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Marginalised mothers: Lesbian women negotiating heteronormative healthcare services

Brenda Hayman

University of Western Sydney

Lesley Wilkes

University of Western Sydney

Elizabeth J. Halcomb

University of Western Sydney, ehalcomb@uow.edu.au

Debra Jackson

University of Technology, Sydney

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Marginalised mothers: Lesbian women negotiating heteronormative healthcare services

Abstract

Lesbian mothers share mainstream existence with other mothers by virtue of their motherhood, but remain marginalised by their non-heterosexual identity. This paper will draw on the qualitative findings of a recent Australian study that examined the experiences of lesbian mothers. Using a story-sharing method, data were collected using three methods; a demographic data sheet, in-depth semi-structured interviews and journaling. The findings demonstrated that participants experienced various forms of homophobia when interfacing with healthcare services and providers and included exclusion, heterosexual assumption, inappropriate questioning and refusal of services. Strategies used to avoid homophobia included screening and crusading.

Keywords

marginalised, heteronormative, healthcare, services, women, mothers, lesbian, negotiating

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Key words

Lesbian, mother, healthcare, nursing, heteronormative, homophobia, vulnerable populations, story-sharing, qualitative research

Introduction

Until recently, lesbian health has been considered proportionate to women's health and this thinking has led to misunderstandings about the unique health risks experienced by lesbian women (Aids Council of NSW [ACON], n.d. p.8). Evidence has shown lesbians to have a higher morbidity rate in breast, uterine, colon and ovarian cancers, heart disease, stroke, mental health problems (Wagner, 1997) and polycystic ovary syndrome, obesity, misuse/abuse of drugs and alcohol, exposure to significant stress and tobacco smoking (US Department of Health and Human Services Office on Women's Health [USDH], n.d.). In Australia, McNair (2009) demonstrated that lesbian women were more likely to smoke and inject drugs and were also more likely to be, or have been, the victims of abuse. Mulligan and Heath (2007) add that lesbian women are more likely to experience stress, depression, anxiety and self-harm than heterosexual women.

While sexual orientation is not specifically the cause of these conditions, it can be considered a social determinant of health as is gender, socio-economic status or ethnicity (ACON, n.d. p.8). Coupled with the morbidity data, lesbians experience homophobia when interfacing with heteronormative healthcare services and providers (HS&P), subsequently elevating the

health risk to this already vulnerable population. Bjorkman and Malterud (2009) add that “lesbian women face unique challenges when accessing healthcare” (p. 238) and add that lesbian women experience some health problems more frequently than their heterosexual peers, due to marginalisation. Fundamentally, the distinctive healthcare needs of lesbian women go unnoticed, are deemed unimportant or are simply ignored (DeBold, 2007; Weisz, 2009).

Background

A *de novo* family is a family constellation that comprises a lesbian couple and children they planned, birthed and are raising together (McNair, 2004). Hequembourg (2009) refers to *de novo* families as ‘lesbian-headed’ while Bos, van Balen & van den Boom (2004) use the term ‘two mother’ families. Lesbian mothering first became visible in the 1970s (Clarke, 2008; McCann & Delmonte, 2005) and *de novo* families have been able to realise growing recognition, acceptance and visibility in the broader socio-cultural milieu (Clarke, Kitzinger & Potter, 2004; Renaud, 2007). The number of *de novo* families is increasing in Australia and internationally (Australian Bureau of Statistics, 2009; Hequembourg, 2009). So much so, that the literature is increasingly using terms like the lesbian baby boom and the gayby boom (Spidsberg, 2007) to describe this phenomenon and alteration in social demographic (Bergen, Suter & Daas, 2006; Irwin, 2007).

Lesbian mothers share mainstream existence with other mothers by virtue of their motherhood, but remain marginalised by their non-heterosexual identity (Ben-Ari & Livni, 2006). The passage to motherhood can be particularly demanding for lesbian mothers as they navigate the usual challenges of motherhood alongside the adversity of birthing and raising

children in a heteronormative social context inclusive of stigmatisation, discrimination and homophobia (Goldberg & Smith, 2008; Webber, 2010). Homophobia is defined as the “explicit fear or hatred of homosexual people and activities” (Higgins, 2007, p. 283). The characteristic heteronormative nature of the healthcare environment precipitates distinguishing patterns of homophobic behaviour and results in “overt discrimination, violation of rights and social ostracism” (Christensen, 2005, p. 60), prevents the delivery of holistic and individualised care and hinders the development of therapeutic relationships (Christensen, 2005; Goldberg, Ryan & Sawchyn, 2009). The loss of control, isolation and vulnerability that a person typically experiences when they are hospitalised are emphasised for lesbian mothers accessing HS&P (Christensen, 2005). Homophobic HS&P can reinforce the “isolation and alienation” and further marginalise lesbian mothers (Irwin, 2007, p.73).

This paper will draw on the qualitative findings of a recent Australian study that examined the experiences of lesbian mothers. The aim of the study was to explore how lesbians construct mothering. While generating data it was revealed that, despite increasing visibility and social acceptance of lesbian mothering, heteronormativity and homophobia continue to permeate health service delivery. Subsequently, negative attitudes toward lesbian mothers affect the way in which they access healthcare. When a vulnerable person, such as a lesbian mother, is exposed to homophobia in the healthcare environment, this serves to further marginalise them (Irwin, 2007) and magnify their risk of poor health outcomes. It is important that heteronormativity is recognised and strategies to provide quality healthcare to lesbian mothers are developed and practiced. This papers presents findings generated from the larger study and in doing so, will identify and discuss the types of homophobia

experienced by lesbian mothers when interfacing with HS&P and offer strategies for implementing inclusive healthcare.

Method

Lesbian couples who had planned, conceived, birthed and were raising their children together participated in this qualitative study. A convenience sample of 17 self-identified lesbian couples ($n = 34$) was recruited through women's health care services, lesbian publications and word of mouth. Participants were aged between 28 and 58 years (mean 39.8 years). Couples had been in their relationship for between 3 and 18 years (mean 9.6 years) and had been co-habiting between 2.5 and 17 years (mean 9.0 years). Collectively the families had achieved 21 pregnancies, producing 23 children consisting of 11 boys and 12 girls, including two sets of non-identical twins. The age of the children ranged from two months to 10 years (mean 2.58 years). The combined family income ranged from \$AU23, 000 to \$AU400, 000 (mean of \$AU118, 000).

Data were collected using three methods, a demographic data sheet, in-depth semi-structured interviews and journaling. Participants were interviewed as couples between March and August 2010 and at that time a demographic data sheet was completed by each participant. Journaling took place soon after each interview and continued for a period of one month.

The interviews were semi-structured, in-depth interviews that were either audio recorded ($n=13$) or captured as text via an online messaging program ($n=2$). Story-sharing was the method

used during the interviews. Story -sharing is the reciprocal exchange of relevant stories between the participant and researcher during qualitative interviews with the purpose of generating rich data (Hayman, Wilkes, Jackson & Halcomb, *in press*). The interviews took place face-to-face ($n=7$), either via an internet web camera program ($n=5$), an instant messaging program ($n=2$) or over the telephone ($n=1$). The interviews lasted between 45 minutes and two hours.

Journaling is a “valid method of accessing rich qualitative data” (Hayman, Wilkes & Jackson, *in press*). Journaling was accomplished online via a popular social networking website for ten of the 14 couples who had internet access. One couple who did not have internet access engaged in an email journal with the principal researcher. Participants were encouraged to share their mothering experiences in their journal. Participants included text, music with lyrics, photos and drawings. The participants were later asked to interpret the non-text contributions to their journals in words to ensure that their meanings were not misinterpreted by the researcher.

Constant comparative analysis of interview and journal data was used to identify and isolate patterns in the participant’s stories (Thorne, 2000). Patterns in the analysed text exposed major and minor themes. Further, reflection, journaling and discussion of the data promoted a reflexive approach and helped raise consciousness in relation to the researcher’s beliefs, biases and patterns of thinking.

Ethics

Ethic approval was sought and approved from the University of Western Sydney Human Research Ethics Committee prior to commencing data collection. Pseudonyms have been used for all participants in reports and publications to protect the privacy of participants.

Findings

Analysis of the data of the larger study generated four major themes and 16 minor themes and 12 sub-themes (see Table1). The major themes are: becoming mothers, constructing motherhood, legitimising our families and raising our children. The discourse that both underpinned and united each of the themes was the experience of homophobia. It is judiciously noted that not all participants identified that they experienced homophobia in relation to their interface with HS&P. However the findings demonstrate that some *de novo* families experience homophobia when accessing healthcare and that, in anticipation, they implemented specific and deliberate strategies in an effort to maintain the safety of themselves and their children. Subsequently, the focus of this paper will be the four types of homophobia experienced by participants as well as the strategies they implemented to avoid homophobia when interfacing with the healthcare system. Homophobia was experienced by participants in the form of; exclusion, heterosexual assumption, inappropriate questioning and refusal of services. Strategies used to avoid homophobia include screening and crusading. Each of the types of homophobia will be explored further below. Later, we will identify and discuss the strategies implemented by participants to avoid homophobia and offer some strategies to promote culturally sensitive and inclusive healthcare.

Types of homophobia

Four types of homophobia were experienced by participants during their interface with the healthcare services; exclusion, heterosexual assumption, inappropriate questioning and refusal of services (See table 1). Each of these is explored in detail below.

Exclusion

Several participants experienced homophobia in the form of exclusion. In particular, non-birth mothers were not accepted as genuine or legitimate parents and were essentially prevented from participating in various health-related procedures. Lucy explained, '*my partner was not allowed into recovery after IVF – male dads were allowed*' and Phoebe added '*[Name of Hospital] gave us a pack and it was a book for the father and a book for the mother. They didn't have anything else and just said "sorry, that's all we have"*'. Further, inappropriate terms (like sister, friend and mother) were reportedly used by healthcare providers to identify non-birth mothers in *de novo* families. Exclusion experienced by lesbian mothers led to feelings of anger, sadness, frustration and the need to frequently legitimise the parental role of the non-birth mother. For some participants, these experiences meant that in the future they made decisions not to disclose sexual orientation, relationship status or method of conception during HS&P interactions. Homophobia essentially generated a barrier between lesbian mothers and HS&P.

Heterosexual assumption

Another form of homophobia identified by participants was heterosexual assumption. Frequently the women were presumed to be heterosexual and this made them feel

'embarrassed' (Mia), *'uncomfortable'* (Ellie) and *'self-conscious'* (Grace). Mattie explained *'... there are always assumptions made – especially since we have the same last name, people think we are sisters'*. Holly added another example of heterosexual assumption when she said, *'We were having a tour [of the birth centre] and this woman who was giving us the tour said, "Well where's the father?" We don't want to be somewhere that thinks there should be a father hanging around'*. These stories demonstrate how the heterosexual assumptions of HS&P generated negative feelings and experiences when dealing with the healthcare system. Heterosexual assumptions by healthcare providers further excluded and marginalised an already vulnerable population.

Inappropriate questioning

The participants articulated that they were asked what they perceived as inappropriate questions that they felt were asked of them *only* because they were a lesbian couple. Such questions were asked during various stages of maternity care, including immediately after the birth. Questions about how the couple conceived were most common. Phoebe recalled, *'People ask us odd questions at times which aren't entirely appropriate, but for the most part I think it is genuine curiosity'*. One couple shared that, immediately after the delivery of their baby, healthcare staff asked them about their method of conception and joked about how conception may have occurred. The participants said this made them feel embarrassed and uncomfortable. Many of the participants interpreted the questioning (however uncomfortable or inappropriate) as an opportunity to educate healthcare providers about their families, healthcare needs and preferred terminology. In relation to terminology Holly remarked that *'I think every form we filled in was like that [heteronormative], so there is a kind of systematic or institutional homophobia'*. She was referring to the forms at the hospital for example, where lesbian couples and mothers did not 'fit' into the set responses provided. This led to

feelings of exclusion and vulnerability. Jane also identified filling in forms as a problem when she discussed the admission of their child to hospital and there was no space for the non-birth mother on the form to be identified as a parent. She relayed that she crossed the 'father' section out and added the words 'other mother' to the form – to make it fit her family. Inappropriate questioning, whether verbally or via forms, can make lesbian mothers uncomfortable in a healthcare setting and this discomfort could amplify reluctance to access HS&P in the future.

Refusal of services

The fourth type of homophobia experienced by participants was refusal of services. On several occasions, participants were denied health services solely because of their sexual orientation and/or same-sex relationship. Refusal of services was not a personal choice on the part of individual healthcare providers, but instead one enforced by legislation. Melanie said '*You couldn't be socially infertile which is what they called it, to access it [IVF]*' and Lilly added, '*Anyway there was a female doctor [there] who was very nice ... but she refused to give Kate a referral. I think she said she was catholic ...*'. Phoebe and her partner experienced refusal of services on more than one occasion and said, '*... we were rejected by the first two [hospitals] because they said it was unethical for them to assist a single woman because they don't recognise same-sex couples as being a valid couple*'. In this situation, Phoebe and her partner were forced to travel interstate to access fertility services not legally available to them as a lesbian couple in their home state. Since the time of this incident, the laws have changed and in all States and Territories of Australia, lesbian couples have comparable access to fertility services to heterosexual couples.

The four types of homophobia demonstrate behaviours that operate to distance lesbian mothers from HS&P. With the increased morbidity rate of some illnesses and conditions experienced by lesbians, disengagement from healthcare services will only serve to escalate the already vulnerable health status of this population.

Strategies to avoid homophobia

When interfacing with HS&P, lesbian mothers anticipated heteronormativity. Accordingly, they formulated strategies they thought would circumvent homophobia. Conceivably, the reason some participants did not experience homophobia, was because of these particularly deliberate approaches. Lesbian mothers implemented two clear strategies to protect themselves and their children from homophobia; *screening* and *crusading*.

Screening

Screening was an activity often engaged by participants prior to physical contact with HS&P. They explained that they would contact the service, usually by phone, and ask questions about the service philosophy. In some instances, they asked the service or provider, “*How do you feel about having lesbian clients?*” (Billie). Essentially, screening was used to evaluate services for their attitude to the sexual orientation and same-sex relationship status of potential clients. The response determined whether participants accessed that particular service and an affirmative response meant the participants were likely to utilise the service. Any intimation of homophobia rendered the service unsuitable. This strategy was not as useful for participants living in outer urban areas where fewer services were available. In some instances, participants were told that the service was unable to meet their needs due to

legal restrictions. This did not necessarily represent homophobia by the individual service or healthcare provider, but rather homophobia by the community – a community represented by the government making decisions that precluded access to fertility services by lesbian couples. Many participants also screened health care services and providers via the internet, searching blogs and forums for positive or negative comments and some participants sought referral from lesbian friends. Screening was a successful strategy that reduced the risk of exposure to homophobia when interfacing with HS&P.

Crusading

Some participants stated that they were always *out* about their sexual orientation and that if HS&P were not comfortable or accepting, then they would access an alternate service. Participants said they thought of themselves as “crusaders” and considered it their responsibility to educate people and to normalise their sexual orientation and same-sex relationship, in the context of accessing healthcare. They recognised that some healthcare providers may not have had exposure to lesbians and *de novo* families and it was an ideal opportunity to educate them.

Participants expressed that it was important for them to stop being invisible. Charlie summed this up adeptly by saying, “*as consumers and as women we just have to keep voicing our needs and make sure that we don’t go back; we keep going forward and empowering ourselves in the system*”. In the spirit of raising visibility and not standing for less than equality, two couples made formal complaints about the homophobia they experienced while accessing healthcare.

Discussion and recommendations

Participants in this study were a highly educated cohort with effective communication skills and access to resources. Despite this fact, many experienced and were adversely affected by homophobia when accessing HS&P. This finding is consistent with other literature (McManus, Hunter and Renn, 2006; Larrison and Dykes, 2009; Lee, Taylor and Raitt, 2010). Homophobia and hetero-centrism can affect the health and well-being of lesbian women (Victorian Government Department of Health, 2009). Despite this, lesbian women continue to experience negative, homophobic and heterocentric interactions with HS&P

Lesbian women continue to experience distinctive challenges and significant health disparities when interfacing with HS&P in comparison to the heterosexual community (Tjepkema, 2008; National Academy of Sciences, 2011). This occurred particularly when accessing maternity services because of the very nature and characteristics of their same-sex relationship, hence lesbian couples are reported to be vulnerable when interfacing with HS&P (Spidsberg and Sorlie, 2011). Other studies demonstrate that lesbian women feel fearful about accessing healthcare and disclosing their sexual orientation to healthcare providers (Wilton and Kaufman, 2001; Platzer and James, 2000). This was evident in our study when the participants felt ashamed, fearful, angry and embarrassed. Hutchinson, Thompson and Cederbaum (2006) add that lesbian women are less likely to access preventative healthcare due to a fear of homophobia. This fear of HS&P has been shown to influence lesbian women's decisions to access healthcare services. This is important as WHO (1986) stated that, reduced access to quality healthcare is a predictor of poor health outcomes for all people, including lesbian women and indeed when they are pregnant.

One of the significant findings in our study was the extent of homophobic exclusion in health services and by health professionals. These exclusions incorporated levels of interaction with the non-birth mother during pregnancy and birthing and in the heteronormative language of assessment forms and health promotional materials. This echoes the findings of others, particularly in relation to maternity services (Renaud, 2007; Dibble, Eliason, DeJoseph and Chinn, 2008; Erlandsson, Linder and Haggstrom-Nordin, 2010).

Exclusion was again illustrated by inappropriate questioning and refusal of services and while this is not new, it was reiterated in the voices of the participants in this study. It reinforces that HS&P need to be more appropriate in their language and actions. It has been previously reported that assumptions of heterosexuality lead to communication barriers between lesbian women and healthcare providers (Bonvicini and Perlin, 2003; Rondahl, 2010).

Communication barriers inevitably affect the quality of health service delivery and poor outcomes can occur.

Like lesbian women in other studies, the participants in this study used resourcefulness to counteract the negativity of inappropriate communication (Renaud, 2007; Mulligan and Heath, 2007). As proposed in these other studies, our participants chose services where they were less likely to be discriminated against and also requested exclusion of staff that were homophobic. Lesbian women were more likely to choose a healthcare worker who is accepting of their sexual orientation, and that lesbians often engaged in screening to determine attitudes about sexual orientation of HS&P. The authors above further stated that lesbian women interview health services to assess their attitude to homosexual people.

Renaud (2007) also identified that lesbian women shared experiences of various healthcare services and advised each other about positive experiences and cautioned each other about services they evaluated as homophobic. The lesbian women in our study also shared positive and negative experiences of various HS&P via internet blogs and word of mouth.

In order to overcome heteronormative services, participants in the current study reported that they used their resilience and resourcefulness to negotiate the healthcare system to identify the services and practitioners most likely to deliver culturally sensitive or “lesbian-friendly” healthcare. This highlights the need to recognise that homophobia is a major hazard to lesbian health (Wagner, 1997). Measures need to be taken in order to assist this vulnerable group to access healthcare. It is evident that the healthcare environment could be improved by inclusive policy development for *de novo* families. These policies should include health promotional materials, health assessment forms and education for staff that recognises the unique needs of the *de novo* family during the pre, peri and post natal period. The restructuring of health assessment and interviews that use gender-inclusive language should be part of this reform. Additionally, heteronormative health promotional resources should be reviewed and designed in a way that includes lesbians and lesbian health issues. The generation of a database that identifies lesbian-friendly healthcare environments will help endorse utilisation of those services and subsequently promote the health of lesbians mothers.

This study has shown that whilst society is moving forward, homophobia is still evident in the health service and with health personnel. When heteronormative practices, attitudes and policies are modified lesbian women and their *de novo* families will be able to unreservedly

access healthcare. The vulnerability of these families is evident by the way they are treated by HS&P.

Conclusion

It is evident from this study that *de novo* families are vulnerable group when accessing health care particularly during the pre, peri and post natal period. While the lesbian women in this study were able to use their own resourcefulness to achieve appropriate care other less educated or socially able couples may need to be guided through a system which is often harsh and not meeting their needs. In order to do so, the health environment needs to address the issues around homophobic exclusion, inappropriate language and refusal of treatment to vulnerable *de novo* families.

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	<p>We are <i>both</i> the mother</p> <p>Non-birth mothers: strategies that tie non-birth mothers to their children</p>	<p>Let's get committed!</p> <p>Your name, my name: what's in a name?</p> <p>Birth certificates and medicare cards: formal recognition</p>
4. Raising our children	<p>Strategies to stay safe</p> <p>Teaching resilience</p> <p>Tribulations of motherhood</p>	<p>Choosing safe environments</p> <p>Attitudes that promote Safety</p> <p>Screening and advocacy</p> <p>Love and pride</p>