Lesbian Parents Negotiating the Health Care System in Australia

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Twenty Australian lesbian-parented families were interviewed in multigenerational family groups about the interface between their public and private worlds. Experiences of the health care bureaucracy were difficult, whereas many participants found individual providers to be approachable and caring. Three strategies were used for disclosure of their sexual orientation to health care providers: private, proud, and passive. Influences on the strategy used included family formation, role of the non-birth parent, geographic location, and expected continuity of care. Parents displayed a high degree of thoughtful planning in utilizing their preferred disclosure strategy in order to optimize safety, particularly for their children.
The health care experiences of individual lesbians have been well documented over the last two decades, particularly in North America (Koh, 2000; Stein & Bonuck, 2001) and also in Australia and New Zealand (Kelly, 2005; Saphira & Glover, 2000). Many of these are negative, including encountering health care providers who make assumptions of heterosexuality, lack lesbian-specific knowledge, or fail to recognize and understand the social context of lesbian lives (Robertson, 1992; Stevens, 1994b; Mathieson, 1998). There is a body of research that explores lesbian experiences of fertility care (Daniels & Burn, 1997; Jacob, Klock, & Maier, 1999) and maternity care (Olesker & Walsh, 1984; Zeidenstein, 1990; Wilton & Kaufmann, 2000), but little research exploring health care for lesbian-parented families. Some of the health care issues are likely to be similar to those now well documented for individual lesbians, for example, that “negative societal beliefs continue to be a major barrier that lesbian and gay families face” (Eliason, 1996, p. 13). It cannot be assumed, however, that lesbian parents’ health care experiences will be the same as those of individual lesbians. For example, one study showed that lesbian mothers had more difficulty accessing support systems than childless lesbians (Gartrell, Banks, Reed, Hamilton, Rodas, & Deck, 2000). Also, while individual lesbians repeatedly are reported to delay or avoid health care due to fears of negative responses, lesbian parents do not report avoiding health care for their children (van Dam, 2004).

Disclosure of lesbian orientation to health care providers (HCPs) is frequently raised as an issue by individual lesbian health care consumers (Robertson, 1992; Jordan & Deluty, 1998; van Dam, Koh, & Dibble, 2001; McDonald & Anderson, 2003). Some researchers suggest that coming out is an absolute requirement of effective health care and “is integral to the development of trusting relationships” (Johnson & Guenther, 1987, p. 237). Other studies have shown that disclosure is directly related to increased satisfaction with health care (Dardick & Grady, 1980; Mikhailovich, Martin, & Lawton, 2001), and is associated with the promotion of resilience and coping (Oswald, 2002). Disclosure is not desired or desirable in all encounters, however, and the decision to disclose or not within a health care setting is a dynamic and conscious one (Jordan & Deluty, 1998; Oswald, 2002). Stevens criticizes the reliance on disclosure as a sole measure of quality health care, finding that there is a range of other dimensions of the interaction that are just as meaningful, including an appropriate power balance, emotional respect, being valued as a person, a recognition of diversity, and having a voice (Stevens, 1994a). Again, there have been few studies exploring disclosure by lesbian-parented families in the health care system. In one Australian study involving 92 lesbian and gay families with 167 children, 49% of parents were fearful of negative consequences of disclosure, and 27% reported negative experiences with HCPs related to their sexual orientation (Mikhailovich et al., 2001). They identified a number of advantages of nondisclosure, including avoidance of discrimination and judgment, and avoiding the need to educate
providers. Some did not disclose, believing that their sexual orientation was not relevant. Those who had disclosed (77%), however, identified advantages of disclosure including the development of trust and the recognition of the non-birth partner as a parent; and 89% of gay and lesbian parents were highly satisfied with their child’s health care.

Lesbian-parented family experiences deserve more research attention to fully understand their different contexts and concerns. Lesbian mothers share a marginal existence by virtue of their nonheterosexual identity and a mainstream existence by virtue of their motherhood status (Hequembourg & Farrell, 1999). The legal situation in the state of Victoria, Australia, creates further marginalization. Lesbians and single women are not eligible to access clinic-based donor insemination; the partner of the lesbian birth mother is not legally considered a parent of their child; nor are lesbians eligible to adopt children. This legislation is currently under review by the Victorian Law Reform Commission, with recommendations to remove discrimination on the basis of sexual orientation and marital status with regard to access to assisted reproductive services and adoption. This article explores how lesbian parents negotiate the health care system. Lesbian-parented families pose challenges for HCPs, testing their potentially traditional perceptions of “family” by displaying diverse parental roles, diverse family constellations sometimes involving more than two parents, or incorporating the role of sperm donor(s) into the family. The findings of this study will assist in providing HCPs with a more in-depth understanding of lesbian parents. This was part of a larger study designed to develop theory, which previously has been lacking, about the experience of lesbian-parented families in their intersecting private and public lives (Muzio, 1993).

**METHODOLOGY**

This was a qualitative study using a grounded theory approach. Grounded theory was chosen as an appropriate methodology by which to generate theory within a relatively new research area. The study was unique in that multigenerational in-depth interviews were used to gain perspectives from both parents and children, and in some cases grandparents and donors. Interviews were nonstructured, which allowed for the story of how the family negotiated the interface between their private and public worlds to emerge, with family members able to make sense of their own experiences as they listened to one another’s views (Perlesz et al., 2006a).

In a grounded theory approach there is not a predetermined hypothesis; rather, we were interested to explore the experience of families from their perspective. The research question addressed in this article is how lesbian-parented families negotiate and deal with their interface with the health care system? Other findings from this study regarding education contexts, and
definitions and descriptions of family are reported elsewhere (Lindsay et al., 2006; Perlesz et al., 2006b).

Lesbian parents were recruited in one Australian state, Victoria. It can be notoriously difficult to recruit from stigmatized groups or “hidden populations” such as this one, so the sampling strategy followed established methods of purposive and snowball sampling via the lesbian community and professional networks (Plumb, 2001) to recruit potential participants. From this pool we used theoretical sampling to select a sample for maximum diversity with varied ages, family formation methods, ethnicity, class, and geographical location in urban, rural, and regional Victoria. The selected lesbian parents were invited to nominate which family members they wanted to be involved in a family interview, and all but one family with age-appropriate children included their children.

Sample
Twenty lesbian-parented families were involved in this study. Participants included 36 lesbian parents (aged between 29 and 62 years) parenting 43 children (aged 2 months to 38 years), 20 of whom participated in the study (aged 4 to 34 years). Three grandparents and two donors/fathers also were interviewed. The families were from a wide range of economic backgrounds (including one or both parents who were unemployed, on pensions, working part time or full time) and geographic locations (five families from rural Victoria, five from outer metropolitan Melbourne, and 10 from inner metropolitan Melbourne).

The families were ethnically diverse and included 11 families from Anglo-Australian backgrounds; two families with Australian Aboriginal backgrounds; two had members from Southern European backgrounds; three were from Northern European backgrounds; and three had Eastern European backgrounds. There were two families with Asian backgrounds and one with a Latino background. In 11 of the families, the children had been conceived in a previous heterosexual relationship (for these we use the term stepfamily), and in nine families children had been conceived within a lesbian relationship, which we have termed de novo families (McNair, 2004). Four of the lesbian parents, all of whom had children from a previous heterosexual relationship, were single at the time of the interview. All the children from de novo families were under the age of 7, with the exception of one 13-year-old.

Data Gathering
Written consent was obtained from all adults and for the children before they were interviewed. The families were interviewed in one single in-depth interview (lasting from one-and-a-half hours to 5 hours and sometimes
Data Analysis

All interviews were audiotaped and transcribed, and transcripts were sent to families for checking, none of whom requested alterations of the content. Transcripts were all deidentified by the interviewer before being sent to each member of the research team, including changes to all names, ethnicity, and locations. Analysis was carried out by two researchers using the constant comparative method according to the grounded theory approach (Strauss & Corbin, 1998). Codes were developed by the researchers independently, one using a manual, paper-based system and the other using N-Vivo qualitative computer-based software (Version 2, QSR International, Doncaster, Victoria, Australia) Initial codes represented specific positive and negative experiences with health care. These experiences then were clustered according to similarities. For example, disclosure emerged as one common category, with various subcategories. Having developed categories, the data were searched again looking for underlying meanings, for example, why particular disclosure patterns were used, and how disclosure patterns related to experiences of health care. Once theoretical constructs were being formed, both analyzers compared results and reached agreement on the final analysis presented below. Where quotations are used in the article the participants are identified using pseudonyms; their status as birth mother, non-birth mother, or child; and whether the children were born into a previous heterosexual relationship or within a lesbian relationship.

FINDINGS

Two key themes emerged from the data, one relating to experiences with the health care system and the other to levels of disclosure about the parents’ sexuality. These will be presented in turn. Overriding issues were safety and vulnerability and the level of choice and control over disclosure participants had within the health care experience. We have chosen to use Giddens’s Theory of Structuration as our theoretical framework for understanding control, and in particular Davis’s application of this theory to
the doctor–patient relationship (Davis, 1988). In brief, Giddens’s theory links the individual “agent” to the system in which they function (Giddens, 1987). The theory recognizes that individuals have agency, that is, that they are at least partially in control of their actions and partially can explain them. Some individuals influence the actions of others; however, within the invariable imbalance of power there is a dialectic of control, in which both sides retain some control. Davis suggests that this dialectic operates within the doctor–patient relationship, which provides a more complex understanding than the medicalization model, which claims that doctors are all powerful, particularly when the doctor is male and the patient is female. We analyzed participants’ discussion of health care interactions through the lens of the level of control that they indicated they had, specifically their control over information about their sexual orientation. Consistent with Davis’s work, the dialectic of control applies to this setting.

Experiences of health care were raised by parents in all but one family. With the exception of an 18-year-old and 34-year-old in one family, children did not discuss their experiences of health care. Some adult participants discussed dealing with the health care system, while the majority discussed experiences with individual HCPs.

Dealing With the Health Care System and Providers

The Australian health care system is centered on a primary care system, which is provided largely within general practice. This is funded through a mixture of public “Medicare” payments to general practitioners (GPs) for visits and approximately one-third of patients also are required to pay a “gap payment,” which is not covered by Medicare. Patients can select the GP and the practice they attend, and approximately 80% of the population attend a GP in any year (Australian Institute of Health and Welfare, 2004). Secondary and tertiary health care is provided through universal and free access to publicly funded hospitals as well as through a private hospital system. Approximately 35% of the population has private health insurance. There is a wide range of choice of HCP, from no choice in the public hospital system, to limited choice of GP in rural areas, and extensive choice in inner urban areas. A lack of choice can be very difficult for lesbian parents, especially if they face negative attitudes toward their sexual orientation and family structure.

The bureaucracy

Many parents regarded the health care system as a challenge, and many of these challenges were related to the lack of recognition of the existence of lesbian-parented families. For example, Helen, a non-birth mother of
adolescent children in a stepfamily in regional Victoria articulated her concerns:

There are no boxes that we fit into anywhere. . . . Interfacing with larger systems became difficult. . . . school, health, and finances I found the three most difficult areas.

The meaning of this challenge for Helen emerged a little later in the interview. Dealing with these systems highlighted to the family that they did not “fit” as they would have hoped:

We forget we are different, and it comes as an enormous shock when someone likes to remind us, . . . “oh God, forgot we are different.”

A number of examples were given of not fitting in when dealing with the health bureaucracy, including a lack of representation on data-collection forms and inability to access donor insemination. Some examples involved the failure of the system to recognize the non-birth mother as a legal parent, for example, the absence of the non-birth mother’s name on the child’s Medicare card, which is required when accessing publicly funded medical services. While this had been difficult for two families, another successfully had added the non-birth mother to the card. Others highlighted various inconsistencies in the way that the system dealt with lesbian-parented families. Some non-birth mothers were assumed to be the legal parent when they presented with their children. This often was neither clarified by the practitioner nor corrected by the non-birth mother at the time. Some parents were concerned about the legal ramifications of providing consent for medical procedures, however, particularly in an increasingly litigious society:

We spent a bit of time in the children’s hospital, and it was after that that we realized it was really important that we were both able to sign consent for him. Most people were terrific, but there was one doctor who wouldn’t give information to Janet (non-birth Mum). . . . We were the most vulnerable when Nathan was in hospital. (Maeve, birth mother, de novo family)

**Individual Health Care Providers**

Unlike the bureaucratic systems, which often were perceived to be inflexible and outdated, participants described a range of interactions with individual providers such as GPs, maternal and child health nurses, hospital midwives, and occasionally specialist doctors and counselors. While none of the participants in our study described overt homophobia, many described
heterosexist assumptions. For other participants, their HCPs did not embrace their sexuality immediately, but over time they did try to understand the social context of being lesbian. Tania, non-birth mother of a 2-year-old child in a de novo family described her experience of attending an antenatal class at an outer suburban hospital:

It was a bit challenging to some of the nurses who weren’t as aware and as comfortable with a gay relationship. . . . One in particular was a bit cold to me at first, and then . . . she was fine after all.

Other participants described more positive experiences: being accepted as normal, feeling respected, comfortable, or safe with their provider. These findings mirrored a “wish list” of sensitive lesbian care outlined by McDonald and Anderson (2003), that the provider should be respectful, recognize the woman’s partner, be informed, act as an advocate, and challenge myths. Some participants displayed willingness to help improve the awareness of their HCP. One couple related a reaction they had had from a doctor, and felt that it was “funny” but affirming:

A doctor at the women’s clinic (said). . . . “Oh I’m so glad I’ve met you because I’ve never known a lesbian family before and I would have had all these terrible ideas and, you know, I can see you really love your child and you are so caring, and I would have never known” . . . it was really quite amazing for her to see a “real” lesbian family and to realize . . . it is all very normal.
(Ella, non-birth mother, de novo family)

The failure of HCPs to recognize the birth mother’s partner as a parent was one of the most difficult experiences for many of the participants in this study. This also was found in a survey-based Australian study of 151 lesbian parents (Perlesz & McNair, 2004). In the current study eight of the families (six de novo families and two stepfamilies) gave explicit examples of the non-birth mother being ignored, rendered invisible, not regarded as next of kin, or deliberately excluded from decision making by HCPs. One couple (de novo family, living in rural Victoria) suggested that this was much more important to them than being recognized as partners, and highlighted their sense of vulnerability more generally:

Jacqui (birth mother): The doctor . . . just assumed that Fiona was the grandmother . . . Now, I would have expected better from a doctor than to make those sorts of assumptions.
Fiona (non-birth mother): Yes . . . when you have a child, then all of a sudden you are going out into the world with a child, then I’m in incredible tension. I’ve never felt unsafe around my sexuality . . . it’s now become a major issue for me [since becoming a parent].
Although most families who described the lack of recognition of the non-birth mother were de novo families, this also was experienced by two stepfamilies. One lesbian partner, Helen, did not describe herself as a parent, and yet she was still very much connected in a responsible and close relationship with her partner’s children (now aged 18–30 years). Helen had at times taken on a parenting role throughout the 10 years she and Nicki had been in a relationship:

_Helen:_ It’s been challenging, because it’s been hard to demonstrate that I have a legitimate opinion to anyone who is external to the family, about things that matter. For example, when the girls were having their babies, if I was to show up on my own, ... then I had to persist to try and get in because I’m not a family member, according to hospital rules, I can’t get in. . . . So that has been really difficult.

_Bianca_ (daughter, 18): And I’d kick up a stink and say, ‘Excuse me, let her in’.

**SAFETY AND VULNERABILITY IN THE HEALTH CARE SYSTEM**

Participants described two contrasting feelings in dealing with the health care system: safety and vulnerability. These issues are presented in more detail in another article (Perlesz et al., 2006b); however, they will be discussed briefly here in relation to health care. Positive experiences with HCPs tended to generate a sense of safety, while the negative experiences created vulnerability. The examples above show that a lack of recognition of the non-birth mother is a common basis for vulnerability, which is exacerbated when women do not feel that they could control or influence that recognition. McDonald and Anderson (2003) state that the health care system “should be a safe place for lesbians to authentically talk about their relationships with lovers, friends and family” (p. 708). This desire is reflected by some of the participants in our study, while others preferred not to speak about their family, even in potentially safe health care settings. Stevens describes a range of protective strategies that individual lesbians use in health care systems when they feel vulnerable or unsafe, including screening providers before attending, taking a support person, being vigilant, controlling the amount of information divulged, and escaping from the situation, but rarely challenging mistreatment (Stevens, 1994b).

Protective strategies of the participants in our study were very similar to those outlined by Stevens, despite the added context of being parents. Several described actively searching for a sensitive GP by screening the receptionist for appropriate attitudes, and asking for recommendations from friends:
Well, I rang the clinic and said, “OKay, I need to find myself a very open minded doctor,” and the receptionist said, “Well, they are all pretty open-minded. What do you mean?” I said, “Well, I’m part of a lesbian couple and we’re having a child together,” and she said, “Oh, OKay, I suggest Doctor so and so”...I felt OKay about going there because she didn’t seem at all taken aback by it. And he (the doctor) is OKay; he is a really great guy.
(Theresa, birth mother, de novo family)

Others presented together as a couple, the “united front,” to gauge reactions. One couple actively described their respective roles as birth mother and non-birth mother to their GP. Another participant working for a rural local council surveyed local family doctors’ knowledge of lesbian issues to assist lesbians in her area locate “user friendly” GPs. Others took a “pot luck” approach when attending a new doctor, with no preparatory work.

Reactions to vulnerability varied. Many participants did not challenge negative reactions when they felt vulnerable. For example, one couple had experienced a homophobic nurse following delivery of their child 2 years earlier:

We didn’t make a formal complaint....The problem is you are so vulnerable, and we hadn't slept....You lose a sense of power.
(Fiona, non-birth mother, rural de novo family)

Others who felt vulnerable changed HCP in response to negative attitudes. For example, Donna, a single mother of an 11-year-old, said she changed doctors because when she came out when she was pregnant “He was a bit strange about it.” None of the participants in our study, however, described delaying care or not accessing care at all. While avoiding HCPs may be an option for single lesbians, it is not really possible for lesbian parents when their child is sick. It can be seen that regardless of the perceived level of safety or vulnerability, participants exercised a measure of control over their health care experience, particularly in electing to change provider when needed. Actively determining whether they disclose their sexual orientation is another level of control, which will be presented in the next section.

Disclosure of Lesbian Sexuality Within the Health Care System

Disclosure emerged as a central theme and was raised by most participants. Lesbians accessing health care have different preferred levels of disclosure, depending on a number of factors. In one qualitative study involving 33 lesbians, four interactional or disclosure stances were described: passive disclosure, passive nondisclosure, active disclosure, and active nondisclosure
(Hitchcock & Wilson, 1992). From our study we have identified three strategies for disclosure: “private” (deliberate or active nondisclosure), “proud”¹ (a commitment to active disclosure), and “passive” (leaving disclosure in the hands of the HCP). In building a theoretical approach to the determinants and outcomes of these strategies, we have analyzed the connection between the strategies for individuals and families, and the contextual issues that influence them.

**The private strategy**

Some parents deliberately were silent with regard to their sexuality within the health care system, the “private” disclosure strategy. Seven of the 20 families had a predominantly private strategy, five of whom were stepfamilies (one single) and two *de novo* families, both of whom lived in a rural area. Pollack (1990) suggested that lesbian parents have been invisible and that they have “colluded in that invisibility” (p.183) by remaining silent. This perspective lacks appreciation of the social context and the consequences of coming out. In fact, participants revealed a number of reasons for taking this approach, which was generally an active choice. One reason was a belief that their sexuality was not the business of, or relevant to, the HCP. There was also a sense of resentment by one parent:

> Straight people don’t have to justify their story, and I don’t have to justify mine.
> (Donna, single birth mother)

Another reason for deliberate silence was to protect their children (and themselves) from negative attitudes, which often had been encountered during previous health care experiences. Carmel, a birth mother of four children in a stepfamily, had felt judged by a psychiatrist to whom she had taken her daughter in the past. She therefore was more guarded:

> So really I don’t think I ever took her (her daughter) to a service where I had to (disclose). For years we went to a neurologist and I didn’t tell him I was gay, I was just the mother of the kid.

This strategy particularly applied to stepfamilies in which the mother’s partner did not regard herself as a parent, although some did have an active parenting role, such as Helen, who was quoted earlier. In at least four families the birth mother’s partner deliberately excluded herself from

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¹ In labeling one strategy as “proud,” we are not disregarding the fact that many participants using a private strategy also can be proud in themselves; however, we are highlighting the different public face that each present.
parenting roles in the public arena including health care, despite taking on parenting responsibilities within the family. Excluding herself publicly was thought to be easier than disclosure and was protective for both herself and her partner and in particular their children in an attempt to keep their family life private. In relation to levels of disclosure in other areas of their lives, some families were consistently private throughout, particularly rural families. Other families were open about the parents’ sexual orientation at school, but not to their regular HCP (Lindsay et al., 2006).

While some parents had a high degree of control over choosing and maintaining this strategy, some lost control by being “outed” without their permission by a child or by someone else outside the immediate family. Others felt “forced” into the private strategy due to their potentially homophobic social context. This particularly applied to the two rural couples who previously had been very open about their sexuality, but altered their strategy when they had children and moved from an urban to a rural area. Although both non-birth mothers in these two families regarded themselves as parents from conception, they both changed their disclosure strategy to reduce the risk of homophobic responses and the negative impact on their families. For these two couples, creating a level of safety was accompanied by discomfort about not being able to be honest or authentic. Jacqui, the birth mother in one of these families, feared being open in their new environment. She commented that it was “tedious” that they were never assumed to be a couple, while acknowledging that they preferred not to openly disclose:

In one respect I feel sometimes I’m being deceptive, not being honest about our relationship by not correcting people, but at the same time, why do I need to tell this stranger...that I’m in a lesbian relationship....It’s always a given that I’m Imogen’s mother, but it’s also a given (assumption by others) that I have a husband.

Gramling, Carr, and McCain (2000) also found that lesbians who were making decisions about coming out to their families of origin felt forced into silence if they predicted negative reactions. They highlighted, however, that “maintaining a heterosexual façade is intrinsically stressful and fear of discovery intensifies the emotional tension” (p. 655). Not being able to relate authentically to HCPs was stressful for some of the families in our study, not due to a fear of discovery, but due to the forced silencing of the non-birth mother and the potential impact that could have on the children.

THE PROUD STRATEGY

In contrast to the private group, another nine families had a predominantly proud disclosure strategy. These families displayed firm beliefs in the need to disclose their relationships and family structure. Some advocated this in
all parts of their lives, and others only with services that were to be ongoing. Six of these were *de novo* families, two were single mothers, and one was a couple in a stepfamily. All of these families lived in urban areas, except for one single-parent family.

Many couples chose to “present a united front”, that is, to attend health services together as a family unit and make their family structure clear from the outset. For example, Ella (the non-birth mother, *de novo* family) attended all health care visits with her partner Sally during the antenatal period:

*Ella*: I think we have had a charmed experience of lesbian parenting.
*Sally*: Even in the hospital we never had any problems whatsoever.
*Ella*: It was never a problem.
*Sally*: We were “bang” out there straight away.
*Ella*: Before the nurse even sat down in her seat, it was like, “HI, I’m Ella, and this is Sally. Sally is the one giving birth”.
*Ella*: . . . That was the spiel, and I think, really, after the third nurse, they all knew we were lesbians . . . We had heard similar stories.

In contrast to the two rural *de novo* families who had shifted to a private strategy after they had children, several couples chose to be more open than they had been before they had children.

There were a number of reasons for the proud strategy. Most related to the need to be honest, to avoid confusion, to role model appropriate attitudes for their children, and to highlight the parenting role of the non-birth mother. McDonald and Anderson (2003) refer to this as maintaining authenticity, as Lucy and Sarah demonstrated:

Lucy (birth mother, *de novo* family): We’ve always been really out and open about it right from the beginning, haven’t we.
Sarah (non-birth mother): Not that it’s been an easy thing necessarily to do.
Lucy: No, but it’s a decision we’ve taken . . . so we’ve done it at crèche, . . . schools, with doctors. The dentist we don’t . . . I don’t think they realize we are even together.

They did not elaborate on why the dentist was singled out in this way. Toward the end of the interview, Lucy reiterated her stance:

Just a little message out there is to really just say who you are and be proud of your family and not to hide it. Because once you start hiding it, then you feel there is a secret and there’s something wrong with you . . . and how do you let your kid know that this is fine, this is normal, ordinary—but at the same time giving the message that this is a terrible secret and you mustn’t tell anybody?
These families therefore avoided the uneasy sense of dishonesty faced by some of the private group, but they exchanged that for potentially being more vulnerable to homophobia.

THE PASSIVE STRATEGY

Three families (including two stepfamilies and one single parent) displayed a passive strategy to disclosure in health care, in that they chose to hand over the control of disclosure to their HCP. For these parents, whether their relationship status and sexual orientation was known publicly was of less importance than for those with private or proud strategies. It seemed that the two couples using this strategy were indifferent to whether the HCPs knew. The role of the birth mother's partner required less public affirmation, yet it was not a secret. One example of this strategy in action was being happy to disclose if asked. Other studies have shown, however, that few HCPs actively facilitate disclosure with their lesbian patients; therefore, parents using a passive strategy are unlikely to be asked (van Dam et al., 2001; Westerstahl, Segesten, & Bjorkelund, 2002).

Both couples described situations in which the non-birth mother presented with her child to a HCP and was assumed to be the birth mother and therefore the legal parent, and they did not correct this assumption:

Jo (non-birth mother): No one ever asks. They probably just assume...and if they assume I'm Mum that’s fine. I don’t feel any great need to say, “Well, actually I’m not his Mum, but...
Bridget (birth mother): Because in that situation you are, you know.
Jo: Yeah, I'm his parent.

It can be expedient not to correct this assumption, as declaring a nonbiological connection may generate more problems regarding who is legally the next of kin for decision-making purposes; however, it does place the non-birth mother in a legally vulnerable position. Technically, without a parenting order from the family court, she has no legal status to give such consent.

The parents using a passive strategy displayed a reasonable level of comfort with the passive nature of their disclosure or nondisclosure. The outcome may not be as positive if control were to be completely removed, however, such as where there is disclosure without permission. Frida, the single parent using a passive strategy, described that her former husband had told the Social Security department (from which her single-parent benefits were generated) about her sexual orientation, which caused her to feel more vulnerable within that system.
CONTEXTUAL ISSUES INFLUENCING DISCLOSURE STRATEGIES

We found both private and public contextual issues that influenced disclosure strategies. One private contextual issue was the method of family formation. The majority of parents in de novo families used a proud strategy, whereas most of those in stepfamilies used a private strategy. Van Dam also has described a difference for lesbian de novo versus stepfamilies, finding that mothers in lesbian stepfamilies perceived more stigma and received less support from families, friends, and colleagues, and they were less likely to disclose to health care providers due to this stigma (van Dam, 2004). Parents in lesbian stepfamilies may be more worried about proudly “outing” themselves for several reasons. They may fear heterosexism and homophobia more than lesbians who have chosen to parent together from birth because of the complex family and friendship loyalties and realignments that occur after separation, divorce, and repartnering. Moreover, the average age of children in the stepfamilies in van Dam’s study was significantly higher than the age of children from de novo families, which was also the case in our study. The perceived need of lesbian parents to protect the sensitivities of their older children by not disclosing their sexuality within the health care system may be more relevant to high school children who are more likely to be embarrassed and feel stigmatized than it is to preschoolers and primary school-aged children.

For the parents in our study, another private influence on the disclosure strategy was the role and identity of birth mother’s partner. Where the partner identified as a parent, which occurred in all de novo families, this was strongly associated with having a proud strategy, including the need to publicly affirm the non-birth mother’s role. Where the partner did not describe herself as a parent, the disclosure strategy was more likely to be private or passive. Other private contextual issues did not appear to influence disclosure strategies, however, including the length of the parents’ relationship, their ethnicity, or their income level.

Public influences on disclosure included the geographic location, with a rural location increasing the fear of negative public reactions and prompting private strategies due to the more homophobic rural environment (Oswald & Culton, 2003). This points to an influence of the sociopolitical context more broadly. Attitudes toward homosexuality and lesbian parented families gradually have been improving over the past three decades, since the gay liberation movement began in the 1970s. Gay and lesbian rights now have become a human rights issue, with calls for normalization from the public health arena (Miller, 2001), and for acceptance of lesbian and gay people as full citizens (Richardson, 2004). Families in our study did make reference to the social context of their lives, particularly improvements in attitudes that they had witnessed; however, this was not pursued in detail within the interviews.
HCP issues also influenced disclosure. Participants chose a proud strategy more often when the relationship with the HCP was likely to be ongoing, while they were less likely to disclose when contact was sporadic (such as with the dentist). For example, one family described not being out to an emergency doctor, but being open with their usual GP. While past negative experiences did influence some parents to remain private, those parents with a proud strategy actively sought out providers who reacted more positively.

A CONTINUUM OF DISCLOSURE STRATEGIES

We have described the predominant strategy used by each family within the health care system. Disclosure strategies were not always fixed, however, with some families shifting between strategies according to the system or context. This was seen best in various strategies used by Lorraine, a rural, single mother. At one stage, Lorraine emphatically stated her need to be honest as a reason for a proud approach:

I tend not to go to someone (a GP) if I don’t feel that I can trust them and if I can’t tell them, the truth, no matter what that truth might be.

She was willing to modify this, however, depending on the recipient:

I try to avoid speaking if I think it might upset somebody too much at the time, but I don’t like pretending to be something I am not.

Later in the interview, she described a passive strategy:

If the subject came up (of being lesbian) I’m not going to hide a damn thing, but I think it’s unreasonable to just tell somebody something unless there is a need.

Helen and Nicki (stepfamily living in a rural area) described how they choose where to be on the disclosure continuum in different contexts:

*Interviewer:* So you have made a conscious decision... about your relationship as a couple is not anybody else’s business?

*Helen* (non-birth mother): That’s right, so it doesn’t distract the poor loves.

*Nicki* (birth mother): Depends on whether you want people to know you or not. That’s what really allows you to show who it is that you are in your private life... it’s about expediency too, it’s like these people are not people who are going to be our best friends, we just want them to do their job and move on.
And a little later in the interview:

_Nicki_: And if you are going to be discriminated against or judged because of a certain aspect, then you don't bring that on . . . I mean you don't want to be the focus of really, really negative attention.

**INDIVIDUAL VERSUS FAMILY STRATEGIES**

Most couples agreed on their disclosure strategy within the health care system and were consistent when discussing it throughout the interview. Maureen and Annette, however, each chose different strategies with different health care providers. They mostly were open (for example, with their family doctor) for their “children’s sake” unless they felt there would be a disadvantage. Conversely, Annette remained silent regarding her sexual orientation with her own specialist. This is likely to have compromised care for Annette through her inability to reveal information about the family stress she was experiencing:

_Annette_: Actually it is amusing. Our family doctor who also sees my ex-husband, knows about our relationship. Family doctors must see all the passing parade, and she’s fine.

_Maureen_: She’s hip to the groove.

_Annette_: So we do pick our health services it would be true to say.

_Interviewer_: So are you discerning around your relationship or generally?

_Annette_: No, just discerning around the doctors I see.

_Maureen_: And the relationship. I wanted to see Annette’s [specialist], and Annette wouldn’t let me go because he is a good friend of her father.

_Annette_: Ohhh. Yeah, that would be too much information.

_Maureen_: And he asks her, “Do you have stress?” This is at a time when we were absolutely on Mt. Everest from the stress of it all, and Annette’s going, “no”.

For another family, there were clearly different strategies amongst different family members:

_Interviewer_: What about health and GPs? How have you managed that?

_Anna_ (one birth mother): We don’t really go to doctors.

_Greta_ (other birth mother): No.

_Katherine_ (24-year-old daughter of Anna): I don’t think I’ve ever told my GP for any reason.

_Anna_: Our GP we’ve told.

_Greta_: If we haven’t told her, she’s worked it out.

_Anna_: No, we’ve told her.

_Denise_ (35-year-old daughter of Greta): I’ve told her anyway. She knew there was some connection between one of you and me . . . and she
didn’t know who, I said it was Greta who was my mother and she said, “Oh right”. You could see her thinking, (so I said) “You know they’re together” She said, “Yeah, I think I knew that.”

So the strategy seemed to be passive for Greta (the GP “worked it out”), active for Anna (we “told”), and private for Katherine. Meanwhile, Denise confessed to having disclosed on behalf of her mothers.

DISCUSSION

We have found that the majority of the participants in our study acted purposively and thoughtfully in dealing with the health care system and HCPs. As lesbian parents, they exist on the margins of society, and for our participants in Victoria, on the margins of the law. They are therefore compelled to be more reflective, to plan and negotiate contact with the mainstream more cautiously and perhaps self-consciously than heterosexual patients and even lesbians without children. They were active in their choice of provider, using a variety of protective strategies to ascertain the level of safety and sensitivity they might face. They were willing to adapt their approach depending on the responses they encountered.

Our findings suggest that lesbian parents particularly within de novo families generally were open about their sexual orientation, with many choosing the proud disclosure strategy, while parents in stepfamilies tended to have passive or private strategies. The deliberate openness of de novo families seemed to be largely influenced by the desire to make public the role of the mothers as equal parents from birth. There were other apparent influences on the level of openness, including living in an urban environment where attitudes toward homosexuality tend to be much more accepting than in rural areas. The age of the parents in de novo families generally was younger than the parents in stepfamilies, and this also may have had an influence if being younger meant that these women had not personally experienced negative sociopolitical contexts. Further studies would be required to tease out the strength of these different influences, and whether it is family formation method or generational change with different experiences of the sociopolitical context that is more dominant.

There were two particular gaps in our sample that possibly would have limited the range of disclosure influences that we found. One is that the passive disclosure strategy was seen in just three families. The influences on this strategy were really not clearly articulated by these families, and we suggest that this would be an important area for future research to create a more comprehensive understanding. The other gap is that there were no families at the time of the interview in which children had chronic illnesses requiring regular contact with HCPs. Such children may be more connected
with their own health care and therefore likely to influence the interaction and the disclosure strategy. As it was, the children in the study generally were healthy, which may explain their lack of comment about their own health care.

It would be interesting to understand whether lesbians modify their disclosure strategies once they become parents, and also as their children get older. A previous cross-sectional study showed that prospective lesbian parents expected significantly higher levels of discrimination than were reported by current parents, and they were less open about their sexuality (McNair, Dempsey, Wise, & Perlesz, 2002). There were examples in our study of parents changing their approach in both directions after they had children. A longitudinal study design, following lesbians from before they were parents well into their children’s adolescence and beyond, would help to answer this question.

Control of information about their sexual orientation is crucial to maintaining safety in the health care system. The need to be safe arises from fears or actual experiences of sexuality-based discrimination in health and other public systems. Our study has highlighted two important differences in the motivations for creating safety and control for lesbian parents as distinct from those reported elsewhere for single or coupled lesbians. One is the degree to which the non-birth partner identifies as a parent, and arising from that, the importance for her to be recognized by others as such. The second is the need to protect their children from discrimination by controlling the public knowledge of information about their family structure.

Street, Krupat, Bell, Kravitz, and Haidet (2003) have found that effective communication between patients and doctors is influenced by the degree to which the desired levels of control between the respective people are matched. We extend this beyond communication to the whole health care experience. Davis’s application of Giddens’s Theory of Structuration does provide a helpful model here (Davis, 1988). Giddens’s theory that all individuals have at least some control over their actions in systems holds true for the lesbian parents in our study. There is a dialectic of control between the families (with their choice of HCPs and their strategies of disclosure) and the HCPs (with their responses to the families). We argue that the participants in our study, in their role as “patients”, generally desire control over disclosure of the parents’ sexual orientation, and the more control they attain, the less vulnerable they feel.

The degree of control of disclosure is influenced by system and individual factors. At the health care system level, less control is possible due to the inability of the health care bureaucracy to accommodate diverse family structures. At the level of the individual patient–doctor interaction, participants described more flexibility and awareness, and all three disclosure strategies enabled some control over health care provider awareness of their sexual orientation. Even the passive strategy encompassed a choice
in deferring control to the HCP. The level of control however, still can be compromised by a lack of awareness by HCPs of variable disclosure needs and variable roles of the non-birth mother. A desired strategy may be usurped by HCPs without the parents’ permission. For example, a parent with a proud strategy may be forced into silence to protect her child from a potentially homophobic provider and so is no longer acting according to her own standards of authenticity. This was the case for Carmel cited previously and for the two previously out couples who moved to rural areas. Similarly, a parent who prefers privacy and finds that her sexual orientation is discovered, as was the case for Frida, could feel vulnerable and exposed.

What about the HCPs in this equation? Giddens’s theory suggests that they too must be agents, or active participants, in constructing their side of the interaction. They also need to be reflectively monitoring what they are doing. Giddens suggests that the majority of knowledge enabling such monitoring is tacit, or taken for granted. According to Davis, the doctor (or other HCP) must respond using the rules and resources common to the health care system (Davis, 1988). Facilitation of disclosure of sexual orientation is not currently part of the institutional practice for HCPs, however, due to the lack of education in this area and the marginality of nonheterosexuality. There is minimal tacit knowledge amongst HCPs of the importance of sexual orientation in the lives of lesbian-parented families, and some of the study participants perceived this and described their need to inform HCPs of their reality.

We are therefore finding a more complex relationship among disclosure, safety, and control within health care than previously described. Previous studies imply that full disclosure by lesbian parents to HCPs is desirable (Perrin & Kulkin, 1996; Mikhailovich et al., 2001). We suggest that it is the achievement of control over the implementation of the preferred disclosure strategy, rather than disclosure per se, that influences perceived safety in health care.

A number of questions arise from our study that remain unanswered. First, we did not explore the HCP’s perspective in this study, in particular, how the HCP’s approach to disclosure influenced the health care experience. We wonder, for example, how the lesbian parent with a private disclosure strategy would react to an HCP who asked very direct questions about sexual orientation. None of the participants discussed an experience of being asked directly. Future studies that include the HCP perspective would be very valuable. Another question is the influence of single-parent status on the health care experience and disclosure patterns. It could be assumed that single lesbian parents could avoid any mention of their sexuality in the context of their child’s health care, yet two of the four single parents in our study had a proud strategy and were openly lesbian in most encounters with the health care system. The limited number of single parents in our study did not provide enough breadth to examine this area adequately.
CONCLUSIONS

The main contribution of this study is a repositioning of disclosure of sexual orientation by lesbian parents within health care. We suggest that it should be viewed not as a desired endpoint but as a contextually driven and variable strategy. Several contextual factors influence disclosure, including the location of residence and perceived social attitudes, consistency of the relationships with the HCP, and possibly the age of the children. The role of the partner of the birth mother appears to be a central determinant of the preferred disclosure strategy. Many partners, particularly from de novo families, regarded themselves as equal parents and desired active involvement in their child’s health care, which motivated a proud disclosure strategy. By contrast, some partners of women in stepfamilies also had a parenting role within the family, but they chose to be silent within the health care environment to improve the perceived safety for themselves and their child/ren.

A paramount concern for the parents in our study was to protect their children from exposure to discriminatory attitudes. With the exception of two adult children in one family, children did not comment on their own health care at all. This may indicate that parents successfully negotiated the system on their children’s behalf or that children were not as affected by interactions with HCPs. Many participants related very positive stories about their HCPs and often displayed a high level of tolerance and even humor in observing their provider’s learning curve regarding lesbian parenting. There was a level of acceptance that their role was partly to educate such providers, assuming they displayed openness and flexibility. Conversely, inflexibility and assumptions of heterosexuality were not tolerated, particularly when they resulted in a lack of recognition of the non-birth mother as parent.

These findings indicate several ways that HCPs could improve their support of lesbian-parented families. First, it is important not to assume that all lesbian parents desire disclosure of their sexual orientation within the consultation. Some will feel safer and more comfortable if their lesbian relationship or identity is not known, whereas others will feel truly authentic only if their context is fully open. Second, where two women present together with a child or children, it is advisable to clarify their relationship to each other and to the child/ren; their respective parenting roles; and the language they use to describe these relationships. HCPs can also help make the health care system more responsive and aware of lesbian parents through modifying health care data collection forms, and advocating for the rights of the non-birth mother in decision making for her child. While our study demonstrated that many lesbian parents can negotiate a safe and effective passage through the health care system, HCPs can improve the experience by building their own skills and knowledge for working with these families.
RB was the PhD student and research assistant on this study. All other authors are Chief Investigators. Interviews were conducted primarily by RB, with AP conducting one interview and supervising the PhD. RM and RB independently conducted the analysis of the health-related themes within interview transcripts, and then compared their codes and themes. RM conceived the theoretical model and wrote the first draft of the paper. All other authors provided ideas and editorial advice for subsequent drafts.

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