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Midwifery Practice: Moving towards Professional Status and Community Recognition

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Abstract

Historically, midwifery has struggled to gain and maintain professional status and identity. Amid the challenges of fulfilling the characteristics of a profession (Flexner 1915, Bixler & Bixler 1959, Pavalko 1971, cited in Ellis, Hartley 2004, pg. 156) and working under the subsumption as a special branch of nursing, midwifery practice has been influenced, defined and governed by Codes of Ethics, Practice and Conduct. However, recognition and acceptance by the general public and other professionals is the ultimate goal of any professional group (Wilkerson, 1998). Increasing public awareness of midwives has a dual role in that it also provides women with knowledge of models of care in pregnancy, thereby promoting the World Health Organisation recommendation: ‘the need for every woman to have skilled care in pregnancy, childbirth and the immediate postnatal period…midwives are the most appropriate primary health care provider…’ (WHO 1996, pp 1, 7). Therefore, community awareness of midwifery needs to be raised to achieve these objectives. In this paper, I will consider the Nursing Board of Tasmania’s (NBT) ‘Code of Practice for Midwives in Tasmania’ 2003 and the Australian College of Midwives’ (ACMI) ‘Code of Ethics’ 2001. After exploring these documents, I will outline the role they, and the organisations controlling them, have in regards to the professional practice of midwives. I will then look briefly (due to size constraints of this assignment) at strategies the profession can adopt to raise community knowledge of the role and function of the midwife.
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Defining the Code of Ethics and the Code of Practice, as they pertain to midwifery, provide clarification as to the impact they have on practicing midwives. The ACMI (2001) describes ethics codes as ‘…often a mix of universal principles and strongly held values specific to the “professional” group and its culture.’ A much clearer definition to reinforce this is that of Thomas and Pierson (1996, pg. 140) who define a Code of Ethics as:

A body of guiding principles for professional organisations to set the professional standard for good practice in relation to service delivery, client relationships and relationships between professional and other occupational groups.

The purpose of a Code of Ethics is to promote high standards of practice, establish frameworks for behaviour and responsibilities, provide reference points for self evaluation and provide a channel for professional identity and maturity (Life Skills Coaches Association of British Colombia, 2006).

When defining the Code of Practice the difference between these two codes then becomes clear. Esterhuizen (2006, pg.105) cites Bandman & Bandman (1985) in defining a code of professional practice as ‘a system of rules and principles by which a profession is expected to regulate its members and demonstrate its responsibility to society’. Once again, this definition can be reinforced by the Irons’ definition of a code of practice, which states:

A code of practice is an agreed set of activities, actions, technical requirements, responsibilities or responses to events or conditions that apply to a profession, trade or industry. These are often based on international or national standards…have been agreed upon by a professional body in an act of self regulation, considered necessary to restrict entry into the profession and to ensure that general professional practice is conducted at the highest level of integrity and quality. Sometimes…formalised into law, with particular practices described and strict requirements… with penalties if not strictly enforced (Irons 2002).

The purpose of the Code of Practice for Midwives in Tasmania is to ‘provide practical guidance to midwives in practice in Tasmania; and to inform consumers of the role and responsibilities of midwives.’ (NBT Code of Practice for Midwives in Tasmania 2003, pg.3)
To put these definitions into context regarding midwifery practice, it is helpful to be familiar with the classification of professional codes into three categories, including ethics, conduct and practice (Pritchard 1996, cited in Thompson 2002, pg.526 and Glover 1999, pg. 14). According to the classification, a code of ethics contains broad principles but no mention of the specific meaning in relation to practice, whereas a code of practice contains the standards of care a professional body must give in its service to clients. More simply said, a code of practice tells a profession how it must act and a code of ethics tells the profession why it is right to act that way.

To demonstrate this concept within these codes, one area of practice such as accountability, shall be considered. Midwife accountability features frequently within the domains of the ACMI’s Code of Ethics (2001). One example of these is ‘I.C: Midwives are accountable for their decisions and actions related to outcomes of their care of women.’ (ACMI Code of Ethics 2001, pg. 2). As can be seen, this statement provides midwives with the general principle relating to professional accountability. However, when the same area of accountability is perused in Provision 3.0 of the NBT’s Code of Practice (2003), the statement ‘All midwives must be responsible and accountable for their own practice.’ (NBT Code of Practice 2003, pg. 6) is followed by a commentary of points on how to fulfil that requirement; such as working within the sphere of midwifery practice, demonstrating required competency standards and ensuring continuity of midwifery care.

The fundamental qualities of these codes describe the very nature of the organisations governing them. Apart from establishing frameworks and promoting high standards of practice, the Code of Ethics also provides a vehicle for professional identity. It, therefore, exists for the members of that profession just as professional organisations exists for its members. The ACMI, which governs the Code of Ethics, is Australia’s professional organisation for midwives. As part of its mission statement, the ACMI (2004, pg 20) states that ‘we exist to provide a unified political voice for the midwifery profession; support midwives to reach their full potential;…’ and that one of their key strategic goals is ‘to be an accessible, efficient, transparent organisation providing valued services to members’.

The Nursing Board of Tasmania, on the other hand, governs the Code of Practice for Midwives in Tasmania 2003. As stated previously, one of the purposes of this code is to inform consumers of the role and responsibilities of midwives. Another is to state what the minimum standards/requirements for practicing midwives in Tasmania are. Because this code is a by-law of the Nursing Act 1995, and therefore is part of legislation governing midwives in this state, it is used as a benchmark for assessment of competencies prior to registration and as a tool for professional conduct management. This conforms to the NBT’s role which is ‘to protect the public via the regulation of the profession. It is not an industrial organisation, rather one that has specific legislative responsibilities’ (Verrell 2001,p. 2). It sets standards of practice, registers midwives who meet its requirements, investigates complaints from the public and issues disciplinary action if needed.

The presence of two different organisations with different philosophies is essential so that both the professional and consumer populations are served as optimally as possible. Dr Dennis Kendel (2006 para 5) states:
While there is some alignment between professional self-interest and public interest, it is very difficult for dual purpose organisations to appreciate and consistently respect the fine line that divides the two. It is a fundamental conflict of interest for any professional regulatory body to concurrently serve as the “bargaining agent” for its members…professional regulatory agencies can only be optimally effective if they have a singular purpose, the protection and advancement of the public interest.

So, it can be seen that both organisations have fundamental differences in the types of population that they serve. The ACMI serves the members of the profession while the NBT, a regulatory agency, that incidentally has no legal requirement to have midwifery representation on its Board (Brodie & Barclay 2001, pg. 107; Bogossian 2001, pg. 27), serves the members of the public.

Amongst other defining criteria, the provision of regulatory and professional organisations controlling the codes governing the practice of midwives has meant that midwifery is gaining professional status (Ellis & Hartley 2004, pg. 156). The attainment of public recognition is the now ultimate objective to gain acceptance and raise community awareness. To accomplish this, midwifery professionals need to look at ways to raise community awareness and knowledge of the role and function of the midwife. In addition to this, they need to raise awareness and knowledge of the availability of midwifery services to ensure childbearing women have access to care by a midwife. There are numerous ways of achieving this, such as setting up tables at local fetes, conventions, festivals etc; talks in schools; library displays; media coverage in the form of newspaper articles and news, current affair and variety show segments on television and radio; advertising in magazines and in the form of bumper stickers, billboards or even on the back of buses! A substantial impact could be made by educating and soliciting the support of sanctioned primary health carers, such as general practitioners regarding the midwifery model of care. The first port of medical contact regarding pregnancy for most women is with their general practitioner so to have them support midwifery and refer women on to midwives will add to public approval of the midwifery model of care. More recently, websites such as Birthways.net ‘empowering birthing families’ (Radtke 2005) and women’s’ groups such as the Citizens for Midwifery Group of America and the Metropolitan Doula Group of New York (MGD Newsletter 2004) have come into vogue advocating for midwifery. In fact, Wagner (2005) states ‘In every country where I have seen real progress in maternity care, it was women’s groups working together with midwives that made the difference.’

Whatever strategies are chosen in an attempt to raise public awareness of midwifery, several factors need to be considered. Most importantly, the target group should be predominantly young women and adolescents. Therefore holding a table at the local CWA fair attracting elderly citizens or organising talks at early primary school level would not be appropriate. The type of material used and information that is imparted needs to be relevant, positive, informative, interesting and engaging. How, when and who presents the information to the target group is another relevant consideration.

To take an example, a program already running is the “Core of Life” Education Program which provides ‘pregnancy, birth and early parenting education of adolescents’ (Pattrick & Smith, 2006). It is targeted at adolescents in the school setting; is presented by a midwife in partnership with either a youth worker or other health professional; and presents information (that can be “tailor-made” to address local issues) by means of videos, slides, discussions and opportunities for role-play. The
timing of the program and its presentation can be arranged to miss high-stress times such as exams, which could impede assimilation of any information. This type of setting also allows midwifery to be extolled and recommended as a career option!

In summary, Tasmanian midwives are regulated by the Code of Practice for Midwives in Tasmania 2003. The governing body of this code is the Nursing Board of Tasmania which sets standards of practice, registers midwives who meet its requirements and, in its role of protecting the public, investigates complaints and issues discipline if required. In addition to this, midwifery has a Code of Ethics 2001, governed by their professional body, the Australian College of Midwives Incorporated, whose objective is to provide valued services to its members. The purpose of these two codes is to inform practicing midwives how and why to act in the prescribed way. By their very existence, they also facilitate the professionalisation of midwifery. A priority objective for the profession is to ensure that childbearing women have access to care by a midwife. Within this context, acceptance and recognition by the general public constitute an important goal. There are several ways in which this can be achieved, but several factors need to be considered to provide the optimal dissemination of the information to be imparted. And finally, by gaining the approval and support of other primary health carers, the midwifery model of care can be promoted and direct referral of women to midwives may result.

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Teenage Pregnancy – An Adolescent Health Issue in Australia

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Abstract

Teenage pregnancy and childbirth is an important adolescent health issue in Australia due to its association with detrimental physical consequences and long-term negative psychosocial outcomes for both mother and child. This essay will begin by reviewing some key statistical data relating to teenage pregnancy and will then explore its association with negative consequences to both family and the community at large. Additionally, it will examine environmental risk and protective factors that influence teenage pregnancy. Whilst numerous determinants are highlighted, the paper will look briefly at two; a child’s home life and access to education. In conclusion, parenting support and home visits to vulnerable new mothers will be advocated in order to ‘improve the environment into which they [teenage mothers] rear the next generation’ (Quinlivan et al., 2004: 203).

Methodology

In this paper the term adolescent or teenage pregnancy will refer broadly to the ages of 14 to 19 year old females.

Related Statistics and Health Outcomes

Registered births to teenage mothers in the less than 15 to 19 year age group totaled 10744 in 2005 (ABS 2005: 41) and accounted for 4% of all births - a birth rate of 16 per 1000 teenage girls. Due to the difficulty in obtaining accurate data, this figure does not include induced abortions of unwanted babies, extra-uterine pregnancies, stillbirths or spontaneous miscarriages. However, in 2003 data obtained from Medicare and the National Hospital Morbidity Database indicated that a further 13855 pregnancies were terminated within this same age group (WHQW 2006). In an interview with ABC Radio in 2003, Dr Henrietta Williams estimated Australia’s abortion rate to be 22 terminations per 1000 teenage girls, a statistic which highlights teenage girls’ reliance on
termination as a form of contraception. In contrast, the United States of America which has the highest rate of teenage pregnancy and birth in western industrialised countries reports 750000 births to teenage mothers at a rate of 75 pregnancies per 1000 teenage girls, 80% of which are unintended and 81% are to unmarried mothers. It is estimated that teenage pregnancy costs the United States $9 billion annually (The National Campaign to Prevent Teen Pregnancy 2007: 1). Compared to the United States, Australia’s rates may not be considered high but they are four times as high as the Netherlands, Japan, Spain and Italy where the rate is 10 pregnancies per 1000 teenage girls (Allison 2004: 1).

Pregnancy can be an overwhelming experience at any age but in a teenager it can create a developmental crisis as the young girl alternates between two stages simultaneously: adolescence and parenthood (Rodriquez & Moore 1996 cited in McMurray 2003: 154 & Quinlivan et al., 2004: 197). ‘Parenting teenagers have not had time to resolve their own stages of role identity and intimacy’ (Hanna 2001: 457) and their cognitive immaturity makes them more inclined to put their needs ahead of the developmental needs of their child. Choosing between proceeding with or terminating a pregnancy is a decision which will have long-lasting repercussions for the teenage mother (McMurray 2003: 155). Statistics indicate that pregnant teenagers are more likely to terminate the pregnancy than proceed with the birth (Skinner & Hickey 2003: 160). However, where childbirth is the outcome, long term negative implications of teenage pregnancy are considerable. Teenage births carry a higher risk of complicated pregnancies, low birth-weight, premature births and the need for neonatal intensive care (McMurray 2003: 155 & Skinner & Hickey 2003: 159). Additionally, infants born to young adolescent mothers are more prone to exhibit inferior cognitive development and lower educational attainment; they are more likely to demonstrate childhood behavioural problems and adolescent antisocial behaviour; and are at an increased risk of suffering from poor nutrition, abuse, neglect and abandonment (Hillis et al., 2004: 320 & Woodward et al., 2001: 1171). Infant mortality within this group is 60% higher than for babies of older women (Swann et al., 2003: 8).

There has been ongoing debate about whether these psychosocial and health disadvantages arise from pre-existing socio-economic environments or whether it is the young age of the teenage mother herself that exacerbates these inequalities (Hillis et al., 2004: 320; Williams & Davidson 2004: 96 & Quinlivan 2004: 203). But what cannot be argued is that the short and long-term
negative consequences come at considerable cost to both mother and child, their families and the wider community. For politicians and governmental agencies, supporting teenage mothers and their children has enormous social and economic impacts (Driessna 2006: 513 & Hanna 2001: 457) and ‘consumes funds [and resources] that could otherwise be deployed elsewhere in the health and social systems’ (McMurray 2003: 155). To the young teenage mother, life course outcomes tend to be characterised by negative public attitudes (Hanna 2001: 462); social isolation (Robson 2006: 309); poverty and prolonged welfare dependence; poor participation in education, training or employment; decreased marital opportunities and greater exposure to physical abuse (Hanna 2001: 457; Quinlivan et al., 2004: 197 & Woodward et al., 2001: 1170). Additionally, Swann et al. (2003: 14) comments on Botting’s (1998) observation that teenage mothers are up to three times more likely to suffer from postnatal depression than their older counterparts. The practical difficulties and psychological pressures of raising a child in an environment bereft of social support, information, stability and financial assistance may contribute to a young mother’s poor self-esteem leading to an increased risk of mental health problems (Leishman 2004: 34). ‘Adolescent depression is a strong predictor of depression in later adult life’ (Rowling et al., 2002: 172) and adolescent parenting has long been identified as a risk factor predisposing infants and children to mental health problems in both childhood and adulthood (Townley 2002 & Zeanah et al., 1997 cited in Elder et al., 2005: 122).

Factors in the Environment Influencing Teenage Pregnancy

Children born to teenagers are at increased risk of growing up in poverty, to misuse alcohol and drugs, to become involved in crime and to become teenage parents themselves (Williams & Davidson 2004: 96). This ongoing intergenerational cycle of social disadvantage, unemployment and poor social functioning suggests that family pathology may contribute to the aetiology of teenage pregnancy (Quinlivan et al., 2004: 197; Hillis et al., 2004: 320 & Woodward et al., 2001: 1182). A host of community, family, school and individual factors have been identified as placing young teenage women at increased risk of pregnancy. For instance, exposure to family violence, early parental divorce or separation, poor relationships with parents (Quinlivan et al., 2004: 198); physical or sexual abuse, alcohol and substance abuse, lower parental education (Hillis et al., 2004: 320); maternal role models of single parenthood (Woodward et al., 2001: 1182); poverty, unemployment and adolescents caught up in the public care system (Knight et al., 2006: 392) are all widely recognised as antecedents to teenage pregnancy.
The most significant risk factor associated with teenage motherhood is childhood exposure to parental separation or divorce and childhood exposure to family violence (Quinlivan 2004: 201; Knight et al., 2006: 398; Woodward 2001: 1180). Many theorists draw attention to a child’s early years in laying down the foundation for all future development (Elder et al., 2005: 121 & Harms 2005: 46) and as a child’s home life is a major determinant, exposure to a dysfunctional, violent or deficient family environment will undoubtedly influence a child’s ‘developmental pathway’ and behavioural outcomes (McIntosh 2003: 230). ‘Family connectedness and good parent-child communication are protective factors for adolescent pregnancy’ (Williams & Davidson 2004: 100 & Hillis et al., 2004: 326). There is good evidence to suggest that a sizeable proportion of teenage pregnancies occur out of an idealised belief that a baby will provide unconditional love and reconnect family members (Quinlivan 2004: 202; Quinlivan & Condon 2005: 918; McMurray 2003: 154). Consequently, some of the vulnerability and risk can be mediated by interventions aimed at enhancing parenting skills, promoting supportive relationships and assisting families cope with difficult personal circumstances.

Another significant influence of early pregnancy are school factors relating to educational performance (Quinlivan 2004: 201 & Woodward 2001: 1172) and school attendance (Knight et al., 2006: 396 & Hanna 2001: 457). Lack of educational achievement is a risk factor not only because of limited career and educational opportunities but also because of its correlation with a lack of motivation and ambition (Quinlivan et al., 2003: 203). Young people uncertain of a purpose in life or a career objective identify parenting as a future role (Quinlivan 2004: 202). In contrast, engagement with education is viewed as a protective factor (Woodward et al., 2001: 1173 & Wellings et al., 2001: 1850). These children usually have a more positive sense of self and are less likely to be influenced by peer pressure. Apart from the academic benefits, schools provide an avenue for children to broaden their social network; to enjoy new experiences and to meet people from varied socio-economic and cultural backgrounds. By learning to understand and accept a more diverse group of their peers, children are less vulnerable to social exclusion (Ridge 2003: 7). Friendships formed in such settings thus have a protective effect.

A Health Promotion Strategy – Home Visits by Nurses
Interventions early in life have a positive impact on later development (Department of Health & Human Services 2002: 29), and childhood is largely influenced by a parent’s competence and ability to create a harmonious and stable home environment. So by improving outcomes for teenage parents and their children, nurses can markedly improve the social and health inequalities of young parents and their children. Mothers play a pivotal role in rearing the next generation. The period immediately following the birth of a child is fraught with tension as young mums suddenly inherit new responsibilities, roles and expectations. Nursing interventions that target new mothers in this transition period should aim to provide practical assistance, information and parenting and social support – strategies which will greatly enhance a new mother’s parenting skills and self-esteem and improve outcomes for her child. Bearing in mind the multitude of research which points to antecedent family and personal factors as determinates of intergenerational cycles of disadvantage, a child health nurse plays an important role in identifying and implementing a program which prevents or enhances child development before the problem becomes irreversible.

‘There is evidence that postnatal support can ameliorate adverse environmental impacts in teenage parenting outcomes [and] the leading strategy for improving postnatal support is sustained home visitation by nurses’ (Quinlivan 2004: 206). Studies have shown that the more effective home visiting programs are those that commence during pregnancy and visit frequently and for long enough so that a therapeutic relationship with the mother is established. Randomised evaluations of two USA and one Australian trial found that nurse home visitation programs were associated with improvements in knowledge and use of contraceptives leading to a reduction in the number of subsequent pregnancies and thus the tendency for lifelong reliance on welfare. Additionally, findings were positively correlated with better parenting skills and an overall reduction in child behavioural problems, child abuse, neglect and childhood injuries (Quinlivan 2004: 206 & Olds et al., 2002: 486). By supporting teenage parents and facilitating contact with other early family services in addition to educating vulnerable young parents of the importance of the early years, a teenage mother’s child is provided with the opportunity to realise their true potential. South Australia is one state that has implemented initiatives to affirm its commitment to improving outcomes for children and families. In February 2006, the South Australian Government responded to the Australian Human Capital Reform Program of Early Childhood and Child Care by initiating a universal program which will see all families of newborns visited by a qualified child and maternal health nurse. The Family Home Visiting Program is not restricted to teenage parents and provides...
additional support to families in need of extra help and up to 34 nurse home visits within the first two years of their baby’s life (Government of South Australia 2006: 6). Whilst it is too early to accurately gauge the program’s level of success, similar programs targeted specifically at teenagers and that are sensitive to the cognitive developmental level of young adolescents can only benefit teenage mothers and their offspring.

The transition to motherhood can be daunting and previously identified environmental, family and personal factors can make this transition even more challenging. Child health nurses who meet with teenage mothers and their children regularly and over a prolonged period of time, who support, educate and encourage young mothers in their parenthood can help prevent negative cumulative effects and enhance the well being and life chances of these vulnerable people.
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Same sex families in Australia

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Abstract

It is an oft-heard lament that families are not what they used to be. This sentiment assumes that families are static through time, culture and region. Families are in fact an ever-evolving social institution. The family unit is responsive to social, political, economic, legal and historical pressures and continues to transform itself due to these external pressures. Contemporary Australian families have diversified from the romanticised version of the 1950’s style two-parent heterosexual unit. Many different family structures exist today. One of these is the gay/lesbian family, or same sex couples parenting children. First, a basic understanding of the history of the family unit is explored. Then, an explanation of gay/lesbian parenting and family units is outlined. Understanding the implications for children with same sex parents is important as a midwifery health professional to provide appropriate and responsive care to this type of family. Social, educational, health, sexual, legal, and parenting implications for children of same sex parents are analysed in greater depth.

Same sex parenting is a controversial topic, tapping into deeply-held personal beliefs. The literature on this topic was mostly biased, either for or against same sex parenting. This depended
on the authors’ views on same sex parenting or which organisation was publishing the work. The author of this paper is naturally writing from a biased viewpoint also, as the author’s personal views reflect the interpretation of evidence and research on the topic. In order to be upfront and remove the pretense of being unbiased, the author of this paper states freely that she is supportive of same sex parents and their children. Even from this viewpoint, an in-depth analysis of the implications of this type of family on children is still possible and relevant to contemporary midwifery practice.

An understanding of family and its historical context is important to gain insight into contemporary Australian families. Healey (1995, p. 2) defines a family as two or more people related by blood, marriage, adoption or a de facto relationship who live in the same household. The most common type is the married couple with or without children. However, single parent families and families of related adults are also considered families. The 1991 census found that ninety-nine percent of households in Australia contain one family. However, the composition of these families is changing. The traditional two-parent heterosexual family unit is now becoming less pervasive as one parent families increase. One parent families are on the rise due to multiple factors. The 1975 Family Law Act legalised no-fault divorce. Consenting adults can obtain a divorce and this frees couples from the “until death do us part” view of marriage. Women gained paid employment outside the home. This increased women's financial security and job opportunities. This also allowed women to break away from institutionalised dependence on husbands for access to money (Burbidge 1998, p. 10). Society's changing attitudes towards divorce, separation, women’s liberation, and equal rights have all shaped present family structures. Blended families have developed with the higher divorce rate. People who remarry and combine children from their other marriages into one family form blended families (Healey 1995, p. 1). Families are traditionally a “main conduit of socialisation” (Calhoun Davis & Friel 2001, p. 669). What will the impact of decreasing numbers of intact two-parent families be?

Families change over time. However, a noticeably rapid period of change for the family unit occurred after World War II. After the trauma of World War II, the surviving men came home from war and stability and security were rebuilt from the ruins of global warfare. Women's roles as mother and homemaker became firmly established in the post war era. Families became more children-focused, and children started to be dependent on their parents longer. Children were no longer sent into the work force to contribute financially to the family. Instead, the family supported
the children (Burbidge 1998, p. 12). Advances in family planning technology allowed for
recreational sexuality separate from procreation. More resources were available for each child as
women and men could better control the number and timing of children (Coontz 2000, p. 291).

Then, the 1960's heralded an increased societal emphasis on individualism. The rights of the
individual and the civil rights movement changed the focus from the family as a single unit to a
group of individuals functioning as a social unit together. In the 1970's, with the introduction of the
Family Law Act 1975 legalising no-fault divorce, separation and divorce rates increased as a
byproduct of this turn towards individualism. Government support in the form of pensions enabled
single parent families to become a financially viable option, thus removing the traditional financial
restrictions on family dissolution (Burbidge 1998, pp. 1-13).

Family structure has changed in the last thirty years. The proportion of families comprising
a heterosexual couple with dependent children has decreased from 49.6% in 1996 to 47% in 2001.
It is still the dominant family structure but other types of families are appearing also. Step families
and blended families are on the rise with people who have been previously married and have
children living together and forming a new family unit (Wise 2003, p. 2). Grandparents are
assuming residential care of grand-children when parents are unable. The number of children per
household has decreased. Children were once viewed as an insurance for parents as they age. The
longer dependence of children on their parents for educational and financial support and the rise of
individualism and separation from family post training and education, means children are more of a
drain on resources than contributors (Coontz 2000, p. 289). In 2001, the fertility rate was 1.73
babies per woman. Twenty percent of women are choosing not to have children at all. This was
previously not an option when women married in order to secure financial stability and were unable
to obtain paid employment outside the home. Families with three or four children were once the
norm and are now rare. Two-child families are more usual these days (Wise 2003, p. 4).

Non-traditional family structures have developed as a result of these societal changes.
Family structure has multiple dimensions. It can be the parents' relationship to the children in their
household, like the biological or non-biological parent. Family structure can also be defined by the
marital status and relationship history of the parents, such as divorced, remarried, or separated. And
parents' sexual orientation can define a family structure as well, as in gay/lesbian/same sex couple
families. All of these family structures provide a variety of diverse families that previously were
unheard of. Single-parent families are the fastest growing type of family unit due to the high divorce and separation rates and births outside of marriage. The status of women has changed and they are more socially and financially independent. Thus, women are often the “main” parent responsible for child-rearing and income-support in single parent families. Some other examples of non-traditional families are step-families, foster, surrogacy, blended and gay/lesbian families. As the conventional nuclear family dominance wanes and non-traditional families develop, questions about the provision and caring for children in these families arise (Wise 2003, vi-5).

With the upheaval of the “traditional” family unit, what is the future for the Australian family? In what direction will families develop? Coontz argues that the concept of the “traditional” family unit is sentimentalisation and that families have always been in a state of constant change. Family is defined by its historical, social, cultural and political context and therefore changes as time and history progress. So, the “collapse of the family” is an overstatement. These diverse family structures that are evolving in present day Australian society are a natural progression in continual family development. The changes to family structure are neither all good nor all bad (Coontz 2000, pp. 283-291). After all, Pollack (1995, p. 106) states that “love makes a family” and love is certainly not going away.

Gay/lesbian families are one of the new family structures in Australian society. Census results have not historically asked about sexual orientation (Healey 1995, p. 10). The 1996 census was the first to recognise same sex couples. This census reported 8 296 same sex couples in Australia, and 1 483 of those with children (Wise 2003, p. 3). However, these statistics should be viewed as an underestimate. Obtaining an accurate count of self-identified same sex couples is fraught with difficulties as many gay/lesbian people fear discrimination due to negative societal views about homosexuality and they hide their sexual identity. Often, mothers and fathers in same sex relationships have children from a previous heterosexual relationship that has broken down. More and more same sex couples are utilising advances in reproductive technology to access an array of family options (Coontz 2000, p. 289). A survey in 2001 of same sex couples in Victoria found that forty-one percent of couples were hoping to have children. Clearly, this new family structure is growing. As it becomes culturally acceptable to have same sex relationships, society's attitudes to the gay/lesbian family will adjust as well (Wise 2003, p. 3).
Gay/lesbian families show a variety of “non-traditional” family structures. Blended families are created when a couple bring children from previous relationships to the family unit. Single parent families form when a heterosexual marriage breaks down after a partner “comes out”, or self-identifies as a homosexual, and the gay/lesbian partner has custodial care of the child or children. Foster care and adoption are non-biological options of parenting for gay/lesbian couples. Gay men use surrogacy to have a biological child of one of the partners. And lesbian women utilise donor insemination, from a known or unknown donor, to have a biological child of one of the partners. Consequently, children in gay/lesbian families can have multiple parent figures instead of the traditional heterosexual model with just two biological parents. Some potential relationships to children are step-parent, birth mother, donor father, surrogate mother, resident co-parent or separated co-parent. A step-parent is the parent of a child from a partner’s previous heterosexual relationship or donor insemination. A co-parent has jointly planned, conceived and raised a child (Millbank 2002, p. 9-16).

The effects of same sex parenting on children is difficult to ascertain. Much of the published literature is biased either for or against same sex parenting, according to the author’s or publisher's own agenda. Christian sources state that there is not enough research and evidence available on such a small “out” gay/lesbian parent population to adequately allay fears for children’s’ welfare. Religious publications give evidence against same sex relationships and parenting, citing child sexual abuse, relationship breakdown, sexual promiscuity, gender identity confusion, peer isolation and ostracisation, need for “father” and “mother” figures for role modelling, reduced mental health and psychological well-being and Biblical edicts. Other organisations who support same sex parenting, such as the Gay Lesbian Bisexual and Transgender Lobby and the Tasmanian Law Institute, state that twenty-five years of research studies have proven that there are no differences between children parented by heterosexual or homosexual people. And in fact, same sex couples are more supportive, egalitarian, and better at co-parenting and interparental relationships than heterosexual parents (Wise 2003, p. 28). While many studies have been conducted analysing the parenting skills of same sex parents compared to heterosexual parents, there is a noticeable lack of literature from the children’s perspectives. Only one source spoke to a child raised in a gay/lesbian family. She was the child of two gay men and she gave favourable reports on social acceptance, both within the family as well as outside (Healey 1995, pp. 11-12).
The biological option of procreation by sexual intercourse between a man and a woman is not an option for same sex couples. Therefore, they have a diverse range of methods of becoming parents. Many people in same sex relationships are parents to children born to a previous heterosexual relationship before their homosexual identity was clear to them, or they “came out.” Blended families are common, as each partner may have children from prior relationships. The usual concerns of step-parenting pressures, contact with the non-custodial parent and financial issues are found in these blended families. Same sex couples seeking to have children together use donor insemination and other assistive reproductive procedures, adoption, fostering and surrogacy (Wise 2003, p. 26).

As assistive reproductive technology becomes more developed, accessible, and known to the public, these options will be utilised more commonly (Millbank 2002, p. 24). Single and coupled lesbians who want to give birth opt for donor insemination. This can be with a known or unknown donor. Depending on the availability and accessibility of fertility services, lesbian couples may choose to go to a fertility clinic and use an anonymous donor. The advantage with this method is that the sperm donor has had health checks and fertility tests. Lesbian couples in the United States are more likely to use an anonymous donor. In Australia, lesbian couples are likely to use a known donor. Self-insemination at home is the preferred technique. The advantage of this arrangement is that the couple know the donor and have chosen them specially to be the biological father of their child. In some cases, this donor becomes a co-parent or uncle-type figure for the child (Millbank 2002, pp. 11-47).

Gay couples use adoption, fostering and surrogacy to have children. However, same sex couples can’t both be the legal parents of an adopted child due to their sexual orientation. Adoption agencies specify that the adopting couple must be a man and a woman married to one another. Same sex couples cannot legally marry in Australia. So, couples usually have one partner adopt the child, leaving the other partner as a parent but with no legal rights to care for the child (Morgan 2002, pp. 24-36). The Tasmanian Law Institute wrote a report in 2003 recommending changes to the Adoption Act in Tasmania that will allow same sex couples to adopt. Opponents argue that adoption for same sex couples is a non-issue as there hasn’t been any demand for the service in Tasmania to date and it is not a pressing public issue (Tasmanian Law Reform Institute 2003, pp.
The social implications for children with same sex parents are varied. There is a negative stereotypical belief that the mental health and stability of same sex couples is less than that of heterosexual couples (Buxton & Warner 2003, p. 28). Some other common social concerns for children in gay/lesbian families are gender confusion, problems with social relationships, family disruption due to shorter relationships between homosexual people, fear of sexual molestation and a difficult social and emotional development due to the parents' sexual orientation (Wise 2003, p. 26). Wise (2003, p. 8) states that studies have shown no causal relationship between children's well-being and the family structure they grew up in. Children can function in any family structure as long as certain conditions are met. Some major factors in child outcomes are family dynamics and environment. Parenting style, behaviours, monitoring and involvement with their children, attitudes, beliefs, values and interparental relationships constitute these positive family dynamics (Wise 2003, pp. 5-10). The relationships between adults, communication, openness and warmth in the home have major environmental impacts on child development (Millbank 2002, p. 5). Same sex parents function similarly to heterosexual parents in these ways and no parenting situation has been inevitably associated with positive or negative outcomes for children (Morgan 2002, p. 33).

A peer implication for children growing up with gay or lesbian parents is conflict. Thirty-three percent of children of same sex couples report being bullied, teased and subjected to homophobic language from their schoolmates (Wise 2003, p. 28). Children may be embarrassed about their parents' sexual orientation when they are in public or at school. Some sources posit that this risk of social ostracisation is detrimental to children in same sex families (Morgan 2002, pp. 73-76). On the contrary, other sources claim that children develop ways to cope with this social pressure from peers and show no long-lasting developmental, psychological or social scars from their experiences (Wise 2003, p. 27). One child of two gay men states that she exercised discretion amongst her school peers, choosing who to tell her parents were gay and who not to tell (Healey 1995, pp. 10-12). Children harass people who are different and at this stage in the development of the Australian family, gay/lesbian families remain different.
Educational implications for children with same sex parents stem from the assumption that all children have two heterosexual parents. As the traditional family evolves into more diverse family structures, schools will have to adapt to keep pace with the changes. School forms usually leave blank spaces for one mother and one father for each student. This fails to cater for single-parent and same sex families. Presently, curricula do not include teaching about gay and lesbian families (Pollack 1995, p. 26). Some gay/lesbian parents are concerned that teachers' negative attitudes toward same sex parents will have negative effects on their children's well-being and self-esteem. Maney & Cain (1997, p. 236) conducted a survey of newly trained teachers in the United States and their attitudes to same sex parenting. They concluded that the majority of the teachers they surveyed felt comfortable with homosexual parents and teaching a curriculum that includes gay and lesbian lifestyles. Female teachers were found to be more comfortable with children of same sex parents and teachers with strong religious views harboured more negative attitudes toward lesbian parents. As diverse family structures emerge into the mainstream and away from “alternative” status, the educational system will have to incorporate these lifestyles into their curricula to represent our diverse society (Maney & Cain 1997, p. 236).

There are few health implications that apply solely to children in gay and lesbian families. One potential problem may be homophobia encountered from health professionals. Twenty-three percent of lesbian mothers reported homophobic attitudes from health professionals during their pregnancies (Millbank 2002, p. 50). Lesbian women may choose not to disclose their sexual orientation to health professionals. An anecdotal example of this is a lesbian couple where one woman was giving birth on the maternity ward at the Royal Hobart Hospital. The midwives assumed that the two women were single mother and support person or friend, and never asked if they were partners. Another person who knew their relationship “outed” them to the health professionals. Homophobic views may affect the children later in life when they visit the doctor with two mothers. Professionally, health workers are bound by Codes of Conduct to treat their clients or patients in a respectful, non-judgmental and non-discriminatory way.

Another health concern for children of same sex couples is sexuality and sexual development. Opponents of same sex couples worry that children will be “subjected to the effects of atypical adult preferences” and the “troubling aspects of 'gay' behaviour, like rampant
promiscuity (Morgan 2002, pp. 25-26).” Rampant promiscuity is not the domain of homosexual people only. And homosexuality has not been proven to be an atypical sexual preference. Calhoun Davis & Friel (2001, p. 669) suggest that factors other than family structure are more significant in a child's sexual development. A child's sexuality is based more on context than parental sexual orientation. For example, the relationship between the child and their mother and the mother's attitudes toward sex affects children's initiation to sexuality more than the parents' sexual identities. A quality mother-child relationship has a protective effect on children, regardless of the sexual orientation of the mother. A mother with more permissive attitudes and behaviours in relation to sex is more likely to transmit these attitudes and behaviours to her adolescent children (Calhoun Davis & Friel 2001, pp. 671-677). Parents who are very involved in their children's lives and have high levels of interaction establish the system of norms and values that their children will live by. The argument that children will be homosexual if their parents are homosexual is unfounded. Heterosexual parenting does not ensure heterosexual children. Homosexual people's parents are heterosexual after all (Buxton & Warner 2003, p. 35)!

There are legal implications for children of same sex couples. The biological mother of a child has social, legal and biological custody of the child automatically. But what about the co-mother? What are the legal duties of a step-parent or co-parent? Adoption by same sex couples was legalised in Western Australia in 2002 (Buxton & Warner 2003, p. 43). The Tasmanian Law Institute in 2003 documented their support for creating a legal pathway for same sex couple to adopt in Tasmania (Buxton & Warner 2003, pp. 5-19). Same sex couples where one partner is the biological parent often apply for adoption by the non-biological parent, step-parent or co-parent. Lesbian couples who use donor insemination apply for adoption by the co-mother. And gay couples apply for adoption if they use a surrogate mother. In this way the continuity of care for children remains intact in the event of an illness or death of the biological parent. Results can be disastrous for children of same sex couples in places where same sex couples are not legally allowed to adopt. There have been instances in the United States where same sex couples can only legally have one parent adopt. Then, the legal parent has died and the children became wards of the state and were taken away from their other social and emotional, if not legal, parent (Pollack 1995, p. 35). Opponents to the amendment of Tasmania's adoption laws argue that less than two percent of the population is gay and there has been no case of a same sex couple wanting to adopt in Tasmania yet (Tasmanian Law Reform Institute 2003, pp. 96-99). The Tasmanian Law Institute
argues that the law that excludes same sex couples is discriminatory on basis of sexual orientation and must be amended, regardless of demand. All these legal issues impact on the future of children in gay and lesbian families.

Parenting issues have important implications for children of same sex parents. Research on same sex parenting over the last twenty-five years has found that sexuality does not affect parenting skills (Buxton & Warner 2003, p. 30). Same sex parents however face barriers and obstacles to parenting. These are the biological, legal or social obstacles highlighted previously. Gay and lesbian couples are usually very motivated parents because they have to work outside societal norms to have children (Pollack 1995, pp. 24-33). All children are wanted in gay/lesbian families and the parents usually went to great lengths to have them (Buxton & Warner 2003, p. 33). There aren't many supports for homosexual parents, but support groups and services will increase as this model of family becomes more common. For example, a lesbian mother in the United States has formed her own Mommy's Group for other lesbian mothers (Pollack 1995, p. 103). Finding good child care can be another hurdle for same sex couples due to homophobic attitudes. All these factors increase parenting challenges for same sex parents and affect their children.

In conclusion, traditional family structures are changing toward more diverse families in contemporary Australia. The history of the evolution of Australian families has been discussed. Gay and lesbian families are one of the diverse range of family structures seen in Australia today. The dynamics of gay and lesbian families are outlined. And implications for children growing up with same sex parents are highlighted, specifically social, peer, educational, health, sexual, legal and parenting issues faced by these families. As Australian society continues to develop over time, “alternative” families, such as gay/lesbian ones, will become more accepted and mainstream.

References


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In Australia the healthcare industry employs in excess of 700,000 people. Over the past two decades it has been growing more quickly than any other industry. Those working in healthcare experience different levels of risk to developing an illness and injury. Occupational stress is one hazard that is almost endemic to the healthcare injury, but within that industry there are wide variations.

According to the British Health and Safety Executive, stress is defined as ‘the adverse reaction a person has to excessive pressure or other types of demand placed on them’ (HSE, 2004: 2). In Australia stress is reported to cost $1.3 bill. and claims have increased four-fold in the past decade. Part of that cost was compensation ($200 mill.) and the rest is made up of the costs of lost productivity, absenteeism, turnover and poor work quality. The cost of stress is extensive. In 2002 stress had the greatest median cost and averaged as the second highest cost of all compensated illnesses and injuries. (Peterson, 2007).

In Australia for the purpose of compensation, mental stress (the category covering work related stress) has six categories. The Australian Safety and Compensation Council (ASCC, 2007) reports that the most common category compensated during 2004-2005 were, in descending order:

- work pressure, then
- harassment, followed by
- exposure to violence;
- other mental state factors, then
- traumatic events, and finally
- suicide or attempted suicide

There are many causes of stress. These include a lack of support from managers and supervisors; conflicts with coworkers; feeling that work is boring; poor interpersonal relationships; conflicts between home and work responsibilities; work overload; and job insecurity.

**Stress in the nursing profession**

The ASCC Interactive Compensation Database was utilized (http://nosi.ascc.gov.au) and it showed that during 2005-2006 Health and Community Services industry employees had the fourth highest incidence rate for stress out of all 19 industry groups. The incidence rate is the number of compensated claims out of 1000 employed. The rate was 1.4 per 1000 employees.
Peterson (2005) discussed the high rates of stress for nursing as a profession, and while there are variations between groups of nurses, the high rate has been constant for some time. In the year 2000 registered nurses had a much higher incidence rate of compensation than any other professional or paraprofessional group in healthcare.

Based on a different measure of stress compensation, the frequency of claims per 100 mill. hours worked, the rate of stress compensation for some male and female nursing groups is high compared to the national average, and in some cases higher than for any other workers. For male registered nurses and male caring and nursing assistants the rates of stress compensation during 2003-05 were high. They were comparable to the high rates for male primary and secondary teachers, but less than half the very high rate for male welfare and community workers (ASCC, 2007).

Of major significance, however, female nurse managers had a very high frequency of compensation rate per hours worked. In fact it was the highest rate per hours worked of any females employed, and at a rate 11 times the average for women. These figures demonstrate an extremely high rate of stress for some members of the profession.

There are many reasons why the health sector has high rates of stress, and why the nursing profession rates are high, particularly those of female nurse managers. The work of nurses is characterised by high work demands, the need to learn new technologies, to work to increasingly intensified schedules, and to respond to emergencies. In many cases their work is performed in both a bureaucratic and professional hierarchy, and some nurses may experience a lack of control. This may be the case for nurse managers. This is known as Karasek’s Demand-Control approach to stress (Karasek, 1979, 1981). That is, stress occurs when a person experiences a lot of work demand but has a relatively small amount of control. Excessive hours worked and shift work with its changing routine also exacerbates stress. Poor management and supervisory practices have also contributed to stress outcomes. For nurses it may be the structure of work relations and their position in the power hierarchy that contributes to increased stress.

**What can be done?**

A risk management approach to stress is an effective way to create conditions at work that are conducive to relatively stress-free environments. It is a way that employers can get to see problem areas in jobs that produce stress, and a method of working together with employees on how to redress the stressful aspects of their jobs. The following method is a risk based approach that can reduce stress and help to deal with it.

Managements need to:

- Carry out a risk assessment on the job, not the person
- Identify employees’ skills and training needs
- Determine if the risk of stress is high or low
- Identify the major factors causing stress
- Consult with staff on what needs to be changed in the job
- Establish an action plan to deal with stress
- Evaluate how effective the action plan was in alleviating stress
Whether they are registered nurses or nurse managers, the same risk based approach can apply. Victorian Workcover Authority (2007a, 2007b) has downloadable software available to help run programs to bring about changes and reduce stress levels at work.

La Montagne and associates (2007) have identified a best practice approach taken by organizations in dealing with stress which would be applicable to the work of nurses. The least effective is to deal only with the stressed individual in offering stress management; next most effective is to bring about changes to the work to reduce stress outcomes; finally organizations which deal with both changes in the job as well addressing the needs of individual employees had the best stress reduction outcomes.

There are a number of areas in nursing which are conducive to high levels of stress. Risk based approaches are being shown to be the best way of dealing with stress related problems and provide a framework where management and nurses need to work together for solutions. Stress is a condition that creates large costs to individuals and is harmful to organizations through producing absenteeism, lost productivity and poor morale, and is in everybody’s interests to address.

References


Victorian Workcover Authority (2007a) Stresswise Toolkit Worksheet

Victorian Workcover Authority (2007b) Stresswise Toolkit Case Study