Online Proofing System Instructions

The Wiley Online Proofing System allows authors and proof reviewers to review PDF proofs, mark corrections, respond to queries, upload replacement figures, and submit these changes directly from the PDF proof from the locally saved file or while viewing it in your web browser.

1. For the best experience reviewing your proof in the Wiley Online Proofing System please ensure you are connected to the internet. This will allow the PDF proof to connect to the central Wiley Online Proofing System server. If you are connected to the Wiley Online Proofing System server you should see the icon with a green check mark above in the yellow banner.

Connected Disconnected

2. Please review the article proof on the following pages and mark any corrections, changes, and query responses using the Annotation Tools outlined on the next 2 pages.

3. To save your proof corrections, click the "Publish Comments" button appearing above in the yellow banner. Publishing your comments saves your corrections to the Wiley Online Proofing System server. Corrections don't have to be marked in one sitting, you can publish corrections and log back in at a later time to add more before you click the "Complete Proof Review" button below.

4. If you need to supply additional or replacement files bigger than 5 Megabytes (MB) do not attach them directly to the PDF Proof, please click the "Upload Files" button to upload files:

5. When your proof review is complete and you are ready to submit corrections to the publisher, please click the "Complete Proof Review" button below:

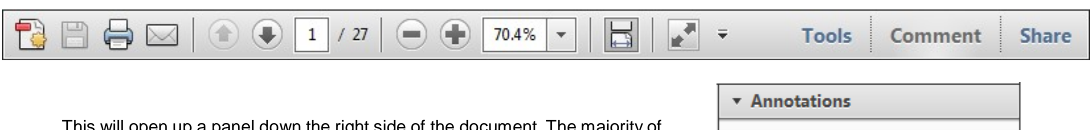
IMPORTANT: Do not click the "Complete Proof Review" button without replying to all author queries found on the last page of your proof. Incomplete proof reviews will cause a delay in publication.

IMPORTANT: Once you click "Complete Proof Review" you will not be able to publish further corrections.

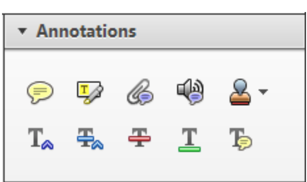
WILEY

USING e-ANNOTATION TOOLS FOR ELECTRONIC PROOF CORRECTION

Once you have Acrobat Reader open on your computer, click on the Comment tab at the right of the toolbar:



This will open up a panel down the right side of the document. The majority of tools you will use for annotating your proof will be in the Annotations section, pictured opposite. We've picked out some of these tools below:

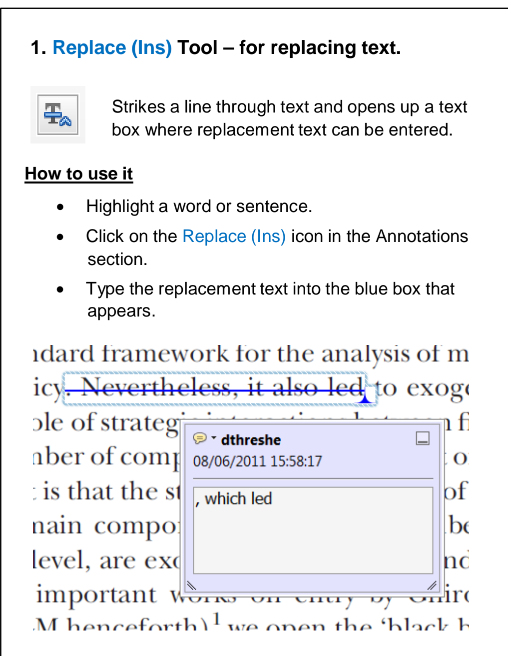


1. Replace (Ins) Tool – for replacing text.

Strikes a line through text and opens up a text box where replacement text can be entered.

How to use it

- Highlight a word or sentence.
- Click on the Replace (Ins) icon in the Annotations section.
- Type the replacement text into the blue box that appears.

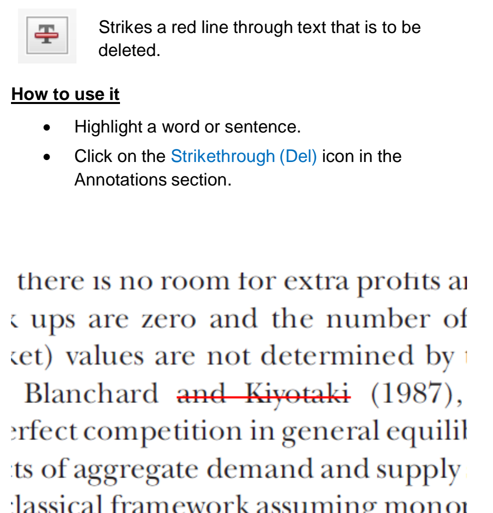


2. Strikethrough (Del) Tool – for deleting text.

Strikes a red line through text that is to be deleted.

How to use it

- Highlight a word or sentence.
- Click on the Strikethrough (Del) icon in the Annotations section.

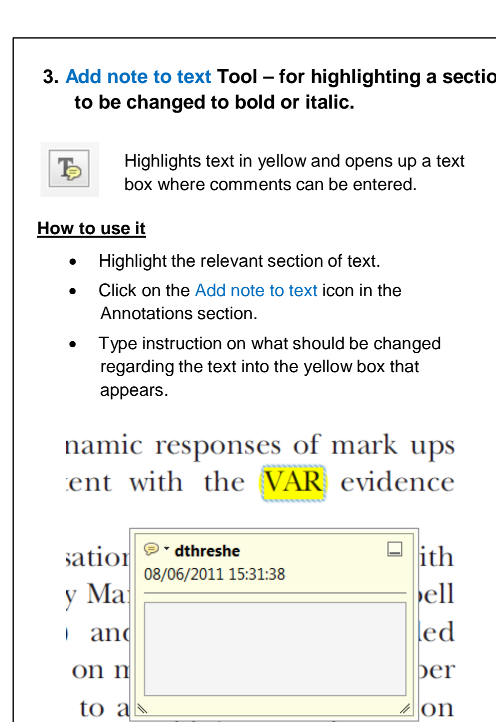


3. Add note to text Tool – for highlighting a section to be changed to bold or italic.

Highlights text in yellow and opens up a text box where comments can be entered.

How to use it

- Highlight the relevant section of text.
- Click on the Add note to text icon in the Annotations section.
- Type instruction on what should be changed regarding the text into the yellow box that appears.

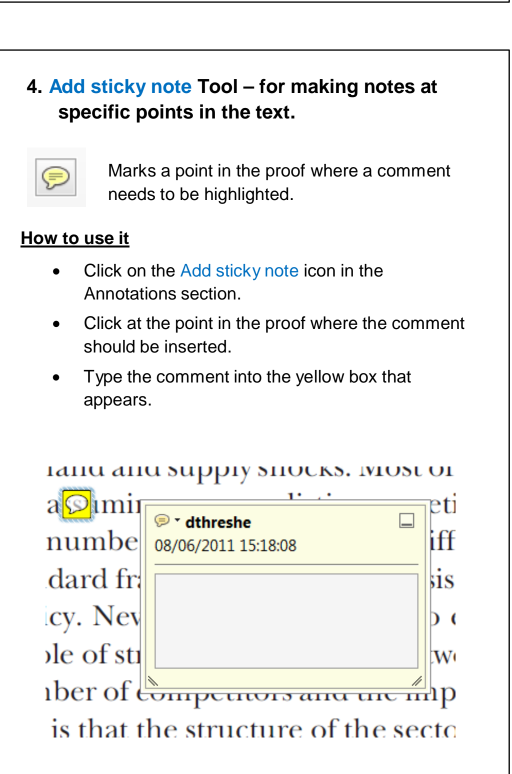


4. Add sticky note Tool – for making notes at specific points in the text.

Marks a point in the proof where a comment needs to be highlighted.

How to use it

- Click on the Add sticky note icon in the Annotations section.
- Click at the point in the proof where the comment should be inserted.
- Type the comment into the yellow box that appears.

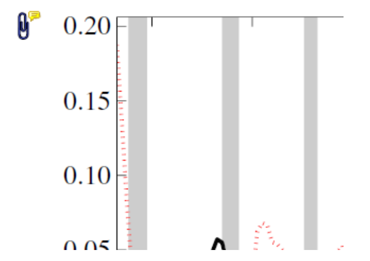


5. Attach File Tool – for inserting large amounts of text or replacement figures.

Inserts an icon linking to the attached file in the appropriate place in the text.

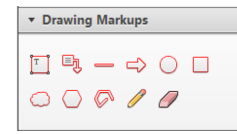
How to use it

- Click on the Attach File icon in the Annotations section.
- Click on the proof to where you'd like the attached file to be linked.
- Select the file to be attached from your computer or network.
- Select the colour and type of icon that will appear in the proof. Click OK.



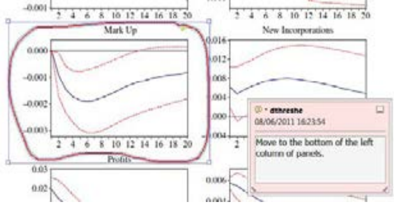
6. Drawing Markups Tools – for drawing shapes, lines and freeform annotations on proofs and commenting on these marks.

Allows shapes, lines and freeform annotations to be drawn on proofs and for comment to be made on these marks.



How to use it

- Click on one of the shapes in the Drawing Markups section.
- Click on the proof at the relevant point and draw the selected shape with the cursor.
- To add a comment to the drawn shape, move the cursor over the shape until an arrowhead appears.
- Double click on the shape and type any text in the red box that appears.



J O C N	13727	Wiley	Dispatch: 18.1.17	CE: Hemalatha P
Journal Code	Manuscript No.		No. of pages: 12	PE: Sharmila K

ORIGINAL ARTICLE

Journal of Clinical Nursing

Accessing new understandings of trauma-informed care with queer birthing women in a rural context

Jennifer Searle, Lisa Goldberg, Megan Aston and Sylvia Burrow

Aims and objectives. Participant narratives from a feminist and queer phenomenological study aim to broaden current understandings of trauma. Examining structural marginalisation within perinatal care relationships provides insights into the impact of dominant models of care on queer birthing women. More specifically, validation of queer experience as a key finding from the study offers trauma-informed strategies that reconstruct formerly disempowering perinatal relationships.

Background. Heteronormativity governs birthing spaces and presents considerable challenges for queer birthing women who may also have an increased risk of trauma due to structurally marginalising processes that create and maintain socially constructed differences.

Design. Analysis of the qualitative data was guided by feminist and queer phenomenology. This was well suited to understanding queer women's storied narratives of trauma, including disempowering processes of structural marginalisation.

Methods. Semistructured and conversational interviews were conducted with a purposeful sample of thirteen queer-identified women who had experiences of birthing in rural Nova Scotia, Canada.

Results. Validation was identified as meaningful for queer women in the context of perinatal care in rural Nova Scotia. Offering new perspectives on traditional models of assessment provide strategies to create a context of care that reconstructs the birthing space insofar as women at risk do not have to come out as queer in opposition to the expectation of heterosexuality.

Conclusions. Normative practices were found to further the effects of structural marginalisation suggesting that perinatal care providers, including nurses, can challenge dominant models of care and reconstruct the relationality between queer women and formerly disempowering expectations of heteronormativity that govern birthing spaces.

Relevance to clinical practice. New trauma-informed assessment strategies reconstruct the relationality within historically disempowering perinatal relationships through potentiating difference which avoids retraumatising women with re-experiencing the process of coming out as queer in opposition to the expectation of heterosexuality.

What does this paper contribute to the wider global clinical community?

- New understandings of trauma include structurally marginalising processes that disrupt dominant models of care and expand traditional nursing assessment skills
- Validating structural trauma reconstructs the context of care to create therapeutic partnerships that aim to provide equitable care to marginalised communities

Authors: *Jennifer Searle*, BSc BScN RN, XXXX, Nova Scotia Health Authority, Halifax, NS; *Lisa Goldberg*, RN, PhD, Caritas Coach, XXXX, Dalhousie University School of Nursing, Halifax, NS; *Megan Aston*, PhD, RN, XXXXX, Dalhousie University School of Nursing, Halifax, NS; *Sylvia Burrow*, PhD, XXXX, Cape Breton University, Sydney, Nova Scotia, Canada

Correspondence: Jennifer Searle, Nova Scotia Health Authority, 1796 Summer Street, Halifax, NS, Canada B3H 3A7. Telephone: +1 (902) 489 7410.
E-mail: jesearle@dal.ca

UNCORRECTED PROOF

© 2017 John Wiley & Sons Ltd

Key words: assessment, feminism, heteronormativity, perinatal nursing, phenomenology, queer, reconstruction, relational care, relationality, trauma-informed care

Accepted for publication: 2 January 2017

UNCORRECTED PROOF

Introduction

Heteronormative practices in health care that assume heterosexuality recreate traumatic coming out processes for queer birthing women. Evidence suggests that healthcare providers, particularly nurses, can incorporate affirming practices into relational care that validate patient experience and thus access new understandings of trauma-informed care. Our research with queer women in birthing contexts across rural Nova Scotia found validation to be a reoccurring theme: one which allowed for difference to be acknowledged, respected and made visible which in turn became meaningful for participants. As such, trauma-informed care strategies, grounded in the phenomenological findings of participant narratives, reconstruct the coming out process so that caring spaces can begin to reconcile the limited opportunities that persons from queer communities have to engage in life-affirming experiences – including those during birth.

Throughout the experiential narratives of participants in our study, hegemonic, heteronormative spaces were found to contribute to the detrimental effects of dominant models of care. However, when the potential for difference was acknowledged, an awareness of the social history of resistance to heteronormativity that queer women experience created opportunities to understand the role of nurses in providing contextually appropriate care. Thusly, holding space *with* difference in what has been historically experienced as a disempowering environment was identified by queer women as an effective practice in the provision of equitable birthing care.

In what follows, we draw on the feminist and queer phenomenological interviews carried out with thirteen queer-identified women who shared their experiences of birth across rural Nova Scotia. Woven throughout the storied experiences was a reoccurring theme of trauma: the complex, challenging and sometimes frightening ways in which women experienced birth, despite the recognition that healthcare providers, including nurses, in some circumstances provided care that was both compassionate and respectful. Nevertheless, findings further show that understandings of trauma must be broadened to recognise the socio-cultural-political factors and conditions that shape the complexity and variability of life, particularly for those who are located in places of difference who may be at risk for what we describe as structural trauma. These discoveries suggest that nurses, having an ethical ability to politicise their practice, can adopt trauma-informed strategies and create care plans that attend to the structural trauma experienced by communities at risk, specifically those who are queer.

Feminist and queer phenomenology: a methodology for queer birthing rural practices

As a philosophy, holistic nursing can be traced back to Florence Nightingale who valued the connection between a patient's health and their environment (Flagg 2015). Given the suggestive evidence that health disparities are disproportionately experienced by populations of difference (Quiros & Berger 2015), a systematic method of contextual and holistic assessment that accounts for the potential of diverse experiences would appear to be lacking from dominant care practices. Phenomenological methodologies are particularly relevant to health research, insofar as they value individual and concrete experiences, centring those who may otherwise be marginalised (Goldberg *et al.* 2009). As such, '[a] phenomenology of practice does not aim for technicalities and instrumentalities – rather, it serves to foster and strengthen an embodied ontology, epistemology and axiology of thoughtful and tactful action' (van Manen in van Manen & Higgins 2016, p. 4). From this perspective, phenomenology is both progressive and radical; it builds an analysis around how perinatal care providers contribute to the structural marginalisation of queer women who access retraumatising healthcare services. A feminist lens further supports our research through exposing the heterosexist nature within which dominant models of care are delivered and aims to create a greater understanding of the potential for harm when accessing healthcare services.

The essentialisation around the female experience veils the structural conditions that shape individual lives (Young 2005). 'Insofar as we learn to live out our existence in accordance with the definition that patriarchal culture assigns to us, we are physically inhibited, confined, positioned and objectified' (Young 2005, p. 42). The complex

© 2017 John Wiley & Sons Ltd

navigational challenges for women within birthing spaces begin to emerge through drawing from Young's (2005) understanding of the socialisation of women and inhibited intention. Thusly, the argument for structural trauma develops by suggesting that women are socialised to mitigate the risk of harm by concealing what may challenge dominant narratives around female embodiment. What is denied both internally by the individual and externally by the structure is carried out to limit the mobility of those who carry a potential for difference, reducing them to objects that can then be used to extend the scope of normativity (Young 2005). The policing of women's bodies becomes a matter of choice: police themselves internally or risk being policed externally by a structure that is designed to privilege the male experience (Young 2005). Thusly, she 'actively enacts her own body inhibition' (Young 2005, p. 44) as protection against a structure that threatens to control, objectify and alienate her from her own body (Young 2005). These are traumatic processes and when the potential for variability in experiences goes unacknowledged, opportunities to safely embody difference are limited. Thus, birthing bodies become restricted and controlled through medicalisation to further the scope of authoritative medical knowledge that alienates women from knowing their own bodies (Young 2005). This is further complicated by the denial of a sexual identity for women who have birthed which positions mothers who seek sexual intimacy in a negative light, making sexuality a challenging subject to approach for perinatal care providers (Benoit *et al.* 2016) and a potentially dangerous disclosure for those who do not conform to the expectation of heterosexuality.

In the light of our interest in queer birthing practices, Wilton's (2004) work, 'Sexual (Dis)Orientation', is relevant in expanding our methodological framework. Wilton (2004) furthers Young's (2005) work in relation to our project, insofar as she reveals how an intersectional identity (being a woman *and* queer) increases the risk for structural trauma. The analysis of intersectionality in this project is limited to that of being a woman and queer and it is necessary to recognise the expanse of diversity that goes unacknowledged, particularly those who are people of colour, immigrants, persons with (dis)abilities and the disenfranchised, which is both beyond the scope of this paper and necessary to investigate in future research. Trauma is thusly understood to be a 'persistent backdrop' for members of the LGBT communities (Brown & Pantalone 2011, p. 1) making systemic marginalisation a structurally traumatic process for queer women. Socio-culturally, the discriminatory practices of homophobia are among the most pervasive structural strategies of control (Wilton 2004). Homophobia is both an internal and external process; practices that marginalise non-normativity are politically legitimised which produces structurally traumatised, self-hating populations who often internalise (or even deny) their queerness as a protective strategy (Wilton 2004, Young 2005, Quiros & Berger 2015).

Ahmed (2006) advances how the risks associated with being a queer woman are understood insofar as she offers spatial considerations around corporeal extension and movement. Structural strategies of control have implications for those who fail to conform to the heteronorm (Ahmed 2006). Heteronormativity denies the potential for queerness, and the threat of exclusionary practices alone puts a person at risk for structural trauma. The expectation of heterosexuality causes those who are queer to endlessly consider the risks associated with admitting and declaring what makes them different (Wilton 2004) versus choosing to internalise their queerness and remain invisible. Coming out in opposition to the expectation of heterosexuality can 'be the site of trauma, anxiety, or stress about the loss of an imagined future' (Ahmed 2006, p. 19) as queerness and reproductivity are often positioned as socio-culturally incompatible (Ahmed 2006). These are considerable factors that inform how queer birthing women access and experience healthcare services.

Protective strategies in self-inhibition may be employed to avoid retraumatisation (Young 2005, Ahmed 2006). When queer bodies enter heteronormative spaces, they re-experience structural strategies of control that aim to straighten and realign them with normative practices (Ahmed 2006) which reproduce the structural trauma experienced from internal and external coming out processes. For many queer women, coming out as queer in opposition to heteronormativity is a lifelong process and is the source of perpetually choosing between internalisation/self-inhibition and re-experiencing structural trauma (Wilton 2004, Ahmed 2006). For queer women, 'coming out' means more than just declaring difference. It entails coming out of a centred positionality that offers safety to those who maintain alignment with the norm. Consequently, it may be safer to be invisible in the centre than to come out as queer in spaces that assume heterosexuality.

Reflecting on strategies of control in spaces that reinforce the constructions of heteronormativity, reproduction, maternity and femininity become an ideal milieu to begin building a body of evidence that can challenge dominant models of care and reductive concepts of difference. Nurses can begin to convey a desire to understand the harm inflicted by oppressive systems of power through acknowledging that current structures traumatise through

UNCORRECTED PROOF

© 2017 John Wiley & Sons Ltd

exclusionary and marginalising processes. Given the phenomenological nature of our research and its interpretation, it is necessary to situate the evidence within both feminist and queer theoretical frameworks to construct and support a larger context of understanding for healthcare practitioners. Through an awareness of the structurally traumatic process of coming out as queer in opposition to the expectation of heterosexuality, nurses can begin to identify opportunities in harm reduction that would avoid retraumatising queer women who attempt to gain access to equitable health care. Recognising the challenges associated with negotiating structural relations of power (Aston *et al.* 2015) centres and validates the structurally traumatic experiences of marginalised populations. Further, this approach fosters the development of clinical strategies that intend to avoid retraumatisation through reconstructing the coming out process, validate diverse experiences through acknowledging the potential for difference and create a broader context for care provision within perinatal health.

Phenomenological methods: engaging, collecting and analysing participant chronicles of care

Phenomenological interviews with thirteen people who self-identified as members of the Lesbian, Gay, Bisexual, Queer, Pansexual and Two Spirit (LGBQP2S) communities provided the narrative data that informed the analysis by which strategies in providing trauma-informed, patient-centred care were developed. We refer to plural LGBQP2S communities in an attempt to attend to the diverse experiences found within what may be commonly referred to as the 'queer community'. Sharing a broad range of experience across sexual and gender identity, participants are referred to as 'queer' with an acknowledgment that many do not identify with or accept this largely contested term. It can be assumed that the use of the word queer in this work aims to encompass the diverse experiences found within the LGBQP2S acronym.

The sample was diverse with respect to intersections of identity including race, socio-economic status, education, age and queer identification. One participant identified as First Nations, one as African-Nova Scotia/White person, another identified as Scottish/French/First Nations, and the remaining ten participants identified as White. The spectrum of socio-economic status ranged from working poor to upper class with the majority of participants identified as working class. Educational backgrounds were equally diverse, ranging from GED to PhD preparation. Ages varied from 18 to 42 years. All participants lived in rural NS during their birthing experience. At the time of their birthing experiences, some participants had male partners, some had female partners, and others had no partner. At the time of the interview, no participants were partnered with a male identified person in a monogamous relationship. For many, self-identification was fluid as they spoke about different times in their lives. This small, purposeful sample of women participants shared their experiences of birthing in rural Nova Scotia which aligned with phenomenological qualitative research, making use of interpretive experiential accounts to gain insights into the subtleties of the 'phenomena under investigation' (Goldberg *et al.* 2011, p. 176).

'[D]ialogical and conversational' (Goldberg 2005, p. 402) interviews served as the medium by which experiential data were obtained for phenomenological analysis. The semistructured nature of the interviews involved questions around the experiences of participants with their perinatal care providers in the context of rural Nova Scotia, how or whether they interpreted their queer identity to have influenced their birthing care, the atmosphere of the birthing spaces they occupied and whether other intersections influenced the provision of care and to share their interactions with perinatal care providers (Heyes *et al.* 2016). Health Research Ethics Board approvals from relevant institutions from across the province of Nova Scotia, Canada, permitted participant recruitment through advertisements that were shared in a variety of settings, including clinics, hospitals, community bulletin boards, social media and various queer events. Participants were also recruited by word of mouth. A website was developed to provide context to potential participants around the intent behind the study, including biographies for members of the multidisciplinary research team.

Semistructured interviews at a date, time and place of mutual convenience were conducted either in person or by telephone by a member of the research team. Interviews lasted 60–90 minutes and participants consented to confidential transcription of audio-digital recordings of their interviews which were submitted to the transcriptionist using pseudonyms so as to reduce the risk of identification. The research team analysed the transcripts along the four existential themes of body, time, space and relation (van Manen 2011). The diverse and complex lineage of understanding as articulated through existential philosophers is taken up in our work through feminist and queer experiences to extend our analysis and redress the ways in which power, oppression and heteronormativity were absent in the original writings. Situated data related to our understanding of queer rural birthing across the theme of spatiality offer insights into how the power associated with the provision of perinatal care uniquely affects queer birthing

UNCORRECTED PROOF

© 2017 John Wiley & Sons Ltd

women and how perinatal providers can reconstruct spaces that would avoid recreating the structurally traumatic process of coming out as queer in opposition to the expectation of heterosexuality.

Findings: practitioner (re)orientation and questioning current models of patient-centred care

In what follows, feminist phenomenology serves as an applied methodology that weaves our literary analysis into a storied text of interpretive experiential findings that are not dictated by the objectifying positivist constraints of other methodologies (van Manen & Higgins 2016). In so doing, we validate structural trauma as a strategy in reconstructing the process of coming out as queer in heteronormative birthing spaces. Reconstructing the coming out process conveys an awareness of care providers in 'understanding something as a living moment *in its livingness*' (van Manen & Higgins 2016, p. 6) and for those whose identities have been shaped by structural trauma, this reconstruction of formerly disempowered identities (Crenshaw 1990-1991) would create centring spaces that aim to validate diverse experiences.

Withholding birthing spaces for queer: lack of validation for difference

The privileging of heterosexuality positions queerness as deviant from dominant sexual practices (Ahmed 2006). For women, the pressure of the heteronorm 'is profoundly damaging, and means that women struggle against a kind of cultural void when piecing together a sexual identity' (Wilton 2004, p. 181). Those who have yet to come out to themselves or who have not questioned their own membership in relation to the heteronorm are typically isolated from alternate and/or diverse expressions of femininity (Wilton 2004). Women thus construct their identities around structurally coercive conditions that can have significantly traumatising effects. The structure employs various political, social and cultural policing strategies to protect normative spaces from threats that aim to realign individuals with the heteronorm, strategically distancing them from an ability to access knowledge about the potential for difference (Wilton 2004, Ahmed 2006). This is illustrated by Victoria, one of the participants in our study when she knew she was different at a young age. She stated the following:

> I classically knew there was something wrong. Not really wrong but that was the perception, there was something wrong, there was something different, yet. And just through a combination of events, buried it, hid it, stuck to the norms of society.

She continued to reflect upon her partnerships with men: 'This is just not me. And that just played over and over and over in the years, that these relationships are not making me happy'.

Not unlike Victoria's words, members of queer communities exemplify the risk of structural trauma. Even prior to an awareness of being queer, individuals can reinforce the societal denial of queerness by making the ability to present as normative by internalising difference into a strategy in self-preservation (Young 2005, Ahmed 2006). Another participant, Estelle, supported this strategy by protecting herself from the trauma that the structure threatens: 'At the time I didn't fully know or want to admit my queer identity'. Thus, the closeted queer becomes a structural resource to extend the reach of heteronormativity, insofar as self-denial embodies larger structural policing strategies that do not allow for difference (Ahmed 2006). If difference emerges, it must therefore be pushed to the margins in order to maintain a normative centre as explained by Victoria when she suggested: 'you oftentimes feel like you're part of the "them" culture instead of part of the "us" culture. [...] It's a form of othering. And I feel securely that I've been allocated to the "other"'.

There is a medical legacy of marking difference (Wilton 2004). At its most detrimental, medicine marked queerness as pathologically different (Wilton 2004). Contemporary policing strategies within medical contexts are, however, subtler, and instead of marking queerness as pathological, it is made invisible (Wilton 2004). Assumed heterosexuality within medical spaces carries a threat to queer women who must access healthcare services (Wilton 2004), placing dangerous limitations on opportunities for embodied difference. Marginalised communities that are at risk for structural trauma must often employ strategies to cope with, internalise, avoid and/or deny retraumatisation, which results in the health disparities that are disproportionately identified in certain populations (Quiros & Berger 2015). Maggie's healthcare provider, for example, failed to address her difference or her specific health needs as a queer woman in the context of the study. Thus, she said, 'Nonetheless, my opinion is that I don't know if my doctor really clues in that I'm a lesbian or not. I have no idea'.

In rural birthing contexts explored in our study, the majority of participants spoke about a lack of consistency around acknowledging the potential for difference, creating an uncertainty around safety and for example, how Kate and her partner could safely occupy space:

UNCORRECTED PROOF

For the most part, people didn't really acknowledge it in any other way. And so you don't know whether to interpret that as they're not acknowledging it because they're acting like it's normal or they're not acknowledging it because they don't recognize it, or you don't know what the reason is.

Regrettably, as evidenced by the majority of participant narratives, current practices were not equitable insofar as they failed to potentiate difference. Thus, queer invisibility in health care merely reproduced the structural trauma around which the identities of queer women were constructed.

Perinatal care providers could become reflexive agents though acknowledging and addressing structural trauma by exploring how a lack of awareness around the power and privilege that is afforded by their structural positionality contributes to the invisibility of other ways of being in the world (Goldberg 2015). Through displacing this power and privilege, perinatal care providers can reconstruct birthing spaces by disrupting heteronormative practices and empower queer women who, now having no need to come out in opposition to heteronormativity, would remain at the centre of care. Kate shared the challenging situation of navigating a birthing space that was not reconstructed by reflexive perinatal care providers:

And so I felt a little disempowered and had to struggle a little bit with that, and tell myself that it was okay to ask questions or to say no or to... You know, I felt a little bit at the mercy of the medical system.

Situating participant narratives within a feminist and queer phenomenological framework provides a lens to understand how experiences of women (within a broader socio-cultural-political context) are often constructed through harms of heteronormativity, gender bias, discrimination and oppression that are inherent to healthcare practices. Systems of care fail to demonstrate the dualistic nature of trauma (individually and socio-cultural-politically) when the potential for difference is not recognised (Quiros & Berger 2015). An awareness of the larger socio-cultural-political context that affects the daily lives of marginalised people on both individual and collective levels (Quiros & Berger 2015) is a necessary reconciliation for perinatal care providers if they are to engage safe and inclusive care models. Current evidence continues to illustrate the pervasiveness of systematic heteronormativity within institutional healthcare spaces that exemplify how structural retraumatisation and the policing of normative spaces often entail an intentional failure to partner with difference (Wilton 2004).

Potentiating difference: validation as a practice that reconstructs the centre (of care)

Women are socialised to interpret their experiences through a relational privileging of the male perspective (Young 2005) which invalidates feminised ways of being in the world. This would suggest that validation is an important part of the female experience and a point of leverage when fostering therapeutic partnerships within institutions of power and privilege. The potential benefit in validating queer women through acknowledging structural trauma is that it would begin to provide meaning to the challenges associated with interacting with a heterosexist structure. Perinatal care could be a positive source of validation for marginalised individuals, however, to provide such validation a transformative redressing of current systems of harm is required. Victoria explains how the pervasiveness of the structure invalidates the queerness of women and the challenges associated with disembarking from the heteronorm. She stated the following:

[W]hen I came out to him [her father], he said, 'Oh, it's just a phase. You'll get over it.' [...] And that's just, you know, not just him and not just the health care, that's the way a lot of people look at it.

Failure to acknowledge the potential for difference is invalidating insofar as it fails to address the structural challenges associated with marginalisation. Heterosexism has been found to significantly influence trauma-related symptoms of lesbians (Brown & Pantalone 2011). This is mirrored in health practices by heteronormative models of care that do not address the needs of certain marginalised populations through denying the possibility of queerness. A lack of awareness around the risks of retraumatising structurally marginalised patients is illuminated by Jackson who shared how a failure to potentiate difference informed the inherently vulnerable birthing experience:

There was no access to any type of midwifery services, any type of spiritual practices, or any person that would go into the labour to talk about anything - spirituality, gender, sexuality, comfort, comfortability being naked and what the boundaries are for this person who's about to expose their body and to give life.

Evidence suggests that trauma survivors who are socially excluded suffer enhanced effects of their trauma (Nietlisbach & Maercker 2009); therefore, a lack of access to services that support the potential for difference goes beyond invalidation as it is exclusionary and contributes to the detrimental effects of marginalisation on communities that are at risk for structural trauma. Within the context of

UNCORRECTED PROOF

© 2017 John Wiley & Sons Ltd

perinatal care, heteronormativity excludes those who are queer and aims to realign them (Ahmed 2006) with expectations of heterosexuality that would enhance the effects of structural trauma.

The evidence on the importance of validation and what happens when women are invalidated in birthing contexts was compelling in our research. Skyler remembered... 'my contractions weren't very impressive...it was kind of discouraging. I wasn't laboring quick enough' Estelle admitted that she was 'left at the end with just an overwhelming sense of disempowerment' and Sally explained, 'I would tell them to have low expectations...My main advice would be to start out being open and honest about who you are to set the tone, and then to not expect very much. But that's pretty depressing advice'. Similarly, queer birthing women who had low expectations often considered their care provision very good when only basic needs were met (Goldberg *et al.* 2009).

Sending women who are new mothers home from the hospital with confidence is deeply validating and a uniquely empowering relational experience for queer women to share with care providers. Anne remembered:

> Just having a child, my emotions and everything were all kind of going crazy. And I was like worrying, oh my god, am I having postpartum depression or something? [...] And I mentioned this to the nurse, and she's just...She chuckled to herself and she said, 'Honey, you had a baby...' You don't need to...You know, you're not having postpartum depression. You're okay.' [...] And she was...You know, she made sure to bring him down. And she sat and visited with us for a bit. And you know, of course, told me how cute he was, and all that kind of stuff. And she just seemed to really, I don't know, be very reassuring. And she was an older nurse so it kind of seemed like she knew everything that was going on, and it really wasn't as big a deal as everybody else kind of made it out to be.

Healing at the centre: validation for creating collaborative and equitable care

Evidence suggests that validation and confidence can be found in women's birth plans; they have value for women and act as a form of protection. However, birth plans are not always viewed as positive by care providers, and as Welsh and Symon (2014) suggest, nurses have often jettisoned them upon arrival, viewing them as contrary to the normative scripts of birth (Moore & Hopper 1995). Yet, if providers are to cultivate practices that function in partnership with difference, care plans provide a potentially transformative collaboration between provider and birthing woman, particularly for those on the margins. As such, an engagement in practices that validate difference would promote the provision of relational and equitable care. In so doing, the provider and queer birthing woman offer a concrete form of consent, situated within a trauma-informed approach to care. Such strategies would assist providers in avoiding making assumptions about queer birthing women whose risk for structural retraumatisation is often heightened by accessing healthcare services. Approaching care with trauma-informed strategies would centre difference and broaden the scope of analysis, such that assessment skills would convey a sensitivity to and understanding of the potential for difference that is unavailable in current healthcare frameworks. Wyn elaborated:

> Okay, like I'm white, I'm female, I have a male partner who's the father of my baby. You know, like I could check off all of those things. But even then I was like this seems limiting [...] [b]ecause as soon as I say female, all these trappings go on me, some of which are accurate, some of which aren't.

Wyn so clearly reminds us that perinatal care providers, especially nurses who are often on the front lines, must expand their understanding of safety to include critical self-reflection and an awareness of the potential for difference. '[S]afe nursing care includes the recognition of social and political conditions of specific groups, while providing health care to people with different values and beliefs, so that a patient/family has no feeling of being devalued, demeaned, or disempowered' (Parisa *et al.* 2016, p. 35). This approach to safety compels nurses to move beyond fall risk assessments and putting up bed rails, to largely redefine accepted norms in health care and to include a consideration of the risk of structural trauma (Parisa *et al.* 2016). Safe nursing care could then involve strategies that would avoid retraumatising those who have experienced the structural trauma of being a queer woman in a heteronormative patriarchy. This would involve intentionally potentiating difference in birthing spaces so that women at risk would not have to come out as queer in opposition to heteronormativity because the centre of care would attend to the possibility of queerness. For queer women, this would validate non-normative experiences and begin to be in accordance with the mandate of patient-centred care. Wyn critically stated:

> And they were like, okay, no sex like for 48 hours before, or 72 or something like that. And at the time, I had a female partner. And so I was like...I didn't even think of it. I was like, okay. And then was getting ready...We were both going into get pap tests. And I was like...My partner was like, 'Okay, we can't have sex for 72 hours.' And I was like, 'That doesn't make any sense.' And she was like, 'But they said.' And I was like, 'No, I'm pretty sure they mean

UNCORRECTED PROOF

© 2017 John Wiley & Sons Ltd

> something else, that they weren't being specific about but they just said sex. Because the sex that we have is not necessarily relevant to what they're talking about.' And so I ended up calling them and being like, 'Hey, just out of curiosity, I'm queer, I have a female body partner, and you told me not to have sex before the pap test. What do you mean by that? Why?' And they were like, 'Oh, no, it's just sperm.' And I was like, 'Well, then use a different word. Use different language. Use different language because my partner just wouldn't have sex with me.' [...] So if I have a partner who has no sperm, it just didn't make any sense to me. And so I saw the crack in that, in that structure, and was like I'm going to look closer at that, break that open and see what's happening in there.'

Similarly, healthcare providers can identify inconsistencies in the structure and critically reflect on the potentially harmful effects towards those who are different. Thus, we can illuminate these cracks through validating queer women and transforming what are currently referred to as therapeutic relationships into partnerships that are developed through collaboration. For Wyn, this could have simply been in the form of using inclusive language explaining that sex with no sperm would not affect the results of her pap test. Instead, this narrative shows how invalidation failed to legitimise Wyn's experience and risked retraumatising her as she had to come out as queer in opposition to heteronormativity insofar as the potential for difference was not accessible at the centre of care.

By drawing on the experiences of participant narratives, strategies are offered that account for the structural trauma that many queer women have endured. Such strategies are relevant to clinical practice, particularly when understood within the broader body of evidence of decreased health outcomes of LGBTQ+ communities when compared to their heterosexual counterparts. These strategies offer potential to guide healthcare providers towards validating queer women by affirming their lived experiences in a context where the potential for difference is at the centre of care. Clinically collected assessment data can then be interpreted in a way that is not solely relative to dominant discourse. For queer women, this would avoid the retraumatising exercise of coming out as queer in opposition to heteronormativity and decrease the risk of being marginalised by dominant care practices.

Experience informed strategies for creating patient centring spaces

Trauma-informed collaboration for perinatal assessment

From the feminist and queer phenomenological narratives provided by the queer women participants, the following critical strategies have been developed for perinatal care providers in current practice with birthing women. These clinical assessment practices offer new strategies for holding space with marginalised individuals, particularly those who are queer, through creativity, caring practices and collaborative efforts that produce transformative knowledge for change. Healthcare providers including nurses can develop collaborative care plans that address the needs of individuals yet simultaneously account for structural risk factors that can be inextricably linked with health disparities of queer women. Trauma-informed collaborative assessment strategies carry a potential to engage in ethical endeavours that are outlined in the CNA code of ethics (2008) that call for systemic and structural change. Within a perinatal context, these endeavours would include addressing factors within the broader socio-cultural-political and historical context of queer embodiment that create barriers to health care and influence health outcomes (CNA, 2008) of queer birthing women. Critical strategies validate by recognising experience as legitimate evidence, intentionally centring queer women and providing health-related meaning to their experiences of structural trauma. Trauma-informed collaboration would provide an alternate perspective to 'do no harm' and avoid the potential to retraumatise, which is often associated with dominant perinatal healthcare models.

Health disparities within the context of perinatal care for participants were often governed by the provision of care that failed to account for structural inequities. For example, many participants felt they *had* to breastfeed; however, there was uncertainty around *how* they would do so successfully. Learning to breastfeed was found to be a difficult experience for many women (Benoit *et al.* 2016); however, for queer birthing women who must come out of a safe and affirming centre of belonging in opposition to dominant practices that assume heterosexuality, these challenges can become insurmountable. Provided in the next section are strategies that disrupt traditional understandings of nursing assessment and dominant health models which aim to broaden the current scope of analysis and offer a diverse context for the provision of equitable care. With each strategy, the tradition of hierarchical models of care is redressed as collaborative partnerships within which providers gain knowledge around a patient's structural positionality. In so doing, these strategies when taken together, centre difference by positioning patients as partners in their care and decrease the risk of structural retraumatisation involved with coming out as queer in opposition to heteronormativity. Practitioner knowledge, such as health promotion, disease processes and the determinants of health are thusly better informed as they connect structural risk factors to

UNCORRECTED PROOF

© 2017 John Wiley & Sons Ltd

possible and/or actual health disparities (Lim *et al.* 2013). The interpretation of data would follow the same process involved in creating traditional care plans (which queer women could then use as a form of protection in much the same way that evidence suggested birth plans were used by participants in the research); however, recommendations would be equitable insofar as they would support and validate diverse life experiences – creating culturally appropriate connections between what patients *have* to do to achieve better health outcomes.

Strategy one

Inspection: critical reflexivity and compassion in creating spaces with difference

Inspection must begin with creating a reflexive awareness which compels a critical understanding of the historical differential in power between perinatal care providers and patients. This further requires a recognition of how this can affect the ways in which queer women understand and manage their health and will be invaluable when considering the legacy of mistrust that must certainly continue to inform patient–provider interactions. Queer women engage in avoidant behaviours with regards to seeking professional advice about their health as these services are 'grounded in institutional and interpersonal assumptions that heterosexuality is the norm for relationships and any variation is considered deviant and subordinate' (Beagan *et al.* 2012, p. 46). Reflexivity must be developed around the positionality of perinatal care providers who are agents within an exclusionary heteronormative context that can be experienced as disempowering to those who identify as queer (Goldberg 2015). Self-reflexive practices, including Caring Science (Watson 2008), entail engaging 'in a creative dialogue and conversation, thus providing a new way of being-in-the-world with self, others, and the global community [...] [and an] understanding [of] how to embody authentic and trusting relationships; create innovative healing environments; and further develop a deeply moral sense of self' (Goldberg 2015, p 15-16). Within self-reflexive practices is found a transformative potential for nurses and other providers, insofar as a relational awareness can be employed as a strategy in disrupting normative assumptions and biases that inform the provision of perinatal care (Goldberg 2015). This strategy is crucial in establishing the delivery of respectful and equitable assessment questions that attend to the potential for difference through an awareness of the dangers associated with structural interactions that are often governed by heteronormative assumptions.

Strategy two

Palpation: comfort and inclusivity to hold space across difference

Unlike traditional palpation that uses the nurse's fingers to feel parts of the body during a physical assessment, the goal of palpation in strategy two is to expand these skills to further feel and touch across difference through a sense of comfort, safety and inclusion with queer women. Thus, to palpate in this assessment asks the nurse to further their knowledge with intentional attention to non-normative experiences that are made invisible by dominant models of care. Nurses must create an awareness around how questions can be used to create a space that would legitimise the experiences of queer women by making queerness available at the centre of care and avoid the problem of coming out as queer in opposition to heteronormativity. This would construct a bond of belonging between perinatal care providers and patients who are members of historically marginalised groups thus reconstructing caring spaces into sites of empowerment.

In the context of care provision with queer women, it will be important to ask inclusive questions such as, 'Would you like to tell me how you identify?' [Example answer: 'lesbian']. More specifically, for the inclusion of queer birthing women, providers must ask their perinatal patients, 'Would you like to share the relationship between your child and the person who provided the sperm for your pregnancy?' [Example answer: 'donor']. These questions centre a potential for difference insofar as space is made for alternative family structures – ones that are not solely between heterosexual couples. This particular question could be immensely validating for those who are currently not served under dominant models of care that assume heterosexuality. This strategic approach seeks mutuality insofar as it aims to convey an understanding that the nurse recognises the limits of their knowledge and invites the patient to collaborate as an equal partner in their care (Aston *et al.* 2015). This is a nontraditional use of palpation, and indeed the healthcare space, insofar as it centres and addresses the potential for difference through reciprocity (Aston *et al.* 2015). Collectively, this strategy advances the assessment of palpation to holistically touch the 'other' who is different thus constructing collaborative opportunities of validation for empowerment.

Strategy three

Percussion: relational partnering in holding space across difference

Building upon the tradition of percussing the body to assess underlying anatomical structures for abnormalities, the

UNCORRECTED PROOF

© 2017 John Wiley & Sons Ltd

intent of this strategy is to develop therapeutic partnerships that create better health outcomes by validating difference and associated structural trauma. Nurses can further expand their assessment skills through a nontraditional use of percussion that gains an understanding of underlying structural trauma and extends the context of care by validating differences that are made invisible by dominant health practices. In so doing, nurses reinforce the centring of queerness by reconstructing historical relations of power (Aston *et al.* 2015) and position patients as experts on their lived experience. Providers must convey that they understand their expertise and knowledge is limited and that without a broader scope of analysis, the potential for care is greatly reduced. Percussion involves creating a point of leverage that elicits more information to better situate the findings of traditional assessment techniques. In other words, validation is used as an intervention that determines the context in which the data is situated. Examples can include, 'Are there any terms associated with being a [lesbian] that I can use that would make you feel safer or that you would like me to avoid?' and specific to perinatal care: 'Are you comfortable sharing the current relationship between you and the [donor] of your child?'.

Strategy four

Auscultation: active and reflective listening to maintain space across difference

Traditional skills in auscultation could be applied in a way that would move nurses beyond listening to anatomical systems of organs and extend assessments to consider sociological systems of trauma. Necessitating the ongoing use of active listening, data are purposefully and respectfully obtained then situated within a larger context of care, lending greater insights into the meaning behind the lived experiences of queer women and how they understand their health. This suggests to patients that collaboration and reciprocity are essential (Aston *et al.* 2015) if care provision will address the unique needs of members from marginalised communities. Along points of affirmation created with care providers, the relationality between queer women and the structure (that in the past may have only acted to disempower them) is reconstructed. In a sense, strategy four is a therapeutic form of consent that aims to further foster a partnership of trust and affirmation between provider and patient. Collaboratively developed care plans that intend to protect those who are vulnerable against the inherent risk of accessing healthcare services thusly become the vehicles of equitable care. Moreover, as an agent of the structure, the provider validates by acknowledging patient-identified factors of difference that may have been used in the past to marginalise them, making visible their structural trauma. Once active listening and reflection have provided adequate insight into how the nurse believes, they should conduct their physical assessment, statements that reflect the knowledge that a patient has shared throughout the encounter would inform how a collaborative assessment will maintain the patient-centred space and avoid retraumatising queer women. For example: 'From what you have shared about your experiences as a [lesbian], it is my understanding that you have specific needs that I hope to accommodate during the physical assessment. During the exam, I would typically explain what I am doing while I am doing it. If you may become uncomfortable or have any questions, you can stop the assessment at any time. Is it okay to begin your physical assessment?'

Conclusions in assessing a future in collaborating with difference at the centre (of care)

Validation in the form of acknowledging the potential for difference can be used as a strategy for those at risk for structural trauma because it mitigates the direct relationship between level of privilege and the associated differential in life-affirming opportunities for marginalised communities. Coming out as queer in opposition to heteronormativity moves patients from a place of belonging and out of the centre of care which reproduces the process of marginalisation that traumatises queer women when they initially admitted their difference and started the coming out process. Healthcare providers can be positive sources of validation and develop care plans that account for structural trauma. Much like birth plans, trauma-informed care plans can serve to validate and protect those who must access care within historically disempowering environments by positioning unique needs and legitimising lived experiences at the centre of care.

Supporting embodied difference creates new points of care insofar as it acts to avoid the need for queer birthing women to come out as queer in opposition to heteronormativity. Evidence suggests there is a tendency to assume heterosexuality in the context of health care which reveals a corresponding need to engage in equitable practices that would centre queer women through potentiating other ways of being in the world so that coming out to care providers is reconstructed into an affirming process. New assessment strategies such as the one offered above acknowledge structural trauma and develop a holistic context that holds the potential for difference. This would create a *practice of*

UNCORRECTED PROOF

© 2017 John Wiley & Sons Ltd

1 *difference* at the centre of care for perinatal care providers which would better focus nursing assessments and inform a provision of care that would enhance the health outcomes of queer women.

Relevance to practice: collaboration and trauma-informed perinatal care

A lack of awareness of the contextual factors that shape a patient's reality makes recommendations potentially detrimental and furthers the marginalisation of vulnerable populations. Evidence informed strategies would challenge traditional understandings of nursing assessment and dominant health models to create a context of care that would build therapeutic partnerships that reconstruct formerly disempowering relationalities between patients and their care providers.

Health disparities that are found disproportionately in marginalised communities are a call to action for nurses who aim to provide equitable, patient-centred care. Addressing structural trauma is an opportunity for nurses to politicise their practice in a way that would reconstruct perinatal care into a deeply validating and healing process for queer women. Trauma-informed care plans could connect the theoretical 'have to' and the practical 'how to' of the recommendations that queer women receive from their perinatal care providers. These strategies in trauma-informed care offer transformative potential within therapeutic partnerships that would forever revolutionise the concept of advocacy into collaborative learning experiences that are grounded in reciprocity.

Acknowledgements

The authors acknowledge the Canadian Institutes of Health Research (IGH), the Nova Scotia Health Research Foundation, the Nursing Research Fund (SON), and the Faculty of Health Professions, Dalhousie University for funding the research from which this paper has been developed. It is with our deepest gratitude that we thank the women who shared their birthing stories, as we aspire to honour the bravery and generosity by which they contributed to our research.

Contributions

XXXXXXX 8

Funding

Canadian Institutes of Health Research, Institute of Gender and Health. Nova Scotia Health Research Foundation. The Faculty of Health Professions and The School of Nursing, The Nursing Research Fund, Dalhousie University.

References

Ahmed S (2006) *Queer Phenomenology: Orientations, Objects*. Duke University Press, Durham, Others.

Aston M, Price S, Etowa J, Vukic A, Young L, Hart C, MacLeod E & Randel P (2015) The power of relationships: exploring how public health nurses support mothers and families during postpartum home visits. *Journal of Family Nursing* **21**, 11–34.

Beagan B, Fredericks E & Goldberg L (2012) Nurses' work with LGBTQ patients: "they're just like everybody else, so what's the difference"? *The Canadian Journal of Nursing Research* **44**, 44–63.

Benoit B, Goldberg L & Campbell Yeo M (2016) Infant feeding and maternal guilt: the application of a feminist phenomenological framework to guide clinician practices in breast feeding promotion. *Midwifery* **34**, 58–65.

Brown LS & Pantalone ???? (2011) Lesbian, gay, bisexual, and transgender issues in trauma psychology: a topic comes out of the closet. *Traumatology* **17**, 1–3. 9

Canadian Nurses Association (2008) *Code of Ethics*. ????, Ottawa, ON. 10

Crenshaw K (1990-1991) Mapping the margins: intersectionality, identity politics, and violence against women of color. *Stanford Law Review* **43**, 1241–1300.

Flagg AJ (2015) The role of patient-centered care in nursing. *Nursing Clinics of North America* **50**, 75–86.

Goldberg LS (2005) Introductory engagement within the perinatal nursing relationship. *Nursing Ethics* **12**, 401–313.

Goldberg L (2015) Cultivating inclusivity with Caring Science in the area of LGBTQ education: the self-reflexive educator. *Faculty Focus*, CULT **23**, 15–17.

Goldberg L, Ryan A & Sawchyn J (2009) Feminist and queer phenomenology: a framework for perinatal nursing practice, research, and education for advancing lesbian health. *Health Care for Women International* **30**, 536–549.

Goldberg L, Harbin A & Campbell S (2011) Queering the birthing space: phenomenological interpretations of the relationships between lesbian couples and perinatal nurses in the context of birthing care. *Sexualities* **14**, 173–192.

Heyes C, Dean M & Goldberg L (2016) Queer phenomenology, sexual orientation, and health care spaces: learning from the narratives of queer women and nurses in primary health care. *Journal of Homosexuality* **63**, 141–155. 11

Lim FA, Brown DV & Jones H (2013) Lesbian, gay, bisexual, and transgender health: fundamentals for nursing education. *Journal of Nursing Education* **52**, 198–203.

van Manen M (2011) *Guided Existential Reflection*. Available at: http://www.phenomenologyonline.com/inquiry/me

UNCORRECTED PROOF

thods-procedures/reflective-methods/guided-existential-reflection/ (accessed XX XX XXXX). [12]

van Manen M & Higgins I (2016) A conversation with Max van Manen on phenomenology in its original sense. *Nursing and Health Sciences, A Conversation with Max van Manen on Phenomenology in its Original Sense* **18**, 4–7.

Moore M & Hopper U (1995) Do birth plans empower women? Evaluation of a hospital birth plan. *Birth* **22**, 29–36.

Nietlisbach G & Maercker A (2009) Effects of social exclusion in trauma survivors with posttraumatic stress disorder. *Psychological Trauma: Theory, Research, Practice, and Policy* **1**, 323–331.

Parisa B, Reza N, Afsaneh R & Sarieh P (2016) Cultural safety. *Holistic Nursing Practice* **30**, 33–38.

Quiros L & Berger R (2015) Responding to the sociopolitical complexity of trauma: an integration of theory and practice. *Journal of Loss & Trauma* **20**, 149–159.

Watson J (2008) *The Philosophy and Science of Caring*, Rev edn. University Press of Colorado, Boulder.

Welsh J & Symon A (2014) Unique and proforma birth plans: a qualitative exploration of midwives′ experiences. *Midwifery* **30**, 885–891.

Wilton T (2004) *Sexual (Dis)Orientation: Gender, Sex, Desire and Self-Fashioning*. Palgrave MacMillan, New York.

Young IM (2005) *On Female Body Experience: "Throwing Like a Girl" and Other Essays*. Oxford University Press Inc, New York.

Zeiler K & Folkmarson Käll L eds. (2014) *Feminist Phenomenology and Medicine*. State University of New York Press, Albany, NY. [13]

UNCORRECTED PROOF

© 2017 John Wiley & Sons Ltd

Author Query Form

Journal: JOCN
Article: 13727

Dear Author,
During the copy-editing of your paper, the following queries arose. Please respond to these by marking up your proofs with the necessary changes/additions. Please write your answers on the query sheet if there is insufficient space on the page proofs. Please write clearly and follow the conventions shown on the attached corrections sheet. If returning the proof by fax do not write too close to the paper's edge. Please remember that illegible mark-ups may delay publication.
Many thanks for your assistance.

Query reference	Query	Remarks
1	**AUTHOR: Please provide author designation for all authors.**	
2	**AUTHOR: Please confirm that given names (red) and surnames/family names (green) have been identified correctly.**	
3	**AUTHOR: Please check that authors and their affiliations are correct.**	
4	**AUTHOR: Please check the telephone number for corresponding author.**	
5	**AUTHOR: Crenshaw, 1993 has been changed to Crenshaw 1990-1991 so that this citation matches the Reference List. Please confirm that this is correct.**	
6	**AUTHOR: Moore & Hooper, 1995 has been changed to Moore and Hopper 1995 so that this citation matches the Reference List. Please confirm that this is correct.**	
7	**AUTHOR: Opening quote has not been given for the closing quote in the phrase "break that open and see what's happening in there." in the sentence "And so I saw the crack…happening in there.". Please check**	
8	**AUTHOR: Please use author initials to indicate how each author contributed to the following categories in the process of the creation of your paper: (1) Study design; (2) data collection and analysis; and (3) manuscript preparation. Each author has to be mentioned in at least one category.**	
9	**AUTHOR: Please provide the givenNames/initials for the author Pantalone for reference Brown and Pantalone (2011).**	
10	**AUTHOR: Please provide the publisher name for reference Canadian Nurses Association (2008).**	
11	**AUTHOR: Please check the page number for reference 'Goldberg (2005)'.**	
12	**AUTHOR: Please provide Accessed date, month and year for 'van Manen (2011)'.**	
13	**AUTHOR: Zeiler and Folkmarson Käll (2014) has not been cited in the text. Please indicate where it should be cited; or delete from the Reference List.**	