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Dutch adolescents from lesbian-parent families: How do they compare to peers with heterosexual parents and what is the impact of homophobic stigmatization?



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ABSTRACT

In this study, we compared internalizing and externalizing problem behavior of 67 Dutch adolescents ($M_{\text{age}} = 16.04$) in planned lesbian families who were matched with 67 adolescents in heterosexual-parent families. We also examined whether homophobic stigmatization was associated with problem behavior in adolescents with lesbian mothers after taking into account demographic characteristics, mothers' scores on emotional involvement, and adolescents' earlier problem behavior (measured at age 4–8 years old). Standardized instruments measuring problem behavior were completed by parents and adolescent offspring, and questions about stigmatization were answered by adolescents with lesbian mothers. The results revealed no differences in internalizing and externalizing problem behavior associated with family type. Offspring in lesbian families who reported more experiences of homophobic stigmatization also demonstrated more internalizing and externalizing problem behavior.

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It is well established that children's psychological development is fostered in parent–child relationships that are embedded within the cultural context in which children are raised (e.g., [Maccoby, 1992](#)). For planned lesbian families (i.e., those in which children are born to mothers who identify as lesbian), the more negative the climate regarding lesbian and gay people, the more difficult it is for mothers to ward off hostile attitudes toward nontraditional families, and the more likely it is that offspring will be bullied because of their mothers' sexual orientation or a homophobic culture at school ([Shapiro, Peterson, & Stewart, 2009](#)). Since there is broad agreement in the psychological literature that teasing and bullying are important predictors of internalizing (e.g., toward the self, such as being withdrawn, anxious, or depressed) and externalizing (e.g., toward others, such as breaking rules or being aggressive) problem behavior ([Achenbach & Rescorla, 2001](#); see for an overview: [Reijntjes, Kamphuis, Prinzie, & Telch, 2010](#); [Reijntjes et al., 2011](#)), offspring in planned lesbian families may be more at risk for behavioral problems than their counterparts in heterosexual-parent families.

The minority stress theory (MST) is a theoretical framework that offers an explanation for potential differences in behavioral problems between offspring in lesbian- and heterosexual-parent families. This theory suggests that sexual

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minority individuals may be susceptible to health problems as a result of stress associated with victimization based on sexual orientation (e.g., Meyer, 2003). Studies using this theory have consistently documented mental health disparities between adolescent and adult lesbian, gay, and bisexual (LGB) populations, and heterosexual populations, related to experienced stigmatization in the LGB samples (for an overview, see: King et al., 2008).

Homophobic stigmatization pertains to the negative attitudes that individuals, groups, or communities have toward nonheterosexual identity or behavior, and the discrimination that accompanies these attitudes (Herek & McLemore, 2013). Although the offspring of lesbian mothers mostly identify as heterosexual (Gartrell, Bos, & Goldberg, 2011), they remain vulnerable to rejection and bullying by peers, negative comments about their mothers' sexual orientation, and/or fears of being targeted for their atypical family structure (Gartrell & Bos, 2010)—thus, according to the MST, susceptible to developing behavioral problems.

Despite predictions of the MST, most research on offspring in female same-sex parent families found no evidence that children or adolescents have more psychosocial or behavioral problems than those in different-sex parent families. For example, in the National Longitudinal Study of Adolescent Health (the Add Health study, derived from adolescent self-reports), measures of self-esteem, academic performance, peer relations, depression, anxiety, delinquent behavior, and substance use were similar for adolescents in both family types (Wainright & Patterson, 2006, 2008; Wainright, Russell, & Patterson, 2004). In addition, Rivers, Poteat, and Noret (2008) found no difference in psychosocial functioning between British adolescents living with their mothers and the mothers' same-sex partners, and British adolescents who were living with their heterosexual parents. Furthermore, results of the U.S. National Longitudinal Lesbian Family Study (NLLFS) showed that adolescents in female same-sex parent families rated their quality of life comparably to their matched counterparts in mother-father families from the Washington Healthy Youth Survey (van Gelderen, Bos, Gartrell, Hermanns, & Perrin, 2012). Finally, with regard to substance use, the NLLFS adolescents were no more likely to report problematic use than matched peers from the 2008 Monitoring the Future national probability survey (Goldberg, Bos, & Gartrell, 2011).

When differences have been found between adolescent offspring in female same-sex and different-sex parent families, they usually have favored the former group. In the Add Health study, for example, adolescents in same-sex parent households felt more connected to their schools (Wainright et al., 2004). In a British study by Golombok and Badger (2010), the offspring in female-headed households showed higher levels of self-esteem and lower levels of anxiety, depression, hostility, and problematic alcohol use than those in opposite-sex parent households. In the NLLFS, the 17-year-old adolescent offspring of lesbian mothers had significantly lower scores on social problems, rule-breaking behavior, and aggressive behavior, and higher scores on social competence, than age- and gender-matched adolescents in heterosexual-parent families (Gartrell & Bos, 2010).

The NLLFS is one of the few studies that looked at differences in psychological well-being within the group of offspring in lesbian-headed households. According to their mothers, 47.5% of the adolescents experienced stigmatization, which was associated with more internalizing and total problem behavior (Gartrell & Bos, 2010). In addition, results based on adolescent reports revealed that those who experienced stigmatization had less life satisfaction and more psychological health problems than the NLLFS group that had not been stigmatized (van Gelderen, Gartrell, Bos, & Hermanns, 2012).

Regarding these prior investigations, some methodological issues should be noted. Neither the Add Health studies (Wainright & Patterson, 2006, 2008; Wainright et al., 2004) nor the Rivers et al.'s study (2008) included questions about the mothers' sexual orientation and/or family constellation at the time of the adolescents' birth. Therefore, it is unclear whether the reports pertain to adolescents who were raised by lesbian mothers since birth; it is possible that the adolescents in both studies had experienced their mothers' coming out, and the consequences of that coming out. In the Golombok and Badger study (2010), adolescents conceived through donor insemination (DI) in single- and lesbian-mother families were merged in the comparison with those born to two heterosexual parents (without DI). Furthermore, none of these studies used multi-informant data on adolescent problem behavior, despite evidence showing that adolescents are better at identifying their internalizing problems, while other related persons – such as parents – are better at specifying adolescents' externalizing problems (e.g., Kosterman et al., 2010). Finally, no previous study has investigated whether the relation between stigmatization and adolescent problem behavior can be explained by other confounding variables, such as offspring gender, parental educational level, parental relationship status (still together or separated), parenting style, or childhood problem behavior—factors shown to be related to adolescent problem behavior (e.g., Amato, 2001; Bolkan, Sano, De Costa, Acock, & Day, 2010; Bongers, Koot, van der Ende, & Verhulst, 2004; van Oort, van der Ende, Wadsworth, Verhulst, & Achenbach, 2011). For example, parental relationship dissolution or uninvolved childrearing can contribute to psychological distress and/or behavioral problems in offspring regardless of the parents' sexual orientation (Amato, 2010; Amato & James, 2010; Perrin, Cohen, & Caren, 2013).

To address the above mentioned methodological issues, the current study compares the internalizing and externalizing problem behavior of adolescents in Dutch planned lesbian families with those of matched teenagers in Dutch heterosexual-parent families through data gathered from the mothers and their adolescent offspring. Based on the MST, we hypothesized that adolescents in lesbian-parent families would show more problem behavior than their counterparts in heterosexual-parent families. In addition, we examined whether experiences of homophobic stigmatization were associated with problem behavior in the adolescent offspring of lesbian mothers after controlling for adolescent gender, maternal educational background, maternal relationship status, parenting style, and problem behavior measurements when these offspring were 4–8 years old. As our data are drawn from a longitudinal study, it was possible to control for these potential confounding variables at two time intervals—childhood and adolescence. Consistent with previous research, our second hypothesis was

that for the adolescents in planned lesbian families, experiences with homophobic stigmatization would be associated with more problem behavior.

Methods

Participants

The sample of adolescents with lesbian mothers was derived from an ongoing longitudinal study on planned lesbian families in the Netherlands (the Dutch Longitudinal Lesbian Family Study; DLLFS), which was initiated in 2000. It was the first study to focus on parental characteristics, child rearing, and child development in a group of 100 Dutch planned lesbian families. Data were collected in three waves, namely when the children were on average 5.8 years old (T1), 9.9 years old (T2), and 16.6 years old (T3). The current study mainly focused on data of T3.

For the present study, index adolescents were excluded from analyses if they were older than 19 years and/or did not complete the questionnaire (see Fig. 1). This yielded a DLLFS analytic sample of 67 adolescent offspring (36 girls and 31 boys), with a mean age of 16.04 years ($SD = 1.32$). Ninety-three percent of the adolescents ($n = 62$) were being raised by lesbian mothers with a Dutch ethnic cultural background, and 93% ($n = 62$) had a mother with at least a college education. Eighty-one percent of the adolescents' mothers ($n = 54$) were still together, and the remaining 19% ($n = 13$) had separated (see Table 1). To compare the children's problem behavior and maternal emotional involvement at T1 between index adolescents who did ($n = 67$) and did not ($n = 33$) participate in the current study, we conducted a multivariate analysis of variance (MANOVA). Results indicated no differences between the two groups, Wilk's $\lambda = 0.98$, $F(3, 100) = .80$, $p = .499$.

We constructed a comparison group of adolescents reared by opposite-sex parents using data from the Zuid-Holland Longitudinal Study (Z-HLS) (Tick, van der Ende, & Verhulst, 2007; Tick, van der Ende, & Verhulst, 2008). The Z-HLS compared two samples of adolescents—one in which the data on problem behavior were collected in 1993, and a second in which the data were collected in 2003. The rationale behind the Z-HLS was that most studies on adolescents' internalizing and externalizing problem behavior were primarily based on parent and/or teacher reports. During adolescence, self-reports are also an important source of information when investigating emotional and behavioral problems. Prior to the Z-HLS, few studies had explored self-reported adolescent well-being, and those that did only included adolescents within a narrow age range, of a single gender (girls), or from school-based samples. Because of these limitations, the Z-HLS used a multi-informant approach in collecting data from adolescents by means of the Youth Self-Report (YSR), and also from their parents through the parental version of the YSR – the Child Behavior Checklist (CBCL). In the DLLFS, the same multi-informant approach was employed using the identical instruments (YSR and CBCL) to measure adolescent problem behavior.

For the comparison with the DLLFS adolescents, we used the Z-HLS data from 2003. In 2003, among the 2317 randomly selected adolescents (between 13 and 18 years old) from 35 municipalities in the Dutch province of Zuid-Holland were 1710 adolescents (73.8%) whose parents agreed to participate. Of these families, there were 614 families for whom both adolescents and parents completed the required questionnaires.

This group of 614 adolescents was used for 1:1 matching with the DLLFS adolescents on gender, age, parental education (highest degree held by the parents), parental ethnic cultural background, and parental relationship status (still together or separated). Each first match on all these variables was used as a comparison adolescent for each DLLFS adolescent. As shown

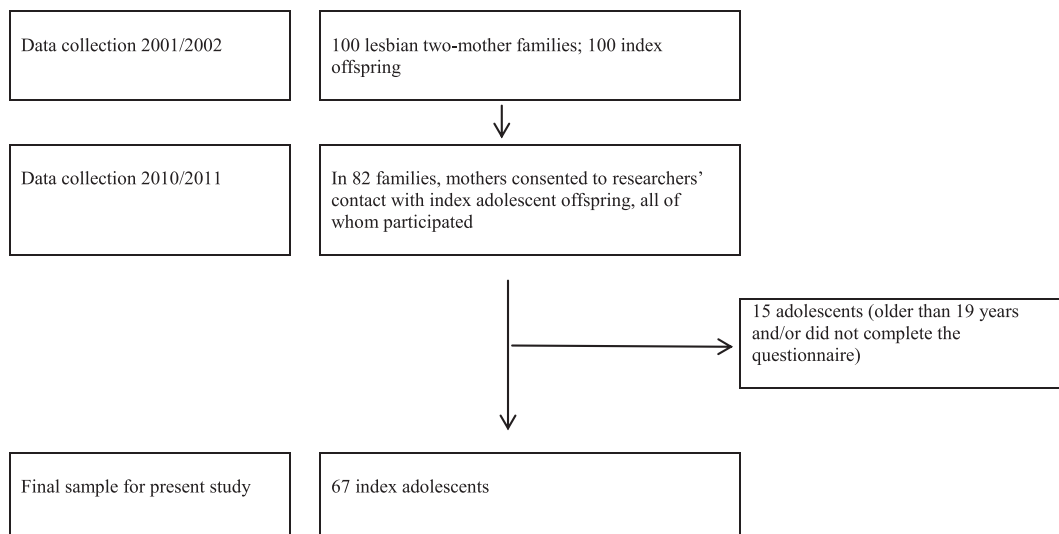


Fig. 1. Flow of participants in the Dutch Longitudinal Lesbian Family Study.

Table 1
Demographic characteristics of the DLLFS and the Z-HLS samples.

	DLLFS	Z-HLS	DLLFS vs. Z-HLS
Adolescent sample size	67	67	
Adolescent age <i>M</i> (<i>SD</i>)	16.04 (1.32)	16.03 (1.33)	<i>ns</i>
Adolescent gender, % (<i>n</i>)			<i>ns</i>
Girls	53.7 (36)	53.7 (36)	
Boys	46.3 (31)	46.3 (31)	
Parental educational level, % (<i>n</i>) ^{a,b}			<i>ns</i>
College degree or higher	92.5 (62)	92.5 (62)	
Less than college degree	7.5 (05)	7.5 (05)	
Ethnic cultural background, % (<i>n</i>) ^a			<i>ns</i>
Dutch	92.5 (62)	95.5 (64)	
Mixed ^c	7.5 (05)	4.5 (03)	
Parental relationship status, % (<i>n</i>) ^a			<i>ns</i>
Continuous couple	80.6 (54)	82.1 (55)	
Separated ^d	19.4 (13)	17.9 (12)	

^a Based on parental report.

^b Parent with the highest degree.

^c Mixed = Dutch/other.

^d Cohabiting with new partner: *n* = 4, living alone: *n* = 7, no information: *n* = 2.

in Table 1, this matching was successful. A MANOVA with internalizing and externalizing problem behavior (reported by both adolescents and their parents) as dependent variables indicated that there were no differences between the selected and the total Z-HLS sample on any variable used in this study, Wilk's $\lambda = 0.99$, $F(2, 97) = .76$, $p = .472$.

Procedure

The participating lesbian families were recruited via the Medical Centre for Birth Control (a Dutch centre that provides donor insemination services to clients regardless of their sexual orientation and relationships status), various experts in the area of gay and lesbian parenting (snowball method), and an advertisement placed in a lesbian magazine. The criteria for enrollment of families were: 1) the children had been raised in the lesbian family since birth; 2) one of the children (the target child) was between four and eight years old; and 3) both parents were Dutch (for detailed descriptions, see: Bos, 2004).

At T3, the mothers and adolescents from the lesbian families who participated at T1 received a letter inviting them to participate in the third wave. The letter provided information about the procedures of T3. Eighty-two families were willing to participate (retention rate = 82%).

When written consent had been obtained from a DLLFS mother for her own participation and for that of her offspring, the mother received a link to her password-protected online parent questionnaire, and her adolescent offspring received an email link to Part I of the password-protected adolescent questionnaire containing questions on demographics and homophobic stigmatization. After completing Part I, each participating adolescent received a link to the password-protected Part II questionnaire – the Youth Self-Report (YSR). Paper-and-pencil versions of the questionnaires were provided if needed. All participants were asked to complete their questionnaires without the help of any other person.

Measures

Problem behavior

Data on adolescent problem behavior were obtained through the adolescents' scores on the YSR and through the parents' scores on the Child Behavior Checklist (CBCL) (e.g., Achenbach & Rescorla, 2001). The YSR and the CBCL are widely used measures of problem behavior in youth; are known for their reliability, internal consistency, and factor structure; and have been standardized with Dutch samples (e.g., Achenbach & Rescorla, 2001; De Groot, 1996; Verhulst, van der Ende, & Koot, 1997).

The YSR asks the adolescent to rate her/his problem behavior during the previous 6 months (answer categories for each item are: 0 = *not true*, 1 = *somewhat or sometimes true*, 2 = *very true or often true*). The adolescent's scores on 31 items related to internalizing problems (e.g., "I would rather be alone than with others" or "I feel too guilty") and 32 items on externalizing behavioral problems (e.g., "I break rules at home, school, or elsewhere" or "I get in many fights") were then tabulated to separate mean sum scores for internalizing and externalizing problem behavior. Cronbach's alphas for internalizing and externalizing problem behavior were .87 and .80 in the DLLFS, and .86 and .88 in the Z-HLS sample, respectively.

On the CBCL, parents are asked to rate the index adolescent's behavior during the previous 6 months. In a list of items that describes the behavior of children and youth, parents are asked to rate whether that item was "*not true*"(0), "*somewhat true*"(1), or "*very true or often true*"(2) for their adolescent. In the DLLFS, the CBCL/4–18 was used, and in the Z-HLS the CBCL/6–18; therefore, only items that were included in both CBCL versions were used to calculate the CBCL scores. For the DLLFS adolescent sample, we used scores of 59 biological mothers and 8 comothers (the latter from families in which the birth-mothers were unavailable). For the Z-HLS sample, the CBCL data were obtained from 66 mothers and one father. In both

samples (DLLFS and Z-HLFS), the parent's scores were tabulated so that the adolescent's problem behavior was reflected in a mean sum score on internalizing (31 items; e.g., "Too fearful or anxious" or "Withdrawn, does not get involved with others") and externalizing problem behavior (32 items; e.g., "Screams a lot" or "Hangs around with others who get in trouble"). Cronbach's alphas for internalizing and externalizing problem behavior were .87 and .86, and in the Z-HLS sample they were .85 and .90, respectively.

Homophobic stigmatization

A 14-item instrument was used to collect information from the DLLFS adolescents about experiences of homophobic stigmatization that took place during the previous year (1 = *never*, 2 = *sometimes*, 3 = *often*). The following are two examples of the items used: "Peers used abusive language towards me" and "Peers asked annoying questions". It was explicitly stated that all incidents must have been related to being raised by (a) lesbian mother(s). An overall score on stigmatization was obtained by taking the means of all items. A high score on this scale indicated more experience with homophobic stigmatization. Cronbach's alpha was .79.

Mothers' emotional involvement at T1

A mean score of 2 subscales of the Child Rearing Practices Report (Block, 1965) was used to measure emotional involvement of the DLLFS biological mothers at T1. The subscales were open expression of affection (e.g., "Express affection by kissing and hugging") and enjoyment of the parental role (e.g., "Interested in being with the child for long periods"), and answer categories ranged from 1 (*completely disagree*) to 6 (*completely agree*). Cronbach's alpha was .58 (9 items).

Total problem behavior at T1

To measure total problem behavior of the DLLFS offspring during childhood, the T1 CBCLs were used. At T1, there were no significant differences in the CBCL reports of the DLLFS biological mothers and comothers (see for more information: Bos, Van Balen, & Van den Boom, 2007). Therefore, in the present study, only the T1 CBCL scores of the biological mothers were used. At T2, in all but 8 cases in which the birth mothers were unavailable, we used the CBCL scores of the biological mothers pertaining to their adolescent offspring.

Analyses

To compare psychological adjustment between the DLLFS and Z-HLS samples, two (sample: 1 = DLLFS and 2 = Z-HLS) by two (gender: 1 = *girl*, 2 = *boy*) MANOVAs were conducted with internalizing and externalizing problem behavior as dependent variables. Both analyses were performed with the adolescent and parental reports, respectively.

To assess whether there was a relation between problem behavior and experiences of stigmatization in the DLLFS sample, four multiple linear regression analyses were performed for each YSR and CBCL scale (internalizing and externalizing problem behavior). Experienced homophobic stigmatization was used as the independent variable, and offspring gender, maternal educational level, maternal relationship status, T1 maternal emotional involvement, and offspring T1 total problem behavior were used as controlling variables. All variables were simultaneously entered into the equation.

Results

Comparison of DLLFS and Z-HLS adolescents on problem behavior

Adolescent reports

The mean scores on internalizing and externalizing problem behavior are shown in Table 2 for the DLLFS and the Z-HLFS samples. A significant multivariate main effect was found for gender, Wilk's $\lambda = 0.86$, $F(2, 129) = 10.13$, $p < .0001$, but not for sample, Wilk's $\lambda = 0.97$, $F(2, 129) = 2.14$, $p = .121$, or for the interaction between sample and gender, Wilk's $\lambda = 0.99$, $F(2, 129) = .97$, $p = .381$. Additional analyses revealed that the gender effect was localized to internalizing problems: girls reported more problems than boys (see Table 2).

Table 2

Means (SD) of adolescent scores on youth self-report and parental scores on child behavior checklist for the DLLFS and the Z-HLS samples.

Variable	Sample		Gender		Sample		Gender	
	DLLFS	Z-HLS	Girls	Boys	F	p	F	p
Youth self-report								
Internalizing problem behavior	9.13 (6.95)	10.28 (7.08)	12.03 (7.26)	7.02 (5.66)	1.21	.273	19.44	<.0001
Externalizing problem behavior	11.13 (5.99)	9.78 (7.05)	10.99 (5.73)	9.84 (7.39)	1.24	.268	01.03	.312
Child behavior checklist								
Internalizing problem behavior	6.13 (5.94)	6.87 (5.68)	7.31 (5.97)	5.56 (5.51)	0.70	.403	3.05	.083
Externalizing problem behavior	4.33 (5.14)	5.39 (6.26)	4.21 (4.61)	5.61 (6.77)	1.12	.293	2.00	.159

Note: The figures from the YSR and CBCL are derived from the tabulated scores of the adolescent and mother checklists; they are not standardized T-scores.

Parent reports

Table 2 also shows the mean scores on internalizing and externalizing problem behavior as reported by the parents. A significant multivariate main effect was found for gender, Wilk's $\lambda = 0.93$, $F(2,129) = 5.03$, $p = .008$. In addition, we found no main effect for sample, Wilk's $\lambda = 0.99$, $F(2, 129) = .62$, $p = .542$, or for the interaction between sample and gender, Wilk's $\lambda = 0.98$, $F(2,129) = 1.45$, $p = .238$. Additional analyses could not localize the gender effect; analyses with internalizing and externalizing problem behavior showed no significant differences between girls and boys (see Table 2).

Analyses within the DLLFS sample: problem behavior and homophobic stigmatization

The mean score on the stigmatization scale was 1.12 ($SD = .16$), with a minimal and maximal score of 1.00 and 1.93 on 3-point Likert scale, and high scores reflecting more experiences of homophobic stigmatization. Combining the answers on "sometimes" and "often," the most frequently reported form of stigmatization was from peers asking annoying questions (52.2%). See Table 3 for the means and frequencies of each item of the stigmatization scale. The mean score on the mothers' emotional involvement at T1 was 5.48 ($SD = .32$), with 4.33 and 6.00 as the minimal and maximal scores on this 6-point Likert scale, and high scores reflecting higher levels of emotional involvement. The CBCL mean score on total problem behavior at T1 was 14.67 ($SD = 9.46$).

Adolescent reports

The entered variables explained 37% of the variance in internalizing problem behavior, $F(6, 60) = 5.78$, $p < .0001$. After controlling for the other variables, homophobic stigmatization was related to higher scores on the internalizing scale ($\beta = .33$, $p = .003$) (see Table 4). Of the controlling variables, only gender was significantly related to internalizing problem behavior. For externalizing problem behavior, 31% of the variance was explained by the entered variables, $F(6, 60) = 4.52$, $p = .001$. After controlling for the other variables, homophobic stigmatization was also related to more externalizing problems ($\beta = .49$, $p < .0001$) (see Table 4).

Mother reports

The models for internalizing and externalizing problem behavior were not significant: $R^2 = .17$, $F(6, 60) = 2.06$, $p = .071$ for the internalizing scale, and $R^2 = .14$, $F(6, 60) = 1.69$, $p = .140$ for the externalizing scale, respectively.

Discussion

The present study was based on a Dutch longitudinal study of adolescents who were conceived through donor insemination and raised in planned lesbian families. Analyses of adolescent and parental reports revealed that, compared to a matched group of adolescents with heterosexual parents, adolescents with lesbian mothers showed no significant differences on internalizing and externalizing problem behavior. However, for adolescents with lesbian parents, internalizing and externalizing problem behavior was associated with adolescent reports of homophobic stigmatization.

This is the first study to use multi-informant data to examine internalizing and externalizing problem behavior in adolescent offspring from planned lesbian families. Our results contrast with those of previous studies on problem behavior in which adolescents in planned lesbian families demonstrated less internalizing problem behavior than age- and gender-matched offspring in heterosexual-parent families (Gartrell & Bos, 2010; Golombok & Badger, 2010). However, it should be

Table 3
DLLFS adolescents: percentages (%) and means of the stigmatization item scores.

Items ^a	Percentages (n)			M (SD)
	Never	Sometimes	Often	
Peers have used abusive language towards me	92.5 (62)	07.5 (05)	00.0 (00)	1.07 (0.26)
Peers have made jokes about me	71.6 (48)	26.9 (18)	01.5 (01)	1.30 (0.49)
Peers have been gossiped about me	83.6 (56)	16.4 (11)	00.0 (00)	1.16 (0.37)
Peers have used abusive language towards my mother(s) ^b	91.0 (61)	07.5 (05)	00.0 (00)	1.08 (0.27)
Peers have made disapproving remarks	94.0 (63)	04.5 (03)	01.5 (01)	1.07 (0.32)
Peers have been hostile to me ^b	95.5 (64)	03.0 (02)	00.0 (00)	1.03 (0.17)
Peers have said negative things about my family situation	95.5 (64)	04.5 (03)	00.0 (00)	1.04 (0.21)
Peers have asked annoying questions	47.8 (32)	41.8 (28)	10.4 (07)	1.63 (0.67)
Peers have said negative things about my mothers	92.5 (62)	07.5 (05)	00.0 (00)	1.07 (0.26)
Peers have hit me ^b	95.5 (64)	03.0 (02)	00.0 (00)	1.03 (0.17)
Peers have kicked me	98.5 (66)	01.5 (01)	00.0 (00)	1.01 (0.12)
Peers have tripped me	97.0 (65)	03.0 (02)	00.0 (00)	1.03 (0.17)
Peers have sent me nasty anonymous electronic messages (e.g., mobile phone text)	98.5 (66)	01.5 (01)	00.0 (00)	1.03 (0.25)
Peers have ignored me	95.5 (64)	03.0 (02)	01.5 (01)	1.06 (0.30)
Overall stigmatization score				1.12 (0.16)

^a It was explicitly stated that the incidents must have happened in the previous year and must have been related to being raised by a lesbian mother(s).

^b One missing value.

Table 4

Multiple linear regression analyses of demographic characteristics, T1 maternal emotional involvement, T1 offspring total problem behavior, and adolescent stigmatization vis-à-vis DLLFS youth self-report scores.

	<i>B</i>	<i>SE (B)</i>	β	<i>t</i>	<i>p</i>
Internalizing problem behavior					
Offspring gender	−7.66	1.55	−.56	−4.94	<.0001
Maternal education	0.23	2.86	.01	0.08	.936
Maternal relationship status	1.17	1.89	.07	0.62	.54
Maternal emotional involvement T1	1.59	2.41	.07	0.66	.512
Offspring total problem behavior T1	0.08	0.07	.11	0.98	.329
Stigmatization	13.73	4.37	.33	3.14	.003
<i>R</i> ²	.37				
<i>F</i> (6,60)	5.80***				
Externalizing problem behavior					
Offspring gender	−1.12	1.38	−.10	−0.81	.422
Maternal education	3.70	2.54	.17	1.46	.151
Maternal relationship status	−1.12	1.68	−.08	−0.67	.509
Maternal emotional involvement T1	0.82	2.15	.04	0.38	.705
Offspring total problem behavior T1	0.11	0.07	.17	1.53	.131
Stigmatization	17.54	3.89	.49	4.51	<.0001
<i>R</i> ²	.31				
<i>F</i> (6, 60)	4.52**				

p* < .01. *p* < .001.

mentioned that the samples in these studies were not comparable on as many characteristics as the participants in our study. For example, although the groups studied by Golombok and Badger (2010) did not differ in gender and social class, they differed in age. Furthermore, Gartrell and Bos (2010) matched the adolescents in lesbian-parent families and those in heterosexual-parent families only on the age of the adolescents. In the present study, the adolescents born in lesbian-mother households and those born in heterosexual-parent families were matched on five demographic characteristics – gender, age, parental education (highest degree held by the parents), parental ethnicity, and parental relationship status (still together or separated). It is possible that the differences found in previous studies were caused not by family type, but by such background variables.

Finding no difference between adolescents in lesbian- and heterosexual-parent families is inconsistent with the minority stress theory (MTS) positing that the stigmatization of minority groups (e.g., planned lesbian families) fosters psychological and behavioral problems (Meyer, 2003). For lesbian women, it is known that the intentionality and effort involved in the transition to parenthood leads to very involved childrearing, potentially protecting the offspring from developing the problems that the MTS predicts (Bos & Gartrell, 2010).

In addition, Bos, van Gelderen, and Gartrell (2014) found that adolescent psychological well-being in intact two-parent families was predicted by the quality of parent–child relationships but not by family structure (same-sex versus opposite-sex parents). For the development of problem behavior, family structure may also be less important than family functioning, thus explaining the inconsistency between our results and the MTS. Because we had no data on parent–child relationships for the Z-HLS group, we were unable to test this theory.

It is important to note that the present study was conducted in the Netherlands. Most reports on planned lesbian families come from the U.S. or the U.K. The Netherlands differs in important ways from these countries with respect to LGB relationships and families. For example, in 2001, the Netherlands became the first country to legalize same-sex marriage, reflecting a long history of social acceptance of LGB people (Keuzenkamp, 2011). Despite this affirmative climate for Dutch same-sex parent families, a finding consistent with the MST was that some DLLFS adolescents had nevertheless been stigmatized for having lesbian mothers, and that this discrimination was linked to higher problem behavior scores. Adolescents in countries that are less accepting of LGB people may be at even greater risk for stigmatization than those in the current study.

It is not possible to draw causal conclusions from our data, since it is not possible to determine the direction of effect. Although we controlled for total problem behavior at earlier ages, we cannot rule out the possibility that anxious, depressive adolescents reported more stigmatization than their counterparts with fewer problems. In addition, the association between stigmatization and problem behavior was observed only in the adolescent reports. When behavioral problems were assessed via mother reports, no significant associations with stigmatization emerged. A possible explanation for the divergence in these findings is that some adolescents who had been stigmatized may have refrained from disclosing it to their parents. Likewise, stigmatized adolescents may have concealed psychological problems (e.g., nightmares, anxiety, fearfulness) that resulted from the discrimination. If this was indeed the case, our findings argue for more proactive parenting around issues of preparing offspring for the prospect of stigma, and helping them feel comfortable sharing experiences of discrimination with family members. In addition, it is important for parents to realize that homophobic stigmatization continues to occur and can be a significant stressor even in countries with more accepting attitudes toward same-sex parent families.

Our study has several other limitations. The DLLFS participants were living in numerous provinces, while the Z-HLS comparison group lived in South Holland. Notwithstanding an earlier study that found no differences in the problem scores of children from South Holland versus children from other Dutch provinces (Tick et al., 2008), regional differences may have

affected our findings. In addition, one cannot rule out a cultural historical effect, since the DLLFS data were collected in 2011, and the Z-HLS data in 2003. Another limitation is that the lesbian mothers were relatively highly educated. In spite of the fact that the comparison sample was matched for parental educational level, the findings cannot be generalized to all lesbian families in the Netherlands. Finally, no objective reports on the adolescents' internalizing and externalizing problem behavior were available. To counteract the possibility of reporter bias in adolescent and parental reports, data should be collected from other informants, such as teachers.

Our study also had some notable strengths. The adolescents were matched 1:1 on gender, age, parental education, parental ethnicity, and parental relationship status, which made it possible to detect differences in psychological adjustment after controlling for the effect of such background variables. In addition, this was the first study to use both adolescent and parental reports to measure problem behavior in adolescents. Furthermore, this was the first study to examine whether the relation between stigmatization and psychological well-being could be explained by other confounding variables. A final strength of this study is that stigmatization was investigated by asking about various contexts in which it occurred. This contrasts with earlier reports on planned lesbian families in which the adolescent offspring were only asked whether they had experienced stigmatization associated with their mothers' sexual orientation (e.g., Gartrell & Bos, 2010).

Conclusion

Previous studies on adolescent psychological adjustment found few differences between American and British offspring in same-sex female parent families and their counterparts with heterosexual parents (Gartrell & Bos, 2010; Golombok & Badger, 2010; Rivers et al., 2008; Wainright & Patterson, 2006, 2008; Wainright et al., 2004). The American and British results have now been replicated and expanded upon in the Netherlands. In sum, our results suggest that even though Dutch adolescents with lesbian and heterosexual parents had similar scores on self-reported and parent-reported problem behavior, for adolescents in planned lesbian families, adolescent-reported homophobic stigmatization was associated with more problem behavior. These findings suggest that same-sex parents could benefit from guidance in preparing their offspring for the prospect of discrimination in order to teach them effective responses to hostile comments and behavior. Routine health assessments should include questions about experiences of stigmatization so that clinicians can recommend support services to those who have been targeted.

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