried about their baby's safety. Parent's experiences in other healthcare services and their interactions with staff informed how they perceived the care from neonatal staff. Parents were not always aware of staff's expectations, and this impacted their confidence as parents as well as needing to complete a checklist which could be perceived as either a lack of trust from staff or an opportunity to feel empowered to care for their baby. Similar to findings of the negative psychological impact that having a baby admitted to a neonatal unit (Bry & Wigert, 2019; Busse et al., 2013; Grunberg et al., 2019; Malouf et al., 2022), parents described feeling alone during their baby's neonatal stay and that although they recognised, and wanted, the focus to be on their baby's care, that they needed care too.

The "loss" theme included four subthemes: "uncertainty and loss of control", "loss of being able to provide the care we want to", "loss of the 'normal' experience", and "loss of who I am". The parents experienced a lot of uncertainty during their baby's admission to a neonatal unit which is similar to findings by Obeidat et al. (2009) where parents experience a loss of control. This uncertainty and loss of control often led to fears that information was being hidden from them and parents would try to regain control through requesting lots of information or "sneaking" (P11) a look at medical information that wasn't always provided to them. This lack of control was perceived by some parents as evidence that they were not fit parents and was often combined with uncertainties about the care provided to them as parents, such as those around accommodation. Parents felt unable to provide the care they wanted to, and this led to feelings of guilt. Furthering findings by Obeidat et al., (2009) witnessing their baby's treatments was distressing for parents and led to self-criticism that they were not able to protect their baby. Parents described the difficulties of witnessing other non-neonatal unit parents experience 'normal' neonatal events and appreciated when this loss was recognised by staff. There was a fear that the lack of a 'normal' experience would impact

the bond parents had with their baby and highlighted the importance of staff in supporting bonding with baby. Some parents felt de-prioritised by services and described the care they received after birth as worse than whilst they were pregnant, which was perceived as indicating they were of less importance once their body was no longer the sole provider for their baby.

Recommendations for healthcare professionals and healthcare providers included the use of language to be inclusive and considerations for how a lack of inclusivity might impact parents' interactions on neonatal units. Further recommendations for proactive actions (if possible), to be undertaken to help the inclusivity of the service and support parents to feel accepted.

Discussion of the Findings

The findings from both the systematic review and the empirical research indicate a need for healthcare professionals and providers to be more aware of heteronormative assumptions and views that exist within healthcare. This may be particularly prominent in services where there is more likely to be a heterocentric focus on the family unit, such as in maternity and neonatal services.

As detailed in the systematic review, mother's expected negative experiences with healthcare professionals, and sometimes these expectations were to protect themselves from being hurt by discrimination (Cherguit et al., 2013; Dahl & Malterud, 2015; Engström et al., 2023; Malmquist & Nelson, 2014). These negative expectations, especially if confounded by negative experiences with maternity healthcare professionals, may continue into a parent's expectations of their interactions with neonatal healthcare professionals. Cherguit et al. (2013) found that positive interactions with healthcare professionals, such as feeling they were being treated equally, were seen as having an eroding effect on these negative

expectations, therefore, the recommendations for maternity healthcare professionals may support those parents that interact with neonatal healthcare professionals. Additionally, it offers the opportunities for neonatal healthcare professionals to engage positively with LGBTQ+ parents and this in turn may help to foster future positive expectations of interactions with healthcare staff.

During the introduction, the limited impact of the legalisation of same-sex marriage on pre-existing attitudes were discussed (Redman, 2018). As identified in the empirical paper, even with same-sex marriage legality and further legal protections in place, parents were still fearful of how staff might interact with them and judgements that they might experience due to their sexual orientation, which was further compounded by fears of how the impact of these judgements could impact their baby's care. Non-birthing parents feared that their legitimacy as a parent may be questioned because of their alternative route to parenthood, such as using a sperm donor, and this may be more visible due to their same-gender partnership. This was also evident in the systematic review, where parents expected to be treated negatively. It may be that the fear has shifted from a fear of being legally recognised as parents, to a fear of being treated differently regardless of their legal status. In both the systematic review and empirical paper, parents' positive experiences with staff and explicit acceptance served to begin to erode the impact of negative experiences. Therefore, it is crucial that healthcare providers consider how they can foster accepting environments for parents.

Both the findings from the systematic review and the empirical paper acknowledged how the use of heteronormative language impacted parents' experiences. In the systematic review, the use of non-inclusive language served to devalue the family unit and devalue co-mothers' identities, and the use of heteronormative terms and inappropriate questions led mothers to feel they needed to defend themselves and their roles. Similarly, within the

empirical paper, the use of heteronormative language led parents to feel invalidated. Interestingly, some parents would use the term ‘other mother’ to describe themselves; these parents viewed this as a challenge to the heteronormative assumptions that were made but there was also a devaluing nature to this phrase as it did not recognise them as an equal parent. Therefore, alongside the external invalidation that parents experience, their way of challenging these heteronormative assumptions may also be internally invalidating their identities. This finding is crucial in considering the impact of language use in how parents experience maternity and neonatal healthcare services, indicating that use of language can lead parents to invalidate their own identity through their attempt at challenging heterocentricity.

Critical Evaluation

Both the systematic review and empirical research employed qualitative methodology to meet the explorative aims identified. The aims of understanding and exploring experiences may not have been met through quantitative methodology, where there is a greater focus on factual data with definitive outcomes (Hammarberg et al., 2016). The idea of experiences and findings as being purely factual does not fit with the author’s epistemological or ontological stance, that each person’s reality is different based on their lived experience. However, there is the chance that social desirability bias existed within the research. Social desirability bias is where a participant may present themselves or their social context in a way that they feel is socially acceptable (Bergen & Labonté, 2020; Bispo, 2022). Although the author aimed to provide a safe space where participants were able to discuss their experiences, there is the possibility that participants felt they needed to present in a specific way to meet the perceived requirements of the research. As identified earlier in the portfolio, people who identify within the LGBTQ+ community are more likely to have had negative experiences in society and healthcare due to other people’s pre-existing attitudes (Clark et al., 2023; Pickern, 2024;

Russell & Fish, 2019). Therefore, there is the likelihood that LGBTQ+ participants may be more conscious of how they present themselves to try to prevent negative experiences, especially given that semi-structured interviews remove the anonymity between the participant and researcher (Bispo, 2022; Grimm, 2010). Given the increased likelihood of participants having experienced negative responses to their identities, the author initially identified themselves as part of the LGBTQ+ community and offered their pronouns, this aimed to foster an environment where participants felt it less likely that there would be a negative response. Additionally, the use of prompts and providing assurances throughout the interviews aimed to minimise social desirability biases (Bergen & Labonté, 2020). At times parents assumed the researcher would share the knowledge that they had of being a lesbian or queer+ parent and this was carefully managed through probing questions to check understandings and reflected upon in the reflexive diary.

An additional consideration is the impact that the authors' epistemological and ontological stance may have on the interpretation of the findings, and the chance that alternative findings may have been developed with a different stance. An objectivist epistemological stance would have impacted the interpretation of the findings due to the belief that an objective reality exists and may have provided findings that aim to present the findings as true for all members of the LGBTQ+ community (Moon & Blackman, 2014). Savolainen et al. (2023) argue that since human bias, including one's own epistemological and ontological stance, is real and measurable, that research should be insulated against it. However, researchers exist within their own reality and their own lived experiences impact how they view others' experiences, therefore, recognising and discussing one's own epistemological and ontological stance is crucial in setting the context of how findings were interpreted. All three authors are white, British, and able-bodied, and have experience as clinicians within maternity and neonatal settings, two of the authors identify as cisgender and

heterosexual and are parents, and therefore, their realities and interpretations of the findings will have been impacted by these characteristics.

Strengths and Limitations of Systematic Review

A strength of the systematic review is the inclusion of bisexual mothers as well as lesbian mothers. The experience of bisexual parents has often been ignored within research and parenting literature (Bartelt et al., 2017; Manley & Ross, 2020; Todd et al., 2016) and therefore, it is important that they are represented within this research. Although, the inclusion allowed for the voice of bisexual mothers to be heard, a limitation is that the systematic review only included mothers that were in same-gender relationships, thus excluding bisexual parents in different-gender relationships. Given the findings that bisexual parents who are single or are in different-gender relationships experience stigma from both heterosexual and LGBTQ+ communities (Goldberg, 2023; Manley & Ross, 2020), further research is needed into their specific experience of maternity services. Only studies of mothers in same-gender relationships were included in the systematic review as it focussed on the experience of visibly same-gender mothers and the experience of bisexual mothers in different-gender relationships are likely to be qualitatively distinct than that of the mothers included within the systematic review. However, future research exploring the experience of bisexual parents in different-gender relationships, would allow for consideration of their experiences to be included in recommendations provided to healthcare providers.

Furthermore, the synthesis lacks studies from non-Western societies and full ethnicity data was not presented in the majority of the studies, therefore, the intersectionality of both ethnicity and sexual orientation may be an additional factor in the experience that is not able to be represented within the current review. Additionally, although all the articles were published after significant legal and policy changes that legitimised same-sex marriage and

protected parents in same-sex relationships, the ages of the children reported in the articles suggest that some mother's maternity journeys were prior to these changes, and therefore, we may not be seeing the full extent of experiences following the legal changes.

A limitation of the systematic review is that the searches did not include MeSH terms and therefore, important evidence may have been overlooked. However, the search terms were developed using those identified by Dahl et al. (2013) and through reviewing the key terms identified in relevant publications. Additionally, reference lists of papers included for full-text review were hand searched to ensure a thorough search was completed. The systematic review did not use a specific tool to develop the searches, such as the SPIDER (sample, phenomenon of interest, design, evaluation, research type) tool (Cooke et al., 2012) due to the already established search terms and criteria used by Dahl et al. (2013) being deemed appropriate for adaptation. Although the SPIDER tool was not explicitly used to develop the searches, it was used to review whether there were additional areas within the search terms that needed to be added. To include a search term of "qualitative design" alongside the research type being "qualitative" may have limited the articles identified by the searches, especially given the small pool of literature available.

The systematic review only included articles that were available in English and had been published in peer reviewed journals. There is a likelihood that additional literature in other languages or published elsewhere may have provided further or alternative useful findings in informing recommendations for healthcare providers and for future research. Furthermore, the authors themselves are British and have experience working in the United Kingdom and National Health Service (including maternity/neonatal services), and therefore also influence the recommendations that were developed. Researchers from different backgrounds may have developed other recommendations that meet the cultural norms and healthcare policies and guidance within their area. The authors have been explicit about their

professional backgrounds within the systematic review to inform readers of the context with which the authors have presented the findings and developed recommendations.

A strength of the systematic review is the use of a quality bias assessment that allowed for consideration of the qualitative methods employed by the study (Stenfors et al., 2020). There is the potential that had a different quality bias tool been used, that different conclusions surrounding the quality of the research may have been made. The authors chose to use a qualitative approach to bias assessment instead of using a quality checklist due to the increased risk of scores not necessarily reflecting the context of the research methodology and quality (Majid & Vanstone, 2018; Stenfors et al., 2020).

The systematic review, although aiming to update and add to the synthesis of findings for lesbian mothers' experiences of maternity services, did not employ a meta-ethnography approach as was done in the original review (Dahl et al., 2013). This was due to the focus not being solely on updating but also adding to the synthesis of findings, such as including all same-gender female relationships, and aiming to provide recommendations to healthcare providers. The systematic review did not directly compare the findings of the original meta-ethnography due to the limitations of comparing two reviews that employed different methodology (France et al., 2016) and instead considered how the current review added to the findings.

Finally, the systematic review included studies with different methods of data collection (interviews, story method approaches, asynchronous methods) and differing aims of understanding the maternity experience of mothers in same-gender relationships. This is not an issue for qualitative syntheses, but did mean there was a variety in the depth of information available about the mothers' experiences of maternity services. Although, all the articles met the inclusion criteria of having meaningful interpretations of the mothers'

experiences; at times only part of the findings were included in the synthesis due to the aims of the original paper being broader than just the maternity experience. Therefore, although the review was able to synthesise findings from a variety of papers, not all findings presented in the papers were included in the synthesis.

Strengths and Limitations of Empirical Research

A strength of the empirical research is the use of reflexivity to guide the interpretation of the findings and consider how the researcher's own epistemological and ontological stance impacted how they interpreted the findings (Braun & Clarke, 2019). Additionally, the research recruited parents from a variety of different areas in England. However, no participants lived in Northern Ireland, Scotland, and Wales and therefore, the findings may have differed with parents settled throughout the United Kingdom. Additionally, all the parents identified as white and therefore, there is limited consideration of how the intersectionality of gender, sexual orientation, and ethnicity may impact the experiences of parents. Given the racial inequalities that exist within the National Health Service (Robertson et al., 2021), LGBTQ+ parents that identify as part of an ethnic minority are likely to view their experiences and their baby's safety through not only the lens of being LGBTQ+ but also having experienced racism and discrimination due to their ethnicity.

A further limitation of the empirical research is that although the researchers aimed to recruit participants from a variety of LGBTQ+ identities, only parents that identified as majority female and as lesbian or queer+ were recruited. Although, this meant the findings were not as representative of the LGBTQ+ community as initially planned, it did allow for the identities included to be represented by multiple parents and therefore, for a decision to be made that the researcher had "heard enough" (LaDonna et al., 2021, p. 608; Morse, 2015). As discussed in the empirical paper, the recommendations are limited to the experience of

lesbian and queer+ parents and there is a risk that healthcare providers may attempt to apply these recommendations without further consideration of the different experiences that gay and transgender parents may have. The authors have stated this within the recommendations with the hope that healthcare providers will consider the broader experiences of members of the LGBTQ+ community when applying the recommendations to their services. Additionally, it was noticed that recruitment through charities that support parents with neonatal experience was not as successful as recruitment through charities aimed at LGBTQ+ parents. Further exploration of the types of charities and groups LGBTQ+ parents with neonatal experiences choose to connect with would allow for future research to directly connect with these spaces enabling greater breadth of participant identities to be included.

A final limitation of the empirical project would be the need for the results to be separated to ensure they are fully explored within the empirical paper. Potential journals with larger word limits were considered however, these journals were mainly aimed at LGBTQ+ issues. Due to the identified need for recommendations for neonatal healthcare providers to be identified, it was felt that a journal that focussed on the neonatal topic area would be more likely to be read by neonatal healthcare professionals and therefore, increase the impact of the research. Although a limitation in the ability to present all the findings in one paper, there is strength in the richness of the dataset produced by the empirical project as evidenced by the findings not sitting within the bounds of a single journal article.

A final strength of the empirical paper is the ease of understanding and implementing the recommendations derived from the findings. The recommendation to “recognise that documentation might not represent each parent” is an act that staff can do without needing to change the system, although it is of course recommended that documentation is altered to be more inclusive. By providing recommendations that staff can action easily, the paper

acknowledges that staff do not necessarily need to, and often cannot, ‘fix’ the system, but through recognising the weaknesses of it, can foster safety for parents.

Implications and Recommendations for Clinical Practice

The findings from both the systematic review and the empirical research suggest that current practices in maternity and neonatal services do not always meet the psychological needs of lesbian, bisexual, and queer+ parents, and practices do not always foster trust and safety in the relationships between parents and healthcare professionals. Therefore, healthcare providers and policy makers need to consider how services can be adapted to support the needs of these parents and consider how wider societal perceptions may impact how parents interact with healthcare professionals.

It is important that services recognise the impact that the lived experience of LGBTQ+ parents have on their interactions and perceptions of healthcare (Guest & Weinstein, 2020) and how these may be compounded when parents are placing their baby in the care of healthcare professionals. LGBTQ+ parents who may have experienced negative attitudes and stigma when accessing healthcare services, and who have experienced heteronormative assumptions as identified in both the systematic review and empirical paper, may be less trusting of healthcare professionals and this can impact the quality of care that both parent and baby receive (Brødsgaard et al., 2019; Shields et al., 2012; Wells & Lang, 2016).

There is limited policy and guidance for how maternity and neonatal services support LGBTQ+ parents and therefore, recommendations for providers have been included in both the systematic review and the empirical paper. These include increasing awareness of how heteronormative views and assumptions can present in individuals and systems, and training for healthcare professionals in how to challenge and reduce their impact. Recommendations

to consider how language use can invalidate LGBTQ+ parents, which includes the language used in literature provided to parents, and that conversations with parents about what they would like to be called can help foster inclusivity, have also been provided. Finally, the importance of explicit acceptance and inclusivity for LGBTQ+ parents has been highlighted as this appeared to impact many aspects of parents' experiences with both maternity and neonatal services.

Implications and Recommendations for Future Research

A future area of research should be to explore transgender and gay parents' experiences of neonatal services; this would allow for recommendations to be provided that serve the wider LGBTQ+ community. Additionally, future research should aim to include parents from a variety of ethnic backgrounds and offer the opportunity for parents to explore their intersecting identities and how these impacted their experiences. Such research may also benefit from researchers with identities that represent those that are being researched to allow for an insider researcher perspective.

Additionally, further research which explores the experience of LGBTQ+ parents' maternity journey after legal changes are needed to fully explore the extent to which they may have impacted parents' experiences. Additionally, the majority of the studies included within the systematic review and the areas that the empirical research recruited from, are Western and as such the recommendations are limited to these settings. Therefore, further research into the experiences of LGBTQ+ parents in non-Western societies are needed.

As identified earlier in the discussion, bisexual parents experience stigma from both heterosexual and LGBTQ+ communities (Goldberg, 2023; Manley & Ross, 2020) and only bisexual mothers in same-gender relationships were included within the systematic review.

Future research should aim to include bisexual parents regardless of their relationship status and consider how their sexual orientation has impacted their experiences.

Personal Reflections

My motivations for this research come from both personal and professional dimensions of a passion for equity for all parents, as well as experience working in a perinatal service with parents who sometimes had negative maternity experiences, but also from my own experience as a queer person. Throughout the research process I used the wheel of power/privilege which has been adapted for various contexts (but to my knowledge the original version comes from the Canadian Council of Refugees (2009)) to consider my own intersecting identities within the research context. This wheel acted as a framework for me to consider where I hold power in spaces, such as being white and being a researcher, as well as considering where I may feel less power, such as identifying as queer and non-binary. I also considered how the heteronormative and cisnormative assumptions I experience when interacting with healthcare professionals has impacted how I engaged with the research and the pressure I placed upon myself to make sure I did the research justice. The research itself has made me face my own views on parenthood and what this might look like for me, and I have valued the reflective journal in being able to express the feelings that came up for me about my future decisions around parenthood.

I found managing the feelings that arose when parents expressed negative interactions with staff to be both helpful and unhelpful. Feeling angry and frustrated that services did not provide the care that I expected them to, helped drive me to continue with the research, but also left me feeling hopeless that with all the legal changes it didn't seem like this was making a big enough difference to maternity or neonatal experiences. I reflected that my age is likely to have influenced the feelings that arose and being younger meant potentially not

having lived long enough to see those bigger changes that take time to happen. The parents I spoke to did not present with the same hopelessness that I, at times felt, and this may be that their ages leant more towards recognising these changes than mine did. I noticed that I needed to pay particular attention to the positive stories that existed to help myself stay balanced in my approach, whilst also recognising the discrimination that the parents experienced. I felt entrusted with the stories shared by the parents, and I can only hope the final thesis portfolio represents their experiences. It has been a privilege to hear the parents' stories and to engage in this research.

Conclusion

This thesis portfolio offers valuable contributions to the knowledge base of lesbian, bisexual, and queer+ parents' experiences of maternity and neonatal services, and subsequent recommendations for healthcare providers. The systematic review provided a synthesis of recent qualitative research to understand the maternity experiences of lesbian and bisexual mothers and acknowledges the challenges that parents experience, whilst also recognising the importance for explicit acceptance and the opportunity for 'good' experiences to positively impact parent's perceptions of care. Recommendations have centred around awareness and understanding of heteronormative views and assumptions for healthcare professionals, and the use of language and explicit acceptance. The empirical research explored the experience of lesbian and queer+ parents experiences of neonatal services and has recognised how these experiences impacted the trust parents had in professionals and their perceptions of care provided to their baby. Recommendations include the use of inclusive language and proactive action to ensure parents feel safe in being accepted as themselves and therefore, safety in the care that is being provided to their baby. The thesis portfolio has acknowledged the limited literature that exists in these areas and recommends for future research to explore these experiences further and to consider intersectionality of identities within this future research.

Declaration of Conflicts of Interest

AH and BB declare no potential competing interest. EN is employed by a healthcare trust and works as part of a Clinical Psychology Team in a neonatal unit. The Doctorate in Clinical Psychology at the University of East Anglia supported this study.

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Appendices

Appendix A: Author guidelines for Midwifery

Introduction

Your paper your way

We now differentiate between the requirements for new and revised submissions. You may choose to submit your manuscript as a single Word or PDF file to be used in the refereeing process. Only when your paper is at the revision stage, will you be requested to put your paper in to a 'correct format' for acceptance and provide the items required for the publication of your article.

To find out more, please visit the Preparation section below.

Introduction

Dr Debra Bick, the Editor of *Midwifery*, welcomes manuscripts for consideration for publication in the journal.

Uniform Requirements

These guidelines generally follow the 'Uniform Requirements for Manuscripts Submitted to Biomedical Journals', published by the International Committee of Medical Journal Editors (ICMJE). *Midwifery* is a signatory journal to the Uniform Requirements for Manuscripts Submitted to Biomedical Journals, issued by the International Committee for Medical Journal Editors (ICMJE), and to the Committee on Publication Ethics (COPE) code of conduct for Editors. We follow COPE's guidelines.

Article types

Full length articles should consist of 5000 words at most (excluding tables and references).

Commentaries should be 2000 words at most (excluding references).

Submission checklist

You can use this list to carry out a final check of your submission before you send it to the journal for review. Please check the relevant section in this Guide for Authors for more details.

Ensure that the following items are present:

One author has been designated as the corresponding author with contact details:

- E-mail address
- Full postal address

All necessary files have been uploaded:

Manuscript:

- Include keywords
- All figures (include relevant captions)

- All tables (including titles, description, footnotes)
- Ensure all figure and table citations in the text match the files provided
- Indicate clearly if color should be used for any figures in print

Graphical Abstracts / Highlights files (where applicable)

Please note that the journal does not accept submissions of Case Study article types

Before you begin

Before You Begin

Before you start we also suggest you look at the style of language and terminology used in the journal.

More details are provided later in these instructions. First time authors are strongly advised to co-author with an academic supervisor or experienced colleague who has been successful in writing for publication. Articles submitted for review must be original works, and may not be submitted for review elsewhere whilst under review for the Journal.

If a related article, based on the same work, has been submitted or published elsewhere, it must be acknowledged in the cover letter to the editor, added to the end of the cover letter, and referenced in the manuscript.

Considerations specific to types of research designs. Manuscripts must adhere to recognised reporting guidelines relevant to the research design.

Clinical Trials

We require the registration of all interventional trials, whether early or late phase, in a primary register that participates in WHO's International Clinical Trial Registry Platform or in ClinicalTrials.gov, in accord with ICMJE recommendations. The trial must be registered prospectively before the first participant is recruited, and full details including the name of the trial register and the clinical trial registration number must be included in the abstract.

We encourage full public disclosure of the minimum 21-item trial registration dataset at the time of registration and before recruitment of the first participant. Reports of trials must conform to CONSORT 2010 guidelines and should be submitted with their protocols. Authors must include a statement in their abstract if their study is not appropriate for registration in a trials registry.

Midwifery encourages the appropriate registration of all intervention studies, including observational quasi-experimental clinical studies and studies that do not include clinical outcomes. A study registration site (such as the Center for Open Science, cos.io) should be used to register their study.

For All Studies

Please upload the appropriate and completed Reporting Guideline Checklist during your manuscript submission process. To find reporting guidelines see: www.equator-network.org

STROBE (Strengthening the Reporting of Observational Studies in Epidemiology) - Observational cohort, case control and cross sectional studies)

STROBE Checklist Quasi-experimental/non-randomised evaluations

TREND (Transparent Reporting of Evaluations with Non-randomized Designs) - Randomised (and quasi-randomised) controlled trial

CONSORT (Consolidated Standards of Reporting Trials) - Study of diagnostic accuracy/assessment scale

- Cluster randomised trials must be reported according to CONSORT extended guidelines
- Clinical trials that report interventions using artificial intelligence must be described according to the CONSORT-AI Extension guidelines and their protocols must be described according to the SPIRIT-AI Extension guidelines

STARD (Standards for the Reporting of Diagnostic Accuracy Studies) - Systematic review of controlled trials

PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) - Systematic review of observational studies

MOOSE - Meta-analysis of observational studies in epidemiology

SQUIRE (Standards for Quality Improvement Reporting Excellence) - Quality improvement in health care

COREQ (Consolidated criteria for reporting qualitative research) - Qualitative research interviews and focus groups

SRQR (Standards for reporting qualitative research: a synthesis of recommendations) - Reporting of qualitative research studies

MMAT - Mixed Methods Appraisal Tool

STREGA - Reporting the results of genetic association studies

Studies in humans and animals

Human and animal rights Ethics in Research - It is important to note that original research studies that do not have appropriate ethical approvals prior to being conducted will be rejected at submission stage. We will consider publication, if the relevant Institutional Ethics Committee provides you with a letter saying that they do not normally provide ethical approval for studies such as the one you conducted. See COPE Guidelines at: http://publicationethics.org/resources/guidelines

Human Research

If the work involves use of human subjects, authors should ensure that the work described has been carried out in accordance with The Code of Ethics of the World Medical Association (Declaration of Helsinki). Please address the ethical aspects of the research in the Methods section. State clearly that the subject gave freely informed consent and, if in dependent relationships with members of the research team, issues of perceived coercion must be addressed. To clarify, women and their families, and students are in dependent relationship with researchers and must not be directly approached by the research team to give consent

on-the-spot. Participating or not participating in the research must not disadvantage participants in a dependent relationship. Any benefit for participating must not constitute a financial inducement. Participant anonymity must be preserved, unless express written approval to use identifying data is provided. The author must retain written consents, or evidence that such consents have been obtained, must be provided to Elsevier on request.

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Animal Research

All animal experiments should comply with the ARRIVE guidelines and should be carried out in accordance with the UK Animals (Scientific Procedures) Act, 1986 and associated guidelines, EU Directive 2010/63/EU for animal experiments, or the National Research Council's Guide for the Care and Use of Laboratory Animals and the authors should clearly indicate in the manuscript that such guidelines have been followed. The sex of the animals must be indicated, and where appropriate, the influence (or association) of sex on the results of the study.

Ethics_In_Publishing

The journal follows the Committee of Publication Ethics (COPE) guidelines and requests authors to familiarise themselves with these guidelines
at: http://publicationethics.org/resources/guidelines.

A few issues that authors need to pay particular attention to are set out below.

It is ethically questionable to break up or segment data from a single study to create different papers for publication - a practice called 'salami slicing'. If the authors have legitimate reasons for reporting separately on different parts of the same study, or the same data set, they should justify that to the editor at the time of submission. Equally, readers need to be aware that different aspects of the same study are being reported, thus the methods section of the submitted manuscript must clearly explain why the submitted paper is justified.

Use of inclusive language. Inclusive language acknowledges diversity, conveys respect to all people, is sensitive to differences, and promotes equal opportunities. Articles should make no assumptions about the beliefs or commitments of any reader, should contain nothing which might imply that one individual is superior to another on the grounds of race, sex, culture or any other characteristic, and should use inclusive language throughout. Authors should ensure that writing is free from bias, for instance by using 'he or she', 'his/her' instead of 'he' or 'his', and by making use of job titles that are free of stereotyping (e.g. 'chairperson' instead of 'chairman' and 'flight attendant' instead of 'stewardess').

Midwifery requires that authors use woman centred language including referring to births rather than deliveries, to give birth rather than deliver and women rather than patients. Papers

that do not adhere to these guidelines will not proceed to peer review. Our journal uses UK spelling, for example, recognise rather than recognize. We also spell fetal rather than foetal.

Engagement of public in research

Please highlight in your text how you have involved those who use the maternity services in your research and how your work has been informed by their involvement, including identification of priorities, designing the research or supporting the research. If engagement of members of the public was not appropriate for your research, please include a statement as to why.

Reporting sex- and gender-based analyses

Reporting guidance

For research involving or pertaining to humans, animals or eukaryotic cells, investigators should integrate sex and gender-based analyses (SGBA) into their research design according to funder/sponsor requirements and best practices within a field. Authors should address the sex and/or gender dimensions of their research in their article. In cases where they cannot, they should discuss this as a limitation to their research's generalizability. Importantly, authors should explicitly state what definitions of sex and/or gender they are applying to enhance the precision, rigor and reproducibility of their research and to avoid ambiguity or conflation of terms and the constructs to which they refer (see Definitions section below). Authors can refer to the Sex and Gender Equity in Research (SAGER) guidelines and the SAGER guidelines checklist. These offer systematic approaches to the use and editorial review of sex and gender information in study design, data analysis, outcome reporting and research interpretation - however, please note there is no single, universally agreed-upon set of guidelines for defining sex and gender.

Definitions

Sex generally refers to a set of biological attributes that are associated with physical and physiological features (e.g., chromosomal genotype, hormonal levels, internal and external anatomy). A binary sex categorization (male/female) is usually designated at birth ("sex assigned at birth"), most often based solely on the visible external anatomy of a newborn. Gender generally refers to socially constructed roles, behaviors, and identities of women, men and gender-diverse people that occur in a historical and cultural context and may vary across societies and over time. Gender influences how people view themselves and each other, how they behave and interact and how power is distributed in society. Sex and gender are often incorrectly portrayed as binary (female/male or woman/man) and unchanging whereas these constructs actually exist along a spectrum and include additional sex categorizations and gender identities such as people who are intersex/have differences of sex development (DSD) or identify as non-binary. Moreover, the terms "sex" and "gender" can be ambiguous--thus it is important for authors to define the manner in which they are used. In addition to this definition guidance and the SAGER guidelines, the resources on this page offer further insight around sex and gender in research studies.

Informed consent and patient details

Studies on patients or volunteers (including organ/tissue donors) require informed consent, which should be documented in the paper. Appropriate consents, permissions and releases

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All authors must disclose any financial and personal relationships with other people or organizations that could inappropriately influence (bias) their work. Examples of potential conflicts of interest include employment, consultancies, stock ownership, honoraria, paid expert testimony, patent applications/registrations, and grants or other funding. Authors should complete the declaration of competing interest statement using this template and upload to the submission system at the Attach/Upload Files step. **Note: Please do not convert the .docx template to another file type. Author signatures are not required.** If there are no interests to declare, please choose the first option in the template. More information

Declaration of Interest

All authors are requested to disclose any actual or potential conflict of interest including any financial, personal or other relationships with other people or organizations within three years of beginning the submitted work that could inappropriately influence, or be perceived to influence, their work. More information.

Use of inclusive language

Inclusive language acknowledges diversity, conveys respect to all people, is sensitive to differences, and promotes equal opportunities. Content should make no assumptions about the beliefs or commitments of any reader; contain nothing which might imply that one individual is superior to another on the grounds of age, gender, race, ethnicity, culture, sexual orientation, disability or health condition; and use inclusive language throughout. Authors should ensure that writing is free from bias, stereotypes, slang, reference to dominant culture and/or cultural assumptions. We advise to seek gender neutrality by using plural nouns ("clinicians, patients/clients") as default/wherever possible to avoid using "he, she," or "he/she." We recommend avoiding the use of descriptors that refer to personal attributes such as age, gender, race, ethnicity, culture, sexual orientation, disability or health condition unless they are relevant and valid. When coding terminology is used, we recommend to avoid offensive or exclusionary terms such as "master", "slave", "blacklist" and "whitelist". We suggest using alternatives that are more appropriate and (self-) explanatory such as "primary", "secondary", "blocklist" and "allowlist". These guidelines are meant as a point of reference to help identify appropriate language but are by no means exhaustive or definitive.

Contributors

Those who meet some but not all of the criteria for authors can be identified as 'contributors' with their contribution specified. All those individuals who provided help during the research (e.g., collecting data, providing language help, writing assistance or proofreading the article, etc.) that do not meet criteria for authorship should be acknowledged in the paper. Acknowledgments should be added to the title page if applicable.

Declaration of generative AI in scientific writing

The below guidance only refers to the writing process, and not to the use of AI tools to analyse and draw insights from data as part of the research process.

Where authors use generative artificial intelligence (AI) and AI-assisted technologies in the writing process, authors should only use these technologies to improve readability and language. Applying the technology should be done with human oversight and control, and authors should carefully review and edit the result, as AI can generate authoritative-sounding output that can be incorrect, incomplete or biased. AI and AI-assisted technologies should not be listed as an author or co-author, or be cited as an author. Authorship implies responsibilities and tasks that can only be attributed to and performed by humans, as outlined in Elsevier's AI policy for authors.

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We have adopted the guidelines of the International Committee of Medical Journal Editors (ICMJE) https://www.icmje.org/recommendations/browse/roles-and-responsibilities/defining-the-role-of-authors-and-contributors.html

Legitimate authors are those that made substantial contributions to all of the following: (1) the conception and design of the study, or acquisition of data, or analysis and interpretation of data, (2) drafting the article or revising it critically for important intellectual content, (3) final approval of the version to be submitted. All potential authors are those that meet requirement (1) above and these people should not be excluded from contributing to the writing and approval of the article.

All authors are required to provide a Conflict of Interest Statement and should complete a standard form, which is available at https://www.icmje.org/about-icmje/faqs/conflict-of-interest-disclosure-forms/

No author should be added who does not meet the first requirement; for more details please read "How to handle authorship disputes: a guide for new researchers" (2003) by Tim Albert and Liz Wage available at the COPE website: http://publicationethics.org/resources/guidelines.

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Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	Page 15
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	Page 16
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	Pages 17 - 19
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	Pages 18 & 19
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	Page 21
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	Page 20
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	Page 20
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	Page 21
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	Pages 22 - 23
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	Page 22
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	Page 22
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	Pages 21 & 22
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	N/A
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	Page 21
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	Page 21
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	Page 21

Section and Topic	Item #	Checklist item	Location where item is reported
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	Page 21
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	N/A
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	N/A
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	N/A
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	N/A
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	Pages 23 & 24
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	Page 24
Study characteristics	17	Cite each included study and present its characteristics.	Pages 24 - 29
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	Pages 31 - 39
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	N/A
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	Pages 24, 25 & 30
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	N/A
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	N/A
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	N/A
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	N/A
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	N/A
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	Pages 48 & 49
	23b	Discuss any limitations of the evidence included in the review.	Pages 49 & 50

Section and Topic	Item #	Checklist item	Location where item is reported
	23c	Discuss any limitations of the review processes used.	Pages 49 & 50
	23d	Discuss implications of the results for practice, policy, and future research.	Page 51
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	Page 20
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	N/A
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	N/A
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	Page 51
Competing interests	26	Declare any competing interests of review authors.	Pae 51
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	Quality bias assessment: page 22

Appendix C: Stenfors et al. (2020) key criteria in evaluating the trustworthiness of qualitative research

Criteria	What it means	How to recognise it
Credibility	The research findings are plausible and trustworthy	There is alignment between theory, research question, data collection, analysis and results. Sampling strategy, the depth and volume of data, and the analytical steps taken, are appropriate within that framework
Dependability	The extent to which the research could be replicated in similar conditions	There is sufficient information provided such that another researcher could follow the same procedural steps, albeit possibly reaching different conclusions
Confirmability	There is a clear link or relationship between the data and the findings	The researchers show how they made their findings through detailed descriptions and the use of quotes
Transferability	Findings may be transferred to another setting, context or group	Detailed description of the context in which the research was performed and how this shaped the findings
Reflexivity	A continual process of engaging with and articulating the place of the researcher and the context of the research	Explanations of how reflexivity was embedded and supported in the research process

Appendix D: Author Guidelines for Journal of Reproductive and Infant Psychology

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Contents

- My Authored Works
- Reprints

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The *Journal of Reproductive and Infant Psychology* is an international, peer-reviewed journal publishing high-quality, original research. Please see the journal's Aims & Scope for information about its focus and peer-review policy.

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Preparing Your Paper

All authors submitting to medicine, biomedicine, health sciences, allied and public health journals should conform to the Uniform Requirements for Manuscripts Submitted to Biomedical Journals, prepared by the International Committee of Medical Journal Editors (ICMJE).

Structure

Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).

The abstract should be be structured with a word limit of 250 words.

The required structure of the abstract is:
Aims/Background, Design/Methods, Results, Conclusion

Word Limits

Please include a word count for your paper.

A typical quantitative paper for this journal should be no more than 3500 words. The word limit excludes title, abstract, tables and references. The limit for a paper based on qualitative methods or systematic review is 5000 words.

Style Guidelines

Please refer to these quick style guidelines when preparing your paper, rather than any published articles or a sample copy.

Please use British (-ise) spelling style consistently throughout your manuscript.

Please use single quotation marks, except where ‘a quotation is “within” a quotation’. Please note that long quotations should be indented without quotation marks.

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2. Should contain a structured abstract of 250 words.
3. **Graphical abstract** (optional). This is an image to give readers a clear idea of the content of your article. It should be a maximum width of 525 pixels. If your image is narrower than 525 pixels, please place it on a white background 525 pixels wide to ensure the dimensions are maintained. Save the graphical abstract as a .jpg, .png, or .tiff. Please do not embed it in the manuscript file but save it as a separate file, labelled GraphicalAbstract1.
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5. Between 5 and 6 **keywords**. Read making your article more discoverable, including information on choosing a title and search engine optimization.
6. **Funding details.** Please supply all details required by your funding and grant-awarding bodies as follows:
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   This work was supported by the [Funding Agency] under Grant [number xxxx].
   For multiple agency grants
   This work was supported by the [Funding Agency #1] under Grant [number xxxx]; [Funding Agency #2] under Grant [number xxxx]; and [Funding Agency #3] under Grant [number xxxx].
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Updated 12-05-2020

Appendix E: Recruitment Posters

Appendix F: Participant Information Sheet

Participant Information Sheet

Study Title

Understanding the experience of LGBTQ+ parents who have had a baby admitted to a neonatal intensive care unit (NICU)

Invitation Paragraph

We would like you to help us with our research study. Please read this information carefully and ask us if there is anything unclear or if you want to know more.

What Is the Purpose of The Study?

We would like to understand what the experience of parents in the LGBTQ+ community who have had a baby admitted to the NICU. We are looking to understand this experience and also how parents feel their experience was impacted by their identity in the LGBTQ+ community.

Why Me?

You identify as a member of the LGBTQ+ community.

You have experience of being the parent of a baby admitted to the NICU.

You did not experience a bereavement whilst your baby was in the NICU.

Do I Have to Take Part?

No. It is entirely up to you. If you do decide to take part:

- You will be asked to sign a consent form.
- You will be given a copy of your signed consent form to keep.

What Will I Have to Do?

We will ask you for some demographic information, e.g., age, sexuality, gender identity, gestation when baby was born. You will be interviewed about your experiences on the NICU. The interview should not take longer than an hour, with the overall research time taking no longer than 2 hours. The interview will take place online using MS Teams. The interview (video and audio) will be recorded using the recording setting on MS Teams.

What Will Happen If I Don't Want to Carry on With the Research?

You can choose to withdraw at any time during the interview. You can contact the researcher or their supervisor (contact details at the end of this sheet) up to 2 weeks after the interview was completed to have your data withdrawn.

What Are the Possible Disadvantages and Risks of Taking Part?

Sometimes talking about difficult experiences can cause distress or brings things up that we didn't realise could affect us, we have included some information on places you can access for support in the debrief sheet. Additionally, before the interview starts we can discuss how

you may want to be supported if you become upset during the interview, this could be taking a break from the interview.

What Are the Possible Benefits of Taking Part?

There are no direct benefits of taking part for you, however, the research may be used to inform services of how they can support LGBTQ+ parents.

What Happens When the Research Study Stops?

You will be given a debrief sheet when the interview is finished. Once all the interviews are complete, we will bring all the information together and analyse it. The recording will be deleted once the interview has been transcribed.

What Will Happen to The Results of The Research Study?

When the study has finished, the results will be included as part of Abby Howes' educational qualification. We would also like to present our findings and put the results in journal articles. The results will be anonymous as you will be given a pseudonym-name. Any quotes used will be shortened as much as is possible whilst keeping their meaning, ensuring they are less likely to be identifiable.

How will we use information about you?

By consenting to participate, you are agreeing to the personal information shared to be collected and used for the purpose of this research study. Any information provided will only be used for the purposes outlined in this Participant Information Statement unless you consent otherwise. The 2018 General Data Protection Regulation Act and the University of East Anglia Research Data Management Policy (2019) will be adhered to at all times. Your information will be stored securely using UEA cloud storage and your identity/information will only be disclosed with your permission, except as required by law. Findings from this study may be included in a publication, but you will not be identifiable. Data will be stored until analysis and publication are completed and then retained for ten years.

What are your choices about how your information is used?

You can stop being part of the study at any time up to two weeks after the interview, without giving a reason, and we will remove any data we have from you.

We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

Where can you find out more about how your information is used?

You can find out more about how we use your information:

- By asking one of the research team
- By looking at the University's website page on Research Integrity https://www.uea.ac.uk/research/about-uea-research-and-impact/integrity

Will the Data Be Kept Confidential?

The data will be kept confidential unless you say something that suggests you are at risk of harming yourself or someone else. If this happens, we will inform the appropriate people to help keep you safe. In almost all circumstances we will tell you before we break confidentiality unless telling you would increase any risk.

Who Has Reviewed the Study?

The ethical aspects of this study have been approved under the regulations of the University of East Anglia's Faculty of Medicine and Health Sciences Ethics Committee.

Contact for Further Information

If you would like any further information about this study, you should contact:

Abby Howes

Norwich Medical School

Faculty of Medicine and Health Sciences

University of East Anglia

Norwich NR4 7TJ

(abby.howes@uea.ac.uk)

If you are concerned about the way this study is being conducted or you wish to make a complaint to someone independent from the study, please contact the administration team who will direct your concerns to a senior faculty member: med.reception@uea.ac.uk

Appendix G: Consent Form

Consent Form and Demographics Questionnaire

Title of Project: A qualitative study into the experience of LGBTQ+ parents in neonatal units

* Required

Consent Form

Please confirm you understand and consent to each statement by typing your initials into each reply.

1. Name *

2. I confirm that I have read the information sheet dated 'version 1.1 07.01.24' for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

   If you consent please put your initial in the below box. *

3. I understand that my participation is voluntary and that I am free to withdraw at any time during the interview or up to 2 weeks after the interview without giving any reason, without my medical care or legal rights being affected.

   If you consent please put your initial in the below box. *

4. I understand that the information collected about me may be used to support other research in the future and may be shared anonymously with other researchers.

   If you consent please put your initial in the below box. *

5. I agree to the interview being recorded by MS Teams. I understand the recording will be destroyed once transcribed.

   If you consent please put your initial in the below box. *

6. I agree to take part in the above study.

   If you consent please put your initial in the below box. *

7. I would like a summary of the findings sent to me via email once the project has finished.

   Please include an email address to send the findings to.

8. Phone number in the case of connectivity difficulties. *

Appendix H: Demographics Form

Demographics Questionnaire

Please only answer questions you are comfortable answering.

9. What age are you?

- ◯ 18-24
- ◯ 25-31
- ◯ 32-38
- ◯ 39-45
- ◯ 46-52
- ◯ 52-58
- ◯ Prefer not to say
- ◯ Other

10. Select an option that best describes your ethnic group or background

- ◯ Asian or Asian British - Indian
- ◯ Asian or Asian British - Pakistani
- ◯ Asian or Asian British - Bangladeshi
- ◯ Asian or Asian British - Chinese
- ◯ Asian or Asian British - Any other Asian background
- ◯ Black or Black British - African
- ◯ Black or Black British - Caribbean
- ◯ Black or Black British - Any other Black background
- ◯ Mixed - White and Asian
- ◯ Mixed - White and Black African
- ◯ Mixed - White and Black Caribbean
- ◯ Mixed - Any other mixed background
- ◯ White - British
- ◯ White - Irish
- ◯ White - Any other White background
- ◯ Other Ethnic Groups - Chinese
- ◯ Other Ethnic Groups - Any other ethnic group
- ◯ Prefer not to say

11. How many children do you have?

- ◯ One
- ◯ Two
- ◯ Three
- ◯ Four or more
- ◯ Prefer not to say

12. How many of your children have been admitted to a neonatal unit?

- ◯ One
- ◯ Two
- ◯ Three
- ◯ Four or more
- ◯ Prefer not to say

13. What gestation was your baby/babies born at? (Please select the gestation of the baby/babies that stayed in a neonatal unit, you may select multiple options)

- ☐ Less than 24 weeks
- ☐ 24+1 to 28+0 weeks
- ☐ 28+1 to 32+0 weeks
- ☐ 32+1 to 39+0 weeks
- ☐ 39+1 weeks or more
- ☐ Prefer not to say

14. Was your baby a singleton?

- ◯ Yes
- ◯ No, twins
- ◯ No, triplets
- ◯ Prefer not to say
- ◯ Other

15. How long did your baby stay in a neonatal unit?

16. What is your sexuality?

- ◯ Lesbian
- ◯ Bisexual
- ◯ Gay
- ◯ Queer
- ◯ Pansexual
- ◯ Prefer not to say
- ◯ Other

17. What is your gender identity?

- ◯ Trans woman
- ◯ Trans man
- ◯ Woman
- ◯ Man
- ◯ Non-binary
- ◯ Prefer not to say
- ◯ Other

Appendix I: Debrief Letter

Debrief Letter

Thank you for taking part in this study looking to understand LGBTQ+ parents' experiences on neonatal units. If you wish for your data to be removed, please contact us by email, within 2 weeks of the date of your interview, (abby.howes@uea.ac.uk) to discuss issues of concern.

If you wish to review your transcript (written script of the interview) and did not previously say yes at the interview, please contact us by email within 2 weeks of the date of your interview (abby.howes@uea.ac.uk).

You can also contact us to request a lay summary of our findings via email (abby.howes@uea.ac.uk).

If you feel you need further support about your experiences, please access support via the following places:

Bliss for babies born premature or sick	Bliss – charity to support families with a premature or sick baby.	https://www.bliss.org.uk/
SAMARITANS	Samaritans – a charity dedicated to reducing feelings of isolation and disconnection that can lead to suicide.	https://www.samaritans.org/
mind	Mind – a charity that provides advice and support to those experiencing mental health difficulties.	https://www.mind.org.uk/need-urgent-help/using-this-tool/
	Your local GP who can help with discussions about further support.	

If you are concerned about your experience during your time on the Neonatal Unit. Please contact your hospital's local PALS team.

https://www.nhs.uk/nhs-services/hospitals/what-is-pals-patient-advice-and-liaison-service/

If you are concerned about the way this study is being conducted or you wish to make a complaint to someone independent from the study, please contact the administration team who will direct your concerns to a senior faculty member: med.reception@uea.ac.uk

Kind regards,

Abby Howes

Trainee Clinical Psychologist

Doctorate in Clinical Psychology (ClinPsyD)

Email: abby.howes@uea.ac.uk

Appendix J: Interview Topic Guide

Topic Guide

“Today I will be interviewing you about your experience in the neonatal unit. The interview will last about an hour. I will listen carefully to your answers. Sometimes I will ask you some more questions about what you have said. I will record the interview using Microsoft Teams so that I can type our conversation up afterwards. There are no right or wrong answers, I would just like to hear about your own experiences.

Some of the things you say will be written in a report. Other people may read this report, but your real name will not be in the report. Apart from the report, I will keep things you say private. However, there is one time I cannot keep what you say private or confidential. If I was worried that you or someone else might be in danger, then it is my job to tell the relevant people to keep everyone safe. In almost all circumstances I will tell you before I tell someone unless this increases any danger.

It is your choice to take part in this interview. You can tell me at any time during the interview if you would like to take a break or stop the interview.

If we lose connectivity or leave the interview unexpectedly, I will ring you using the phone number you provided on the consent form. This number will be deleted from the call log immediately after the interview has finished.

Do you have any questions before we begin?”

1. Can you tell me about your experience leading up to your baby being admitted to the neonatal unit?
    a. What was your experience of maternity services during birth?

2. What was your experience when you first arrived on the ward?
    a. Were you offered the space to talk about why your baby needed to be on the ward?
    b. Was the ward local to you?
    c. Was accommodation an option to you?

3. How did you experience communicating with staff?
    a. Were you offered the opportunity to receive updates?

4. What were your experiences with other parents?
    a. On the ward?
    b. Other parents you knew?

5. Do you think your sexuality and/or gender identity impacted your experience?
    a. How did this impact your experience?
    b. In communicating with staff?
    c. With other parents?

6. Did you access support services at the hospital/outside of the hospital?
    a. What were your experiences with this?
    b. Did you find your gender/sexuality affect your experiences with this?
    c. What was your experience with work parental leave?

7. With regards to the things we have discussed today, is there anything the staff/ward could have done to improve your experience?

8. Is there anything else you feel is important that we haven't discussed?

Appendix K: Ethical Approval

University of East Anglia
Norwich Research Park
Norwich. NR4 7TJ

Email: ethicsmonitor@uea.ac.uk
Web: www.uea.ac.uk

Study title: A qualitative study into the experience of LGBTQ+ parents in neonatal units

Application ID: ETH2324-0061

Dear Abby,

Your application was considered on 12th January 2024 by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee).

The decision is: **approved**.

You are therefore able to start your project subject to any other necessary approvals being given.

If your study involves NHS staff and facilities, you will require Health Research Authority (HRA) governance approval before you can start this project (even though you did not require NHS-REC ethics approval). Please consult the HRA webpage about the application required, which is submitted through the IRAS system.

This approval will expire on **28th March 2025**.

Please note that your project is granted ethics approval only for the length of time identified above. Any extension to a project must obtain ethics approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) before continuing.

It is a requirement of this ethics approval that you should report any adverse events which occur during your project to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) as soon as possible. An adverse event is one which was not anticipated in the research design, and which could potentially cause risk or harm to the participants or the researcher, or which reveals potential risks in the treatment under evaluation. For research involving animals, it may be the unintended death of an animal after trapping or carrying out a procedure.

Any amendments to your submitted project in terms of design, sample, data collection, focus etc. should be notified to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) in advance to ensure ethical compliance. If the amendments are substantial a new application may be required.

Approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) should not be taken as evidence that your study is compliant with the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018. If you need guidance on how to make your study UK GDPR compliant, please contact the UEA Data Protection Officer (dataprotection@uea.ac.uk).

Please can you send your report once your project is completed to the FMH S-REC (fmh.ethics@uea.ac.uk).

I would like to wish you every success with your project.

On behalf of the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee)

Yours sincerely,

Dr Paul Linsley

Appendix L: Approval of ethical amendment

University of East Anglia
Norwich Research Park
Norwich. NR4 7TJ

Email: ethicsmonitor@uea.ac.uk
Web: www.uea.ac.uk

Study title: A qualitative study into the experience of LGBTQ+ parents in neonatal units

Application ID: ETH2324-2289 (significant amendments)

Dear Abby,

The amendment to your study was considered on 26th April 2024 by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee).

The decision is: **approved**.

You are therefore able to start your project subject to any other necessary approvals being given.

If your study involves NHS staff and facilities, you will require Health Research Authority (HRA) governance approval before you can start this project (even though you did not require NHS-REC ethics approval). Please consult the HRA webpage about the application required, which is submitted through the IRAS system.

This approval will expire on **28th March 2025**.

Please note that your project is granted ethics approval only for the length of time identified above. Any extension to a project must obtain ethics approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) before continuing.

It is a requirement of this ethics approval that you should report any adverse events which occur during your project to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) as soon as possible. An adverse event is one which was not anticipated in the research design, and which could potentially cause risk or harm to the participants or the researcher, or which reveals potential risks in the treatment under evaluation. For research involving animals, it may be the unintended death of an animal after trapping or carrying out a procedure.

Any amendments to your submitted project in terms of design, sample, data collection, focus etc. should be notified to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) in advance to ensure ethical compliance. If the amendments are substantial a new application may be required.

Approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) should not be taken as evidence that your study is compliant with the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018. If you need guidance on how to make your study UK GDPR compliant, please contact the UEA Data Protection Officer (dataprotection@uea.ac.uk).

Please can you send your report once your project is completed to the FMH S-REC (fmh.ethics@uea.ac.uk).

I would like to wish you every success with your project.

On behalf of the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee)

Yours sincerely,

Dr Paul Linsley

Appendix M: Example of transcript and coding

Key:

- Highlighted text is that which was coded
- (Highlighted text in brackets) were initial codes

P8 32:54
do you yeah and I I didn't I felt like I wanted to be in that hospital 100% of the time I absolutely hated leaving him at HOSPITAL_B which is bizarre (safety in care of baby) (not feeling able to trust staff with baby's care) because it's one of the leading children's hospitals so CITY's children's hospital is is one of the best in the country some of the best in the world doctor like do you know what I mean [yeah] like the consultants are the but it's a whole different environment wholly different and then we started getting like all these forms that we had to fill out right so I'm filling out these forms and I'm going fuck me 'cause I'm already annoyed now because I need my kid to have this surgery [yeah] I'm already annoyed because I don't feel comfortable in this environment and now I'm getting forms where it says mother's name and father's name right repeatedly over and over every single form that I'm filling out is mother's name and father's name (inclusive language) so I'm

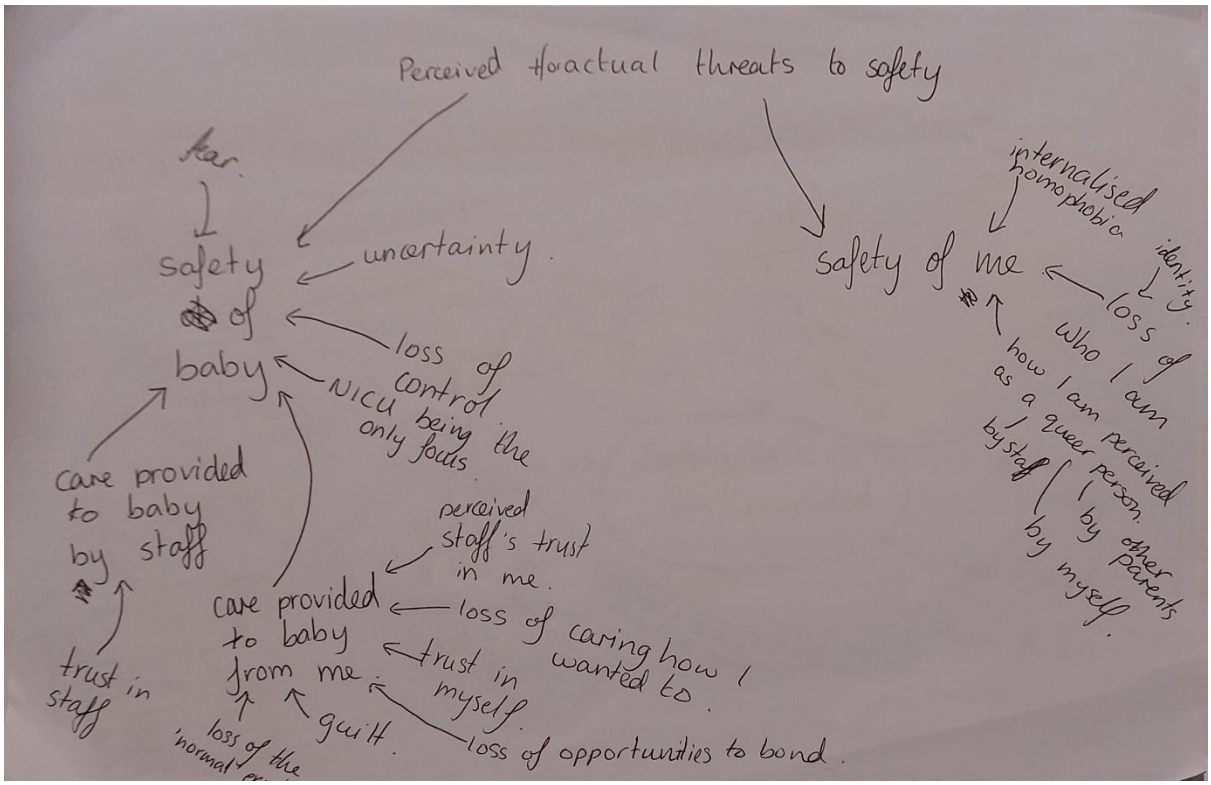
Interviewer 33:52
and was there any acknowledgement from staff that that was the case

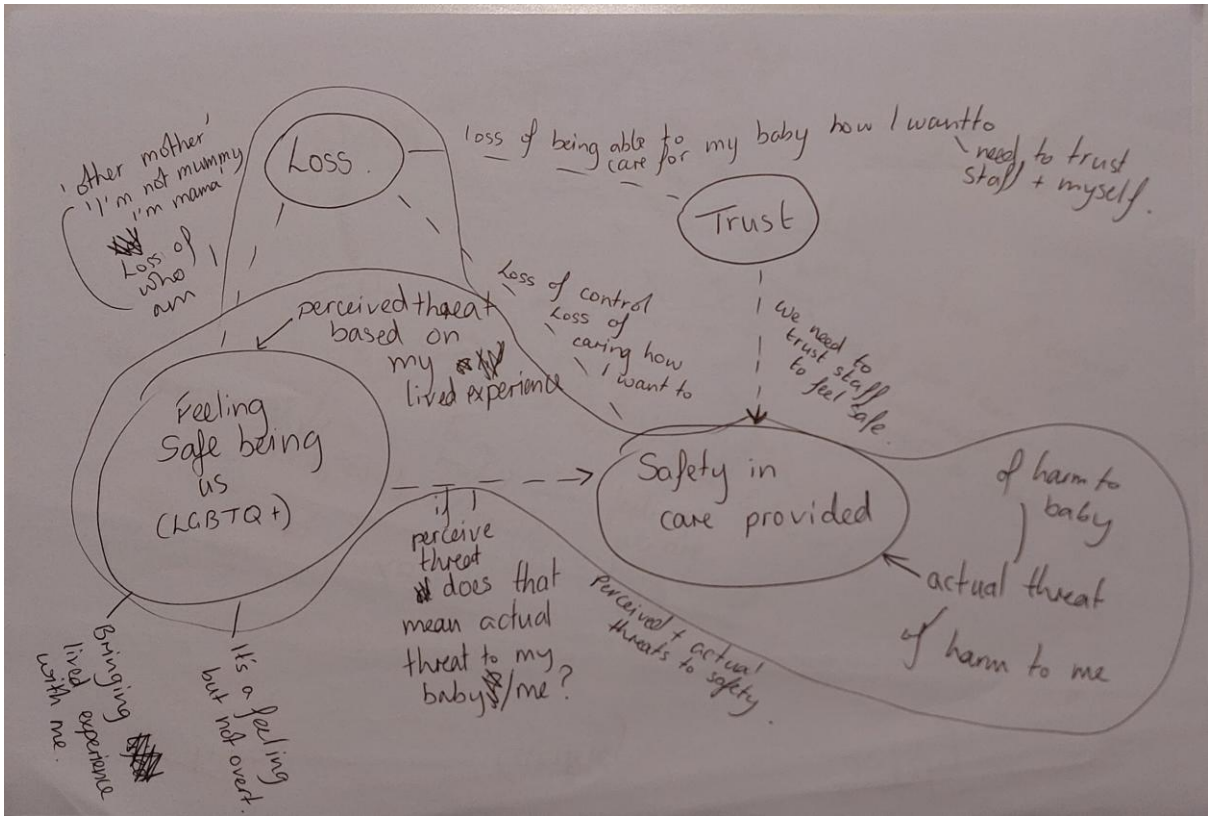
P8 33:54
no none none at all just fill out this form just fill out this form just fill out this form just fill out this form right and we got like a little gift bag thing like a little hamper thing that you get when you go into HOSPITAL_B and then the book was something like me and my dad or something like that and I'm kind of like *sigh* (best intentions not meeting the needs) (safety in who we are) and I'm sat there and I'm going like I'm not gonna let it like 'cause I'm not one to get like amped up about stuff I just I just don't like it's not my style like I firmly like I fight for what I believe in and what not but I don't get irate it's just not who I am but like when it's repeated and repeated and repeated I'm just kind of like you've got to do better (inclusive language)

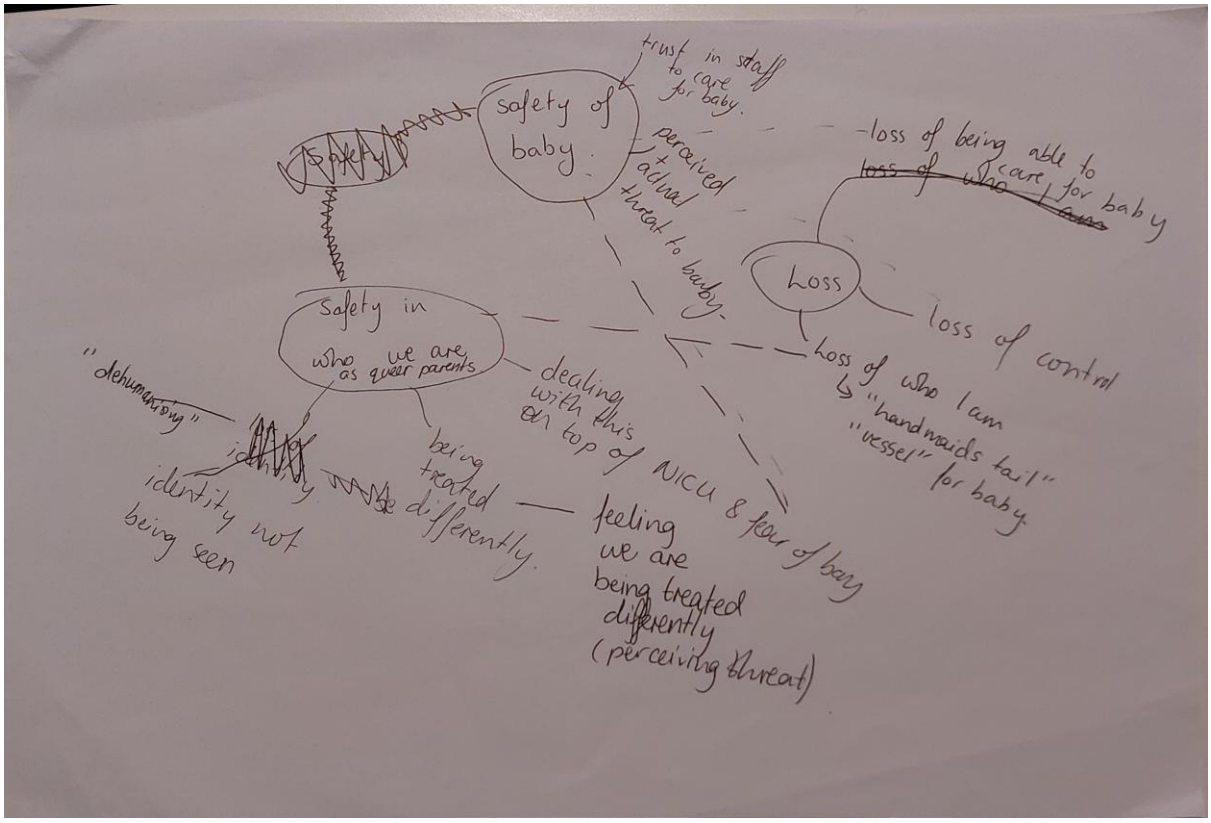
Interviewer 34:38
and it wears you down a bit doesn't it in that in that situation

P8 34:41
but as the other parent in going into this into this situation like you already feel less than right you do like rightly or wrongly like you know that you shouldn't but you do you already feel less than like you contributed less like you're gonna mean less and and you're gonna have to work 10 times harder do you know what I mean just to be mum (context of being a queer person) (feeling you need to work harder to be a mum – non-birth parent) like every time my mum's the every time my son says mama to me I'm kinda like *ha* I did it whereas for P8_PARTNER it's just completely normal do you know what I mean so when you're in that situation and then you almost feel like you're being bashed every time like you're filling out a form (inclusive language) (safety in who we are) it's just an even I even away from you know from the queer environment from from from that from that situation like a single parents in there as well do you know what I mean

Appendix N: Initial thematic maps






trust in staff to care for baby.
safety of baby.
perceived + actual threat to baby.
loss of being able to care for baby
Loss
loss of control
loss of who I am
"handmaids tail"
"vessel" for baby.
Safety in
who we are as queer parents
dealing with this on top of NICU & fear of baby
"dehumanising"
being treated differently.
feeling we are being treated differently (perceiving threat)
identity not being seen

Appendix O: Reflective Journal Extract

The following extract was written immediately following an interview with a participant, at the mid-point of recruitment.

- Participant was younger than many of the other participants – could this have impacted on them feeling able to challenge medical professionals?
- I am a similar age to them – would I feel comfortable challenging medical professionals, I haven't previously.
- Felt like a free-flowing discussion with lots of rich information
    - Could this be because we are a similar age?
    - I found it really nice to hear their way of understanding situations, turning them into sarcastic or humour based ways of talking about things – could this be a protective way of thinking about the challenges they faced
    - Did I lean into the sarcasm too much? I could have delved deeper into where the sarcasm came from, but also wanted to create safety for the participant
- This interview brought up lots of thoughts and feelings which have been building across each interview
    - I felt sad that this participant hadn't always had a good experience and angry on their behalf – I feel I was able to stop this from impacting how I asked questions but I wonder if it affected how I came across
    - This participant mentioned potential charities that could support LGBTQ+ parents' journeys – I felt frustrations that the NHS shouldn't need charities to do the work they should be doing – I am a part of this NHS system in the work I do and the signposting I do
        - I feel this has touched on my own sociopolitical views (that we shouldn't need charities as suitable and inclusive care should be provided by the NHS) and it is important I am aware of this when analysing the data set and developing recommendations
    - Through hearing the challenges participants face with having their own identity recognised in the literature, e.g. mother and mother, it has often led to me reflecting on my own experiences with this. Reflecting on my own experience as a non-binary person and my own frustrations with my identity not being recognised. I wonder *how* this has impacted how I make sense of what they say and *what* aspects of this experience I might ask probing questions about.
- Throughout these interviews, I have come away thinking about what I want for my future, whether I want children or not and how I might experience maternity care as a member of the LGBTQ+ community.