

Lesbian and Gay Parents: Their Experiences of Children's Health Care in Australia

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This study investigates the experiences of lesbian and gay parents seeking health care for their children within the Australian medical system. Previously unavailable demographic data was collected on lesbian and gay families, and qualitative information was sought from parents about positive or problematic health care experiences related to sexual orientation and family constellation. Ninety-two lesbian or gay parents responded to a national postal and Web-based survey. Eighty-nine percent of respondents reported a high level of satisfaction with the health care received by their children. Despite overall satisfaction, however, 49 percent of parents identified fear of disclosure of sexual orientation, and 27 percent reported negative or problematic experiences with their children's health care related to sexual orientation or family constellation. This study indicates that fear of discrimination and homophobic attitudes towards lesbian and gay families remain a factor within the Australian health care system.

KEY WORDS: gay; lesbian; parents; health care; Australia.

BACKGROUND

A growing number of children in Australia have lesbian or gay parents. In 1996, the Australian Bureau of Statistics (1999) compiled data about same-sex couple families identifying 11,288 same-sex male couples and 8,296 same-sex female couples throughout Australia. Of these families, 275 same-sex male couples

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and 1,483 same-sex female couples declared living as couples with children. This included dependant children under the age of 15, and non-dependant children and dependant students (15–24 years of age). As the census did not seek specific information on sexual orientation, data about same-sex families was gained indirectly through questions correlating biological sex with types of relationship within households. This Census data does not include information on gay or lesbian lone-parent families, non-cohabiting same-sex parents, or those who do not openly declare their sexuality, and may significantly under represent the numbers of lesbian and gay families with children in Australia.

A review of the literature indicates that the health care system has not always met the health-related needs and concerns of lesbians and gay men, and a significant proportion of health care providers still hold prejudiced views and condemnatory attitudes towards lesbians and gay men (Schwanberg, 1996; James, Harding, & Corbett, 1994; Rose, 1994; Eliason & Randall, 1991; Harvey, Carr, & Berrnheine, 1990). Homophobia, stereotyping, and stigmatisation by health professionals appear as crucial factors in the experiences of health care for gay men and lesbians (Morrissey, 1996; Baker, 1993). When their sexual orientation is known, gay men and lesbians have reported embarrassment by care providers, fear, ostracism, refusal to treat, demeaning jokes, avoidance of physical contact, rough physical handling, rejection of partners and friends, invasion of privacy, breaches of confidentiality, and feeling at risk of harm (Harvey, Carr, & Berrnheine, 1990; Stevens, 1994; Mackereth, 1994). For lesbians, these negative experiences have impacted upon readiness to seek medical care, causing delays in seeking treatment, fear of disclosure of sexual orientation, feelings of anxiety, vulnerability, and fears of discrimination (Trippet & Bain, 1992).

A proportion of lesbian and gay patients will also be parents, but the extent to which such one-off or repeated negative experiences impact upon self-esteem, parenting skills, and readiness to seek health care for their children is unknown. The extent to which children experience negative attitudes towards their homosexual families is also unknown. It is, however, recognised that children in lesbian and gay families develop and attain socially and academically on par with their peers in heterosexual families (Patterson, 1992).

As more gay men and lesbians openly declare their relationships, health care providers will increasingly become aware of children with at least one parent who is gay or lesbian. Stigmatisation and homophobia surrounding lesbian and gay families can translate into unique difficulties for which assistance may be sought from the health care system. These may include issues concerned with conception choices and family constellation, “coming out” issues, family breakdown or separation, issues of custody and legal rights particularly for non-biological parents, lack of social acceptance, or overt social disapproval for lesbian and gay families and the impact of this on children (Nelson, 1997; Eliason, 1996; Perrin & Kulkin, 1996; Gold, Perrin, Futterman, & Friedman, 1994; Kenney & Tash, 1992; Gentry, 1992; Clay, 1990; Deevey, 1989).

The National Lesbian Family Study, a longitudinal study of 84 lesbian families in North America, is currently under-way. Lesbians who were actively trying to get pregnant or already pregnant were recruited for the study between 1986 and 1992. They were initially interviewed during their pregnancy, and they will be interviewed again when the child is 2, 5, 10, 17, and 25 years old. The children will also be interviewed from the age of ten. The first results reported that the prospective children were highly desired and thoughtfully conceived (Gartrell, et al., 1996), and the second report on interviews as children turn two raised the issue of homophobia in the health care system indicating that 23 percent of the mothers had experienced some homophobia from health care providers during their pregnancy (Gartrell, et al., 1999).

The study reported here was undertaken to gather information about the experiences of lesbian and gay families specifically within the Australian context and medical system, and it sought to inform Australian doctors and health professionals about the needs of gay and lesbian parents seeking health care for their children.

An earlier North American study surveyed 255 lesbian and gay parents in relation to their children's health care (Perrin & Kulkin, 1996). This study found the most positive findings to date with eighty-six percent of parents reporting affirming health care experiences with their children. Seventy-seven percent had disclosed their sexual orientation to paediatricians, and those who had not disclosed their sexuality were no more prone to negative experiences. Problematic experiences related to a lack of understanding and acceptance of same-sex parents, generalised homophobia, and the need to constantly re-explain family constellation to staff.

This study examines the experiences of lesbian and gay parents seeking health care for their children within the Australian medical system.

METHODS

The study recruited two sub-samples of respondents throughout Australia. Both groups self selected to participate in a study utilising a mail out or Web-based questionnaire available on the Internet. Respondents gained information and publicity about the study and survey through lesbian and gay groups and publications, newsletters, organisations, e-mail, and on the Web pages of two existing lesbian- and gay-friendly organisations. A total of 400 questionnaires were distributed to individuals and groups throughout Australia, and the Web survey was available on-line for a period of six weeks.

It has long been recognised that the lesbian and gay population can be difficult to sample. This study depended on reaching lesbian and gay parents via their existing networks and on the goodwill of individual and group contacts to distribute surveys. It is, therefore, possible that the study primarily represents those parents who are more open about their sexuality, and that those who did respond had

some particular motivation for responding. Nonetheless, the method was consistent with other similar studies (Trippet & Bain, 1992; Perrin & Kulkin, 1996; Turner, Scadden, & Harris, 1990), and given that no prior research of this kind has been conducted in Australia, within these limitations of sampling and generalisability, it remains worthwhile to describe the experiences of lesbian and gay parents in this study.

The questionnaire sought to gain demographic data on lesbian and gay parents seeking health care for their children and qualitative data on their experiences in the health care system. The questionnaire contained 10 questions requesting demographic information, 2 concerning satisfaction with care, and 7 open-ended questions seeking information about disclosure of sexual orientation to health care providers, affirming or supportive experiences, difficult or problematic experiences, and suggestions for improvements in health care for children.

Quantitative data was analysed using a computer statistical software package (SPSS 6.1) for the calculations of frequencies, distribution, statistical significance, and cross tabulations. The qualitative data was analysed using a thematic analysis based on the procedures and techniques of grounded theory.

RESULTS

Respondents

A total of 92 responses were received. Seventy-nine respondents returned mail surveys (minimum response rate of 19.75 percent as we cannot be sure how many of the 400 paper questionnaires were distributed to individuals), and 13 responded through the Web-based survey. As summarised in Table I, the sample population had a high level of educational attainment, a mean age of 38 years, and a mean income of \$30,171. Respondents lived in six States or Territories across Australia with no respondents from the Northern Territory. Sixty-four percent of respondents were living as lesbian couples. Twelve percent identified other varied or more complex family constellations including lesbian couples co-parenting with gay couples or donors.

Table II indicates that 46 percent of first-born children had been conceived through donor insemination, and 44 percent had been conceived in the context of a prior heterosexual relationship. A total of 167 children were identified in the study ranging in age from six weeks to 36 years, with 107 (64 percent) of children aged 12 years or under.

Health Care Settings and Providers

Seventy-five percent of families obtained regular health care for their children from a general practitioner (GP), 2 percent identified a paediatrician as their

Table I. Demographic Information

	<i>n</i>	%
Family Constellation		
Lesbian couple	59	64.1
Lesbian single mother	17	18.5
Gay couple	4	4.3
Gay single father	1	1.1
Other	11	12
Income		
<\$10,000	11	12.1
\$10,001–\$20,000	26	28.6
\$20,001–\$30,000	17	18.7
\$30,001–\$40,000	13	14.3
\$40,001–\$50,000	16	17.6
>\$50,001	8	8.8
State or Territory of Residence		
NSW	31	33.7
VIC	17	18.5
SA	8	8.7
WA	9	9.8
NT	0	0
QLD	6	6.5
ACT	15	16.3
TAS	6	6.5
Indigenous Australians	5	5.4
Respondents Highest Education Level Completed		
Year 10	7	7.6
Year 12	4	4.3
TAFE/CIT qualification	15	16.1
Tertiary undergraduate degree	22	23.9
Tertiary postgraduate qualification	37	40.2
Other	7	7.6

child's regular health care provider, and 22.8 percent indicated that other health care professionals (including homeopaths, naturopaths, and nurse practitioners) provided regular health care for their children (see Table III). Some families indicated that regular care was provided by their GP in conjunction with a paediatrician or complementary therapist.

Satisfaction with Health Care

Satisfaction ratings were summarised according to health care setting and provider (Table IV). Eighty-nine percent of lesbian and gay parents reported being satisfied to very satisfied with the care received from general practitioners, 62.3 percent with paediatricians, 61.4 percent with emergency departments, and 60.4 percent with all medical and nursing staff during hospital admissions. Dissatisfaction

Table II. Conception Background and Ages of Children ($n = 167$)

	Child 1 <i>n</i> (%)	Child 2 <i>n</i> (%)	Child 3 <i>n</i> (%)	Child 4	Child 5
Conception Background					
Donor insemination	43 (46.7)	9 (9.8)	2 (2.2)	1 (1.1)	0
Heterosexual relationship	41 (44.6)	33 (35.9)	15 (16.3)	5 (5.4)	2
Adoption	1	0	0	0	0
Foster child	1	0	0	0	0
Other	4	2	0	0	0
Missing data	2	4	2	0	0
Total	92	48	19	6	2
Age of Children					
<1 y	6	1	0	0	0
1–5	22	8	2	1	0
6–12	34	21	9	3	2
13–20	23	14	4	1	0
>20	6	3	2	0	
Unknown	1	1	2	1	
Total	92	48	19	6	2

Where data was missing, the percent reflects the proportion of valid responses in each category.

was reported by 15.8 percent of respondents with emergency departments, 11.4 percent with paediatricians, and 11.3 percent with medical and nursing staff during hospital admissions. We are unable to say if the overall high levels of satisfaction reflects protective strategies in relation to lesbian and gay health care users—in particular, the careful screening and choice of regular health care provider—and whether lack of choice of health care provider in respect of paediatricians and hospital settings underlies higher levels of dissatisfaction in these areas.

The data does suggest that if parents were satisfied in one type of care setting, they were more likely to be satisfied in all other settings. No statistically significant relationship was found between income and educational attainment and the level of satisfaction with care. Those who had completed year 10 or technical college (TAFE/CIT) education, however, had slightly lower overall levels of satisfaction.

Eighty percent of parents indicated that their levels of satisfaction were similar for all children. Those who indicated differences in satisfaction of care for children in the family related dissatisfaction to several factors: children with complex or long-term medical needs, dissatisfaction with medical care irrespective of any

Table III. Regular Health Care Providers

Regular health care provider	<i>n</i>	%
General practitioner	69	75
Paediatrician	2	2.2
Other	21	22.8

Table IV. Overall Satisfaction with Health Care Providers in Various Settings

Satisfaction rating	General practitioner (%)	Paediatrician (%)	Emergency department (%)	Medical and nursing staff (on admission) (%)
Very dissatisfied	0	4.4	3.5	3.8
Dissatisfied	3.3	6.7	12.3	7.5
Neither	7.7	26.7	22.8	28.3
Satisfied	40.7	26.7	36.8	32.1
Very satisfied	48.4	35.6	24.6	28.3

discussion of sexuality, problematic issues within the health care system itself (waiting times, availability of regular care provider, busy staff, or inadequate care); and issues related to perceived homophobia of health care providers (including questioning motivations for having had children and exclusion of non-biological parents).

Sexual Orientation: Disclosure, Non-Disclosure, and Experiences of Care

Despite high levels of satisfaction with care, 49 percent of parents reported fear about disclosing their sexual orientation to their children's health carers. Lesbian and gay parents feared that disclosure might affect the treatment of the child or the response they received as a parent. Concerns were expressed about possible homophobia including judgmental attitudes about a parent's ability to parent. Several parents questioned how and when it was appropriate to disclose sexual orientation in paediatric health care encounters, some indicating they made judgements about disclosure on a need to know basis.

The majority of parents (76.7 percent) in this study had disclosed their sexual orientation. A number of factors were identified as influencing the decision to disclose sexual orientation when seeking health care for their child. These included a belief that it was relevant to the care of the child and a political commitment to being out and open about one's sexuality. This was closely linked with a desire to be honest so the child did not feel their parents' sexuality was wrong, and to have an open, trusting relationship with their child's regular health care provider in which their partner was fully included and recognised as a co-parent.

Respondents identified advantages of both disclosure and non-disclosure of sexual orientation and family constellation. Advantages of disclosure were reported to include better relationships with health care providers, which enabled open communication allowing health care providers to complete accurate information about the child and their family. Disclosure also enabled partners to be included in consultations as providers of information and valued partners or co-parents. Some respondents stated that disclosure of family constellation had the potential

Table V. Satisfaction versus Disclosure and Non-Disclosure of Sexual Orientation

	Yes	No
Disclosure of sexual orientation to regular health care provider	<i>n</i> = 69 (76.7%)	<i>n</i> = 21 (23.3%)
Satisfaction with GP	<i>n</i> = 63 (92.6%)	<i>n</i> = 16 (76.2%)
Satisfaction with paediatrician	<i>n</i> = 25 (71.4%)	<i>n</i> = 3 (30%)

to provide affirmation for the child thereby reducing the stigma of same-sex couple relationships experienced by some children in the broader community.

The rates of disclosure found in this study are similar to those reported in the study by Perrin and Kulkin (1996) but higher than disclosure rates reported in other lesbian populations (Lehmann, Lehmann, & Kelly, 1998). Other research confirms that “most lesbians and gays believe their health care would be of higher quality if they could safely disclose their homosexual identities” (Harrison 1996). This is supported in this study in that if respondents had disclosed to their regular health care provider, trends indicated that they were more likely to be satisfied with the care they received (see Table V).

Those parents who had disclosed their sexual orientation and described positive experiences related these to the way health care providers responded to their children and themselves as lesbian or gay parents, affirming their family constellation. Positive experiences were reported in relation to health care providers who were perceived as respectful, warm, attentive, supportive, caring, and professional.

The 23 percent of parents in this study who had not disclosed their sexual orientation to their regular paediatric health care provider indicated that they saw no advantages of disclosure. Non-disclosure was related to a belief that sexual orientation or family constellation was not relevant to their child’s care or to avoid judgements, homophobia, potential discrimination, and the need to educate health care providers about same sex relationships. Some respondents felt that non-disclosure would ensure equal treatment for their children.

The 27 percent of respondents who reported negative or problematic experiences, related to disclosure of parental sexual orientation or family constellation, reported experiences involving discriminatory, judgmental, and homophobic attitudes from health care providers. This included inappropriate, invasive, or excessive questioning about the child’s family of origin and current family constellation, lack of recognition of non-biological parents, and assumptions about universal heterosexuality.

Suggestions for Change

Suggestions by respondents of ways in which health care providers could enhance the paediatric health care encounter for lesbian and gay families and their

children included recognising and affirming a diversity of family constellations and not assuming that all parents are heterosexual. Similarly, some parents felt it was important not to assume that the significant people in a child's life were biological parents. Some parents expressed the view that health care providers still needed to educate themselves about lesbian and gay issues, such as the impact of homophobia, the lack of public recognition of same sex relationships, and the difficulties this raises for their children within the broader community. Finally, suggestions focused on the use of inclusive language and changes to medical documentation that did not presume heterosexuality or nuclear families as the only legitimate family type.

DISCUSSION

Paediatric health care providers can play a crucial role in creating supportive therapeutic environments for lesbian and gay families. There are a number of general practices and individual practitioners in Australia who have, no doubt, already carefully scrutinised their practice and who are committed to providing care for the lesbian and gay community. Others may only provide care to a small number of individuals and/or their families, and others may not knowingly provide care to any lesbian and gay individuals or families.

Small but significant changes to current practices can improve the sense of safety, acceptance, and openness experienced by lesbian and gay parents and their children with positive outcomes in terms of satisfaction with care. For example, this study revealed a complexity of family constellations in lesbian and gay families that may present difficulties for health care providers when taking family histories, particularly in naming or articulating roles for family members that do not conform to roles within heterosexual nuclear families. This study and other similar research (Stevens, 1994; Nelson, 1997; Perrin & Kulkin, 1996; Gold, Perrin, Futterman, & Friedman, 1994; Clay, 1990; Deevey, 1989) suggest strategies that health care providers could adopt to create supportive environments for lesbian and gay families including:

- the use of gender neutral terms such as "parent" or "partner" in communication;
- the use of language that avoids assumptions of universal heterosexuality in families, e.g., "To understand your child better, is there anything about your family that you think would be helpful for me to know?";
- written forms could similarly be structured to be inclusive of diversity;
- expressions of acknowledgment and understanding of parents' sexual orientation upon disclosure, providing reassurance that sexual orientation is respected by the health care provider;
- basic changes to clinic and hospital surroundings including the display of educational materials and images that reflect family diversity;

- acknowledgment of both parents or all carers of the child;
- becoming informed about the protection of relationships through wills and power of attorney; and/or making appropriate referrals;
- sympathetic and non-judgmental discussion of parental concerns about children including extra social pressures on children who may be experiencing stigmatisation, showing sensitivity to the special circumstances of children; and
- emphasising the strengths and resources of lesbian and gay families.

In the current era, a recognition of diversity and inclusivity needs to underpin developments in children's health care as long as issues of sexual orientation continue to elicit disparate and strong opinions. Health care providers may choose to act as advocates and allies to lesbian and gay parents by being informed about community resources, encouraging families to build strong support networks for their children, or reduce the impact of isolation. Families who experience themselves as outsiders for reasons of class, race, ethnicity, sexuality, or disability may feel particularly exposed and vulnerable in a range of health care settings. Recognising the extent of potential differences between the life-experiences of care-providers and care-seekers will equip health care providers to confront the limits of their social vantage point.

This study shows that health care providers, particularly general practitioners, are uniquely placed to assist lesbian and gay parents to counter negative community attitudes that may impact upon lesbian and gay families and their children. Health care providers can take small but significant steps to reduce parental fear of disclosure of sexual orientation and become allies to parents and children seeking health care within the Australian medical system.

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REFERENCES

- Australian Bureau of Statistics (1999). Census 96: Customized matrix tables.
- Baker, J. A. (1993). Critical issues and trends: Is homophobia hazardous to lesbian and gay health. *American Journal of Health Promotion*, 7(4), 255–256.
- Clay, J. (1990). Working with lesbian and gay parents and their children. *Young Children*, 45(3), 31–35.
- Deevey, S. (1989). When mom or dad comes out: Helping adolescents cope with homophobia. *Journal of Psychosocial Nursing and Mental Health Services*, 27(10), 33–36.
- Eliason M. J., Randall, C. E. (1991). Lesbian phobia in nursing students. *Western Journal of Nursing Research*, 13(3), 363–374.
- Eliason, M. J. (1996). Lesbian and gay family issues. *Journal of Family Nursing*, 2(1), 10–29.

- Gartrell, N., Hamilton, J., Banks, A., Mosbacher, D., Reed, N., Sparks, C. H., Bishop, H., (1996). The national lesbian family study: 1. Interviews with prospective mothers. *American Journal of Orthopsychiatry*, 66(2), 272–281.
- Gartrell, N., Banks, A., Hamilton, J., Reed, N., Bishop, H., Rodas, C. (1999). The national lesbian family study: 2. Interviews with mothers and toddlers. *American Journal of Orthopsychiatry*, 69(3), 362–369.
- Gentry, S. E. (1992). Caring for lesbians in a homophobic society. *Health Care for Women International*, 13(2), 173–180.
- Gold, M. A., Perrin, E. C., Futterman, D., Friedman, B. F. (1994). Children of gay or lesbian parents. *Pediatric Review*, 15(9), 354–358.
- Harrison A. E. (1996). Primary care of lesbian and gay patients: Educating ourselves and our students. *Family Medicine*, 28(1), 10–23.
- Harvey, M. J., Carr, C., Berrnheine, S. (1990). Lesbian mothers: Health care experiences. *Journal of Nurse-Midwifery*, 34(3), 115–119.
- James, T., Harding, I., Corbett, K. (1994). Biased care. *Nursing Times*, 90(21), 28–31.
- Kenney, J. W., Tash, D. T. (1992). Lesbian childbearing couples' dilemmas and decisions. *Health Care for Women International*, 13(4), 209–219.
- Lehmann J. B., Lehmann C. U., Kelly, P. J. (1998). Development and health care needs of lesbians. *Journal of Women's Health*, 7(3), 379–387.
- Mackereth, P. A. (1994). HIV and homophobia: Nurses as advocates. *Journal of Advanced Nursing*, 22, 670–676.
- Morrissey, M. (1996). Attitudes of practitioners to lesbian, gay and bisexual clients. *British Journal of Nursing*, 5(16), 980–982.
- Nelson, J. A. (1997). Gay, lesbian, and bisexual adolescents: Providing esteem-enhancing care to a battered population. *The Nurse Practitioner*, 22(2), 94–109.
- Patterson, C. J. (1992). Children of lesbian and gay parents. *Child Development*, 63, 1025–1042.
- Perrin, E. C., Kulkin, H. (1996). Paediatric care for children whose parents are gay or lesbian. *Pediatrics*, 97(5), 629–639.
- Rose, L. (1994). Homophobia among doctors. *British Medical Journal*, 308, 586–587
- Schwanberg, S. L. (1996). Health care professionals' attitudes towards lesbian and gay men. *Journal of Homosexuality*, 31(3), 71–83.
- Stevens, P. E. (1994). Lesbians' health related experiences of care and non care. *Western Journal of Nursing Research*, 16(6), 639–659.
- Trippet, S. E., Bain, J. (1992). Reasons lesbians fail to seek traditional health care. *Health Care for Women International*, 13(2), 145–153.
- Turner, P. H., Scadden, M. A., Harris, M. B. (1990). Parenting in gay and lesbian families. *Journal of Gay and Lesbian Psychotherapy*, 1(3), 55–66.