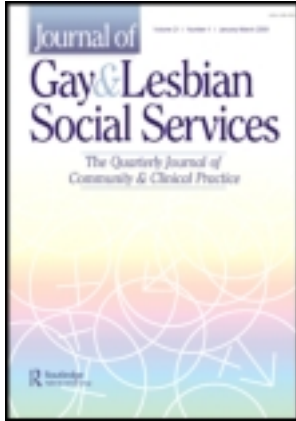


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## Journal of Gay & Lesbian Social Services

Publication details, including instructions for authors and subscription information:

<http://www.tandfonline.com/loi/wgls20>

### Adolescents in Lesbian Families: DSM-Oriented Scale Scores and Stigmatization

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Published online: 22 May 2013.

To cite this article: Henry Bos , Nanette Gartrell & Loes van Gelderen (2013): Adolescents in Lesbian Families: DSM-Oriented Scale Scores and Stigmatization, Journal of Gay & Lesbian Social Services, 25:2, 121-140

To link to this article: <http://dx.doi.org/10.1080/10538720.2013.782456>

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## **Adolescents in Lesbian Families: *DSM*-Oriented Scale Scores and Stigmatization**

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*The present study focused on the Diagnostic and Statistical Manual of Mental Disorders (DSM)-oriented scale scores from Child Behavior Checklists completed by parents of the 17-year-old offspring in the U.S. National Longitudinal Lesbian Family Study (NLLFS; 39 girls/39 boys). In comparison with the scores of an age-matched normative sample (49 girls/44 boys; MANOVA), no significant differences in scores were found. Within the NLLFS sample, adolescents who reported stigmatization scored higher on affective, anxiety, and conduct problems. Although overall psychological functioning of the NLLFS adolescents fell within the healthy range, stigmatization had a negative impact on the well-being of some adolescents.*

**KEYWORDS** *lesbian families, adolescents, stigma, DSM-oriented scale scores, CBCL*

### THE *DSM*-ORIENTED SCALE SCORES OF 17-YEAR-OLD ADOLESCENTS IN LESBIAN FAMILIES

Research on the offspring of planned lesbian-mother families (families headed by one or two lesbian mothers who decided to have children after coming out) has mainly focused on the psychological adjustment and peer relationships of preadolescent children. These studies found few differences between young children raised in lesbian-parent families and those raised in heterosexual-parent families, with regard to problem behavior and

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well-being (Bos, van Balen, & van den Boom, 2007; Bos & van Balen, 2008; Brewaeys, Ponjaert-Kristoffersen, van Steirteghem, & Devroey, 1993; Flaks, Ficher, Masterpasqua, & Joseph, 1995; Patterson, 1994; Steckel, 1987). However, less is known about factors that affect the psychological well-being of these offspring after they have reached adolescence.

Adolescence is a stage of life in which peers play a more focal day-to-day role. Studies have shown that the amount of time spent with peers increases during adolescence. For instance, when asked about the most influential person in their lives, a majority of adolescents in one study mentioned someone of their own age rather than an adult (Steinberg, 2002). It has also been shown that adolescents turn less often to their parents than to peers for day-to-day advice, approval, and emotional support (Eder, 1985; Harter, 1990; Hazan & Zeifman, 1994). Adolescence is also a developmental stage marked by increasing awareness of the differences and similarities between oneself and others (Baumrind, 1995; Rivers, Poteat, & Noret, 2008). Typical teenage individuation involves an exploration of such questions as “Who am I,” “What is my purpose in life?,” and “Where do I belong?” (McLean & Pasupathi, 2012; Schwartz, 2001).

Adolescents in planned lesbian families become increasingly aware of the ways that their families differ from traditional heterosexual-parent families (van Gelderen, Gartrell, Bos, Van Rooij, & Hermanns, 2012). Factors contributing to these differences include the sexual orientation of their parents, their parents’ use of sperm donors to conceive, and their parents’ legal relationship status. Adolescents in lesbian families also have to deal with the fact that some people do not approve of families that are headed by two lesbian mothers. The latest figures from the World Value Survey show that 26.0% of U.S. respondents said that they did “not want a homosexual person as a neighbor”; 32.5% felt that “homosexuality can never be justified”; and 62.9% agreed with the statement that a child “needs a home with a father and a mother” (World Value Survey, 2006). Although dealing with these challenges might have a negative impact on the psychological well-being of the offspring in same-sex-parent families, relatively few studies have explored the association between homophobic stigmatization and clinical symptoms in adolescents.

Three research teams have conducted a series of studies on adolescents raised by women co-parents. Wainright and Patterson (2006) extracted household composition data from the U.S. National Longitudinal Study of Adolescent Health (Add Health), and used this information to identify households headed by two women ( $N = 44$ ). For each of these two-mother households (sexual orientation of the mothers not specified), an adolescent was matched with one from a two-parent heterosexual family. When the two groups of adolescents were compared, no differences were found in substance use, peer relationships, or school progress (Wainright & Patterson, 2006, 2008; see also Wainright, Russell, & Patterson, 2004).

In the investigations conducted by two other research teams, convenience samples were used for longitudinal data gathering. The planned lesbian-mother families were recruited through friendship networks, lesbian or gay organizations, hospital fertility departments, or a combination of these methods (see, for an overview, Bos & van Balen, 2010; Bos, 2012). In one study conducted in the United Kingdom, researchers compared 20 families headed by lesbian mothers (11 couples and 9 single mothers), 27 families headed by single heterosexual mothers, and 36 2-parent heterosexual families. The study began when the children were 6 years old, and the third follow-up took place when these offspring had reached adolescence (Golombok & Badger, 2010). By age 19, the adolescents born into lesbian-mother families showed lower levels of anxiety, depression, hostility, and problematic alcohol use and higher levels of self-esteem than adolescents in traditional father-mother families (Golombok & Badger, 2010).

The U.S. National Lesbian Longitudinal Family Study (NLLFS) was initiated in 1986 with the aim of providing prospective data on a cohort of American lesbian families from the time the index offspring were conceived through donor insemination until these offspring reached adulthood (see, for an overview, Gartrell, Peyser, & Bos, 2011). To date, there have been five waves of data collection, namely during insemination or pregnancy (T1), and when the offspring were 2 (T2), 5 (T3), 10 (T4), and 17 (T5) years old (Gartrell et al., 1996, 1999, 2000; Gartrell, Rodas, Deck, Peyser, & Banks, 2005, 2006; Gartrell & Bos, 2010). By comparing raw data from the parental Child Behavior Checklists (CBCLs) (6–18) on the 17-year-old NLLFS offspring (39 girls and 39 boys) and the gender- and age-matched normative sample (49 girls and 44 boys), it was found that the NLLFS adolescents demonstrated higher levels of social, school/academic, and total competence, and lower levels of social problems, rule-breaking, aggressive, and externalizing problem behavior (Gartrell & Bos, 2010). Within the NLLFS sample, the CBCL parental reports also revealed that when the scores of the 17-year-old index offspring who had experienced stigmatization by T5 (41.1%) were compared with the scores of offspring who had not, no significant multivariate main effects were found for stigmatization, suggesting that stigmatization was not associated with psychological problems (Gartrell & Bos, 2010). A comparison of the CBCL scores on the NLLFS offspring at ages 10 and 17 years revealed that during that 7-year-interval, their scores on social problems and aggressive behavior decreased, and their scores on thought problems and rule-breaking behavior increased (Bos & Gartrell, 2010).

All of these findings are based on the CBCL competence scales along with the broadband and small-band syndrome scales. The CBCL broadband and small-band syndrome scales are generated on principal component analyses and variance sharing of the 113 problem behavior items (see, for further details, Achenbach & Rescorla, 2001). Although the CBCL broadband and small-band syndrome scales have evidenced particular strength, a

shortcoming is that they are not paired with the *International Classification of Diseases (ICD)* or the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (e.g., Aebi, Winkle Metzke, & Steinhausen, 2010; Brunshaw & Szatmari, 1988; Ebesutani et al., 2009). Some scholars have suggested that the CBCL broadband and small-band syndrome scales are insufficiently sensitive to measure internalizing problem disorders (Jensen, Saltzberg, Richters, Watanabe, & Roper, 1993; Kasius, Ferdinand, Van den Berg, & Verhulst, 1997).

In 2001, Achenbach and Dumenci developed a new scoring system for the problem behavior items as a supplement to the broadband and small-band syndrome scales of the CBCL. Known as the *DSM-oriented scales*, the new scoring system was based on experts' ratings of how well the items corresponded to the *DSM-IV* criteria for relevant disorders or groups thereof (see Achenbach & Dumenci, 2001; Achenbach, Dumenci, & Rescorla, 2003). The items that were considered very consistent by at least 64% of the raters were grouped into six *DSM-oriented scales*, namely, affective problems, anxiety problems, somatic problems, attention-deficit/hyperactivity problems, oppositional defiant problems, and conduct problems (Achenbach & Rescorla, 2001). Because the psychometric properties of the *DSM-oriented scales* are favorable, the 2001 CBCL manual recommends their use for clinical and research purposes.

The present study was the first to use the *DSM-oriented scales* on the offspring of lesbian mothers. Because these scales are more detailed, they offered an opportunity to detect offspring who may be at risk. The purpose of our investigation was to compare the *DSM-oriented scale scores* of the 17-year-old NLLFS offspring with an age-matched normative sample. We also examined whether *DSM-oriented scale scores* were associated with experiences of homophobic stigmatization. Furthermore, we investigated changes in the *DSM-oriented scale scores* of NLLFS offspring between T4 (when they were 10 years old) and T5 (when they were 17 years old) to determine whether any differences were related to experiences of homophobic stigmatization. The longitudinal design of the NLLFS allowed us to do this.

## METHOD

### Participants and Procedure

The NLLFS families were enrolled for the first wave of data collection (T1) between 1986 and 1992. Lesbian women who were pregnant through donor insemination or were in the process of insemination were eligible for participation. These women were recruited via announcements at lesbian events, in women's bookstores, and in lesbian-oriented publications. Those interested in the study were encouraged to contact the researchers; all those who did so became study participants. At T1, a total cohort of 84 families was participating in the study. The women were informed about the longitudinal

design of the study, and were contacted again when their children were 2 (T2), 5 (T3), 10 (T4), and 17 years old (T5).

At T5, the parents and their offspring were asked to complete questionnaires; 78 (92.9% of the original cohort) families were willing to do so. One family did not complete all instruments, and so this family was excluded from the analyses. This brought the total  $N$  to 77 (91.7%), with 78 adolescent offspring (including one set of twins). Of the 78 adolescents, 39 were girls and 39 were boys (mean age = 17.05,  $SD = .36$ ).

The Institutional Review Board of the California Pacific Medical Center approved the NLLFS study design. Informed consent was obtained from the parents at each wave of data collection. At T5, a member of the research team contacted parents near their respective offspring's seventeenth birthday. Parents were then asked to complete the institutional review board consent form, and to consent to the researchers contacting their offspring. All parents complied. We then contacted the offspring, who assented to participation.

The mothers completed CBCLs at T4 and T5. We used a paper/pencil version of the CBCL at T4 and an electronic version at T5 (the Achenbach System of Empirically Based Assessment; ASEBA). The parents were given a unique code that gave them access to the questionnaire section of the study's Web site. The adolescents also completed their online questionnaire on a code-protected part of the NLLFS Web site.

## Measures

### DSM-ORIENTED PROBLEMS

The *DSM*-oriented problem scales (affective problems, anxiety problems, somatic problems, attention-deficit/hyperactivity, oppositional problems, and conduct problems) were drawn from the parental CBCLs (Achenbach & Rescorla, 2001). The CBCL consists of 113 problem behavior items. Parents were asked at T4 and T5 to assess their offspring's behavior during the preceding six months on a 3-point scale (0 = *not true*, 1 = *somewhat or sometimes true*, or 2 = *very true or often true*). The scores of 55 items were then summed to construct the 6 *DSM*-oriented scales, as described in the CBCL manual (Achenbach & Rescorla, 2001):

1. affective problems (e.g., is sad),
2. anxiety problems (e.g., nervous),
3. somatic problems (e.g., headaches),
4. attention-deficit/hyperactivity (e.g., fails to finish a task),
5. oppositional problems (e.g., argues), and
6. conduct problems (e.g., fights).

Achenbach and Rescorla (2001) found good reliability on these six scales for their American normative sample. The reliabilities of these six scales for

the NLLFS offspring were also good (Cronbach's alphas between .71 and .83).

#### HOMOPHOBIC STIGMATIZATION

Adolescents were asked about their experiences of homophobic stigmatization. This was assessed through the following question: "Have you been treated unfairly because you have lesbian mom(s)?" (0 = *no*, 1 = *yes*).

#### ANALYSES

To compare the *DSM*-oriented problem scale scores of the 17-year-old NLLFS offspring (T5) with a nationwide probability sample, we used the CBCL mother reports of the non-referred group of the Achenbach study. The data were used with the permission of Dr. Thomas Achenbach, University of Vermont (Achenbach & Rescorla, 2001). We selected from the Achenbach data set the reports of mothers who had 17-year-old offspring; this resulted in a sample of *DSM* scores from 49 girls and 44 boys ( $N = 93$ ). The available demographic data from the Achenbach sample made it possible only to test whether the two samples of 17-year-old adolescents were statistically comparable based on gender, parental socioeconomic status (SES), and parental ethnicity.

The parental SES in the Achenbach sample was significantly higher than that of the NLLFS mothers (see Table 1) and White/Caucasian mothers were overrepresented in the NLLFS sample, but there were no significant differences between the two samples based on gender of the offspring.

A 2 (group: 1 = NLLFS, 2 = Achenbach normative sample)  $\times$  2 (gender: 1 = girls, 2 = boys) multivariate analysis of variance (MANOVA) was

**TABLE 1** Demographic Characteristics of the NLLFS Sample and the Achenbach Normative CBCL Sample

	NLLFS <sup>a</sup>	Achenbach	$\chi^2$	<i>P</i>
Adolescent sample size	$N = 78$	$N = 93$		
Adolescent gender, %			0.12	.725
Girls	50.0	52.7		
Boys	50.0	47.3		
Parental SES, %			7.35	.025
Working class	18.2	12.0		
Middle class	57.1	44.1		
Upper-middle and upper	24.7	43.9		
Parental race/ethnicity			17.41	<.0001
White/Caucasian	93.0	67.7		
Other	07.0	32.3		

<sup>a</sup>Adolescent demographics based on T5;  $N = 78$  index offspring including 1 set of twins (77 families) and parental demographics collected T1–T3.

conducted with the six *DSM*-oriented scales as dependent variables. Additional contrast analyses were conducted whenever a significant group difference was found.

We conducted three analyses for the comparisons within the NLLFS sample regarding *DSM*-oriented problem scale scores in relation to experiences of homophobic stigmatization. First, we computed a 2 (experiences of stigmatization: 0 = no, 1 = yes)  $\times$  2 (gender: 1 = girls, 2 = boys) MANOVA to examine possible differences on the *DSM*-oriented problem scale scores between NLLFS adolescents who reported stigmatization and those who did not.

Second, to assess for the NLLFS offspring the changes between scores on the *DSM*-oriented problem scales at T4 and T5, and the role of homophobic stigmatization in these changes, we conducted a repeated measures model (General Linear Model; GLM). In this GLM we used one within-factor (time: 0 = T4, 1 = T5) and one between-factor (experiences of stigmatization: 0 = no, 1 = yes).

Third, we analyzed the developmental pathways from T4 to T5 separately for NLLFS adolescents who reported experiences of homophobic stigmatization at T5, and for those who did not report these experiences. Four developmental pathways from T4 and T5 were conducted:

1. those who scored in the deviant range at T4 and T5,
2. those who scored in the deviant range at T4 and in the normal range at T5,
3. those who scored in the normal range at T4 and in the deviant range at T5, and
4. those who scored in the normal range at T4 and T5.

These developmental pathways were computed for each of the six *DSM*-oriented problem scales, and deviant scores were calculated based on the *T* values for each score. According to the CBCL manual, scores greater than or equal to the ninety-third percentile ( $T \geq 65$ ) fall within the combined borderline and clinical range (Achenbach & Rescorla, 2001). For each *DSM*-oriented problem scale, a  $\chi^2$  test was conducted to compare NLLFS adolescents with and without experiences of homophobic stigmatization on these pathways.

## RESULTS

### Comparison Between NLLFS Adolescents and Adolescents in the Achenbach Sample on *DSM*-Oriented Scale Scores

We performed a 2 (group: 1 = NLLFS, 2 = Achenbach normative sample)  $\times$  2 (gender: 1 = girls, 2 = boys) MANOVA to investigate any significant differences between the 17-year-old NLLFS and Achenbach adolescents. Means



**TABLE 2** Means and Standard Deviations of *DSM*-Oriented Scales for NLLFS and Achenbach Samples

	NLLFS Sample			Achenbach Normative Sample			NLLFS vs. Achenbach Normative Samples <sup>a</sup>		
	Total	Girls	Boys	Total	Girls	Boys	<i>F</i>	<i>p</i>	$\eta^2$
Affective problems							0.49	.484	.00
<i>M</i>	1.64	1.67	1.61	1.91	1.76	2.10			
<i>SD</i>	2.27	1.96	2.56	2.75	2.33	3.18			
Anxiety problems							0.59	.445	.00
<i>M</i>	0.97	1.00	0.95	1.16	1.09	1.25			
<i>SD</i>	1.57	1.79	1.34	1.58	1.47	1.71			
Somatic problems							1.23	.270	.01
<i>M</i>	0.92	0.95	0.90	0.67	0.35	1.05			
<i>SD</i>	1.49	1.33	1.65	1.38	0.97	1.68			
Attention problems							0.42	.519	.00
<i>M</i>	2.47	2.44	2.51	2.21	2.28	2.13			
<i>SD</i>	2.29	2.10	2.50	2.89	2.76	3.06			
Oppositional problems							2.96	.087	.02
<i>M</i>	2.05	2.13	1.97	1.50	1.33	1.70			
<i>SD</i>	2.24	2.09	2.41	1.86	1.76	1.96			
Conduct problems							4.27	.040	.03
<i>M</i>	2.10	1.82	2.38	1.15	1.17	1.13			
<i>SD</i>	3.74	2.57	4.64	1.97	2.05	1.91			

<sup>a</sup>Based on separate ANOVAs for each subscale.

and standard deviations are shown in Table 2. No significant multivariate main effect was found for group, Wilks'  $\lambda = .924$ ,  $F(6, 155) = 2.13$ ,  $p = .053$ , or gender, Wilks'  $\lambda = .981$ ,  $F(6, 155) = .492$ ,  $p = .814$ . The interaction between group and gender was also not significant, Wilks'  $\lambda = .957$ ,  $F(6, 155) = 1.16$ ,  $p = .331$ . These findings indicate that there are no significant differences on the *DSM*-oriented problem scales (affective problems, anxiety problems, somatic problems, attention-deficit/hyperactivity, oppositional problems, and conduct problems) between the NLLFS and the Achenbach adolescents, or between the girls and boys. The no significant interaction effect means that findings between the NLLFS and the Achenbach samples are the same for girls and boys.

According to Tabachnick and Fidell (2007), separate ANOVAs are only necessary when there is a significant overall effect in the MANOVA. However, it is possible that significant differences on the scales may be masked by the analytic approach taken, and therefore six separate ANOVAs were also conducted (one for each *DSM*-oriented subscale). The findings of these additional analyses are shown in Table 2. Only one significant difference was found: the NLLFS sample scored significantly higher on conduct problems than the Achenbach sample.

## Comparison Within the NLLFS Sample

## STIGMATIZATION AND T5 DSM-ORIENTED PROBLEMS

Of the NLLFS offspring, 40% indicated at T5 that they had experienced stigmatization because they have lesbian mothers. When the T5 DSM-oriented problem scale scores of stigmatized adolescents were compared with those of adolescents who did not report stigmatization, a significant main effect was found on the MANOVA, Wilks'  $\lambda = .81$ ,  $F(6, 60) = 2.35$ ,  $p = .042$ , but there was no main effect on gender, Wilks'  $\lambda = .98$ ,  $F(6, 60) = .24$ ,  $p = .961$ , nor was the interaction between gender and stigmatization significant, Wilks'  $\lambda = .91$ ,  $F(6, 60) = .95$ ,  $p = .47$ . Contrast analyses showed significantly higher affective problem scores, anxiety problem scores, and conduct problem scores for stigmatized adolescents (see Table 3).

According to Frick, Barry, and Kamphaus (2010), the best way to describe CBCL outcomes is to inspect the individual items. We therefore looked more carefully at the individual items on both the affective problem scale (13 items) and the anxiety scale (6 items), and compared the NLLFS adolescents with and without experiences of stigmatization on these individual items. There were significantly higher scores for those who reported experiences of stigmatization compared to those without such experiences on the

**TABLE 3** Means and Standard Deviations of DSM-Oriented Scales for 17-Year-Old NLLFS Offspring and Their Reports of Homophobic Stigmatization<sup>a</sup>

	Experiences of Homophobic Stigmatization						Not Stigmatized vs. Stigmatized		
	No			Yes			<i>F</i>	<i>p</i>	$\eta^2$
	Total	Girls	Boys	Total	Girls	Boys			
Affective problems							6.28	.015	.49
<i>M</i>	1.37	1.95	0.81	3.11	3.00	3.30			
<i>SD</i>	2.26	2.95	1.12	3.46	3.87	2.75			
Anxiety problems							9.01	.004	.20
<i>M</i>	0.88	1.35	0.43	1.93	1.72	2.30			
<i>SD</i>	1.08	1.09	0.87	2.00	2.02	2.00			
Somatic problems							.23	.635	.01
<i>M</i>	0.63	1.05	0.24	0.82	0.83	0.80			
<i>SD</i>	1.41	1.91	0.44	1.52	1.47	1.69			
Attention problems							.61	.437	.03
<i>M</i>	1.61	1.90	1.33	1.96	1.83	2.20			
<i>SD</i>	2.07	2.29	1.85	1.93	2.04	1.81			
Oppositional problems							3.72	.058	.10
<i>M</i>	1.10	1.25	0.95	1.86	1.72	2.10			
<i>SD</i>	1.66	1.77	1.56	1.65	1.53	1.91			
Conduct problems							4.64	.035	.17
<i>M</i>	0.71	0.65	0.76	1.79	1.83	1.70			
<i>SD</i>	1.60	1.81	1.41	2.33	2.68	1.64			

<sup>a</sup>*N* = 69, which is based on adolescents with complete T5 CBCL scores, and who had no missing value on the experiences of stigmatization variable.

**TABLE 4** Means and Standard Deviations of the Items of the Affective Problem, Anxiety, and Conduct Problem Scales and Experiences of Homophobic Stigmatization

	Experiences of Homophobic Stigmatization				Not Stigmatized vs. Stigmatized		
	No		Yes		<i>F</i>	<i>p</i>	$\eta^2$
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
<i>Affective problems</i>							
Enjoys little	.05	.23	.23	.43	04.47	.039	.07
Cries a lot	.05	.23	.12	.33	00.77	.383	.01
Harms self	.03	.16	.15	.46	02.36	.130	.04
Not eating well	.19	.46	.54	.58	07.04	.010	.10
Feels worthless	.14	.35	.31	.55	02.34	.131	.04
Feels too guilty	.11	.32	.19	.49	00.69	.410	.01
Overtired (without reason)	.08	.28	.15	.37	00.80	.374	.01
Sleeps less than most kids	.16	.55	.23	.51	00.25	.620	.00
Sleeps more than most kids	.00	.00	.15	.37	06.51	.013	.10
Talks about killing self	.03	.16	.15	.37	03.44	.069	.05
Trouble sleeping	.19	.46	.31	.62	00.76	.387	.01
Underactive	.14	.35	.15	.37	00.04	.838	.00
Unhappy, sad, or depressed	.08	.28	.46	.65	10.20	.002	.14
<i>Anxiety</i>							
Clings to adults or too dependent	.03	.16	.12	.33	02.01	.162	.03
Fears certain animals, situations, or places	.05	.33	.31	.55	05.24	.026	.08
Fears going to school	.03	.16	.08	.27	00.82	.368	.01
Nervous movements or twitching	.22	.42	.50	.65	04.47	.039	.07
Too fearful or anxious	.05	.23	.35	.49	01.22	.002	.14
Worries	.38	.49	.58	.64	01.93	.170	.03
<i>Conduct problems</i>							
Cruel to animals	.00	.00	.00	.00	–	–	–
Cruelty, bullying, or meanness to others	.06	.23	.04	.20	00.09	.762	.00
Destroys things belonging to his/her family or others	.00	.00	.12	.33	04.54	.037	.07
Doesn't seem to feel guilty after misbehaving	.08	.28	.19	.48	01.22	.273	.02
Breaks rules at home, school, or elsewhere	.22	.49	.38	.57	01.46	.232	.02
Gets in many fights	.00	.00	.00	.00	–	–	–
Hangs around with others who get in trouble	.03	.17	.19	.40	04.89	.031	.08
Lying or cheating	.14	.42	.27	.53	01.15	.289	.02
Physically attacks people	.00	.00	.00	.00	–	–	–
Runs away from home	.00	.00	.00	.00	–	–	–
Sets fires	.00	.00	.00	.00	–	–	–
Steals at home	.03	.17	.00	.00	00.72	.400	.01
Steals outside the home	.00	.00	.00	.00	–	–	–
Swearing or obscene language	.11	.32	.27	.53	02.12	.150	.03
Threatens people	.00	.00	.00	.00	–	–	–
Truancy, skips school	.06	.23	.08	.27	00.11	.740	.00
Vandalism	.00	.00	.00	.00	–	–	–

following affective scale items: “There is very little he/she enjoys,” “Doesn't eat well,” “Sleeps more than most kids during the day and/or night,” and “Unhappy, sad, or depressed” (see Table 4). For the items on the anxiety scale, it was found that adolescents who had experienced stigmatization

scored higher on “Fears certain animals, situations, or places, other than school,” “Nervous, high-strung, or tense,” and “Too fearful or anxious” (see Table 4). For 2 of the 17 items of the conduct problem subscale, adolescents who had experienced stigmatization scored higher than those who had not, namely, “Destroys things belonging to his/her family or others” and “Hangs around with others who get in trouble.”

#### CHANGES IN MEAN SCORES ON THE *DSM*-ORIENTED PROBLEM SCALES BETWEEN T4 AND T5

To assess differences among NLLFS offspring in their levels of affective problems, anxiety problems, somatic problems, attention-deficit/hyperactivity, oppositional problems, and conduct problems over time, and whether their problem scale scores were related to experiences of stigmatization, we conducted a GLM with one within-factor (time) and one between-factor (experiences of stigmatization). This analysis could only be done for adolescents who had completed CBCLs at both T4 and T5 and had also completed the stigmatization variable. This meant that only 71 adolescents (39 girls and 32 boys) could be used for the analyses. We also had to exclude four items on the *DSM*-oriented scales from these analyses, because they were added to the CBCL 6–18, but were not part of the CBCL 4–18 that was available at the time of the T4 data collection. These 4 items were “There is very little he/she enjoys” (affective problems), “Fails to finish things he/she starts” and “Inattentive or easily distracted” (attention-deficit/hyperactivity), and “Breaks rules at home, school, or elsewhere” (conduct problems). The offspring’s gender was not included as a between-factor in the analyses because, as mentioned, the findings at T5 showed either no gender difference or a significant gender  $\times$  stigmatization effect.

The results demonstrated main effects for time (Wilks’  $\lambda = .80$ ,  $F(6, 64) = 5.22$ ,  $p < .0001$ ), but not for stigmatization (Wilks’  $\lambda = .91$ ,  $F(6, 64) = 2.08$ ,  $p = .061$ ), or for the interaction between time and stigmatization (Wilks’  $\lambda = .91$ ,  $F(6, 64) = 1.99$ ,  $p = .072$ ). The means and standard deviations on the *DSM*-oriented problems scales at T4 and T5 are shown in Table 5. The GLM showed a change in the oppositional problems score, with higher scores when the offspring were 10 years old (T4).

#### DEVELOPMENTAL PATHWAYS BETWEEN T4 AND T5

As shown in Table 6, at T4 and T5 most of the NLLFS offspring scored within the normal range on affective problems, anxiety problems, somatic problems, attention-deficit/hyperactivity, oppositional problems, and conduct problems. Only 8.4% had a score on affective problems that changed from normal to deviant across the 7-year time interval between T4 and T5. The percentages of offspring who showed this developmental pathway for anxiety problems (4.2%), somatic problems (7.0%), attention-deficit/hyperactivity

**TABLE 5** Means and Standard Deviations of *DSM*-Oriented Scales for NLLFS Offspring at 10 (T4) and 17 (T5) Years Old<sup>a</sup>

	T4	T5	<i>F</i>	<i>P</i>	$\eta^2$
Affective problems			2.19	.141	.23
<i>M</i>	1.58	2.05			
<i>SD</i>	1.96	3.02			
Anxiety problems			.15	.702	.01
<i>M</i>	1.41	1.25			
<i>SD</i>	1.72	1.61			
Somatic problems			.62	.433	.02
<i>M</i>	0.94	0.75			
<i>SD</i>	1.46	1.53			
Attention problems			1.87	.174	.19
<i>M</i>	1.54	2.09			
<i>SD</i>	2.07	2.74			
Oppositional problems			8.18	.005	.47
<i>M</i>	2.26	1.34			
<i>SD</i>	1.95	1.67			
Conduct problems			2.09	.151	.08
<i>M</i>	0.68	1.05			
<i>SD</i>	1.12	1.87			

<sup>a</sup>*N* = 71.

(5.6%), oppositional problems (4.2%), and conduct problems (5.6%) were also very small. The findings of the  $\chi^2$  showed that for anxiety problems, there was a significant difference between offspring who reported experiences of homophobic stigmatization and those who did not: All three adolescents with a pathway from a normal to a deviant score on anxiety between T4 and T5 also indicated that they had experienced homophobic stigmatization. The percentage of those in the normal range at T4 and T5 was also significantly higher among those who reported no stigmatization. No significant differences were found between NLLFS offspring who had and had not experienced homophobic stigmatization on the other *DSM*-oriented problems scales (see Table 6).

## DISCUSSION

The present study was the first study of adolescents in planned lesbian families in which the *DSM*-oriented scales of the CBCL were used, rather than the traditional CBCL subscales (i.e., the competence scales, and the broadband and small-band syndrome scales). It was based on the NLLFS, the longest-running and largest prospective investigation of lesbian mothers and their children in the United States, in which a cohort of planned lesbian families with children conceived through donor insemination have been followed since the 1980s.

**TABLE 6** Distribution by Longitudinal Changes in Problem Behavior and Experiences of Homophobic Stigmatization<sup>a</sup>

	Experiences of Homophobic Stigmatization		Total N (%)	$\chi^2$	P
	No N (%)	Yes N (%)			
<i>Affective problems</i>				5.90	.117
Deviant T4 → deviant T5	01 (02.4)	00 (00.0)	01 (01.4)		
Deviant T4 → normal T5	03 (07.1)	03 (10.3)	06 (08.5)		
Normal T4 → deviant T5	01 (02.4)	05 (17.2)	06 (08.5)		
Normal T4 → normal T5	37 (88.1)	21 (72.4)	58 (81.7)		
<i>Anxiety problems</i>				9.68	.021
Deviant T4 → deviant T5	00 (00.0)	03 (10.3)	03 (04.2)		
Deviant T4 → normal T5	03 (07.1)	01 (03.4)	04 (05.6)		
Normal T4 → deviant T5	00 (00.0)	03 (10.3)	03 (04.2)		
Normal T4 → normal T5	39 (92.9)	22 (75.9)	61 (85.9)		
<i>Somatic problems</i>				2.37	.500
Deviant T4 → deviant T5	01 (02.4)	00 (00.0)	01 (01.4)		
Deviant T4 → normal T5	02 (04.8)	03 (10.3)	05 (07.0)		
Normal T4 → deviant T5	02 (04.8)	03 (10.3)	05 (07.0)		
Normal T4 → normal T5	37 (88.1)	23 (79.3)	60 (84.5)		
<i>Attention problems</i>				3.62	.164
Deviant T4 → deviant T5	00 (00.0)	00 (00.0)	00 (00.0)		
Deviant T4 → normal T5	00 (00.0)	01 (03.4)	01 (01.4)		
Normal T4 → deviant T5	01 (02.4)	03 (10.3)	04 (05.6)		
Normal T4 → normal T5	41 (97.6)	25 (86.2)	66 (93.0)		
<i>Oppositional problems</i>				1.05	.591
Deviant T4 → deviant T5	00 (00.0)	00 (00.0)	00 (00.)		
Deviant T4 → normal T5	02 (04.8)	02 (06.9)	04 (05.6)		
Normal T4 → deviant T5	01 (02.4)	02 (06.9)	03 (04.2)		
Normal T4 → normal T5	39 (92.9)	25 (86.2)	64 (90.1)		
<i>Conduct problems</i>				2.05	.153
Deviant T4 → deviant T5	00 (00.0)	00 (00.0)	00 (00.0)		
Deviant T4 → normal T5	00 (00.0)	00 (00.0)	00 (00.0)		
Normal T4 → deviant T5	01 (02.4)	03 (10.3)	04 (05.6)		
Normal T4 → normal T5	41 (97.6)	26 (89.7)	67 (94.4)		

<sup>a</sup>N = 71, which is based on adolescents with complete CBCL scores at both T4 and T5, and who had no missing value on the experiences of stigmatization variable.

Overall, the MANOVA showed no significant differences between the DSM-oriented scale scores of the 17-year-old NLLFS offspring and their age-matched peers from Achenbach's national sample. There was one significant difference when separate ANOVAs were conducted: the NLLFS sample scored higher than the Achenbach on conduct problems. However, it should be noted that increasing the number of dependent variables in this analysis reduces the statistical validity of the separate ANOVAs. Within the NLLFS sample, the finding that stigmatized adolescents demonstrated more conduct, affective, and anxiety problems contrasts with a previous study examining the traditional CBCL subscale scores of the NLLFS adolescents in

which stigmatization was not found to be associated with behavioral problems (Gartrell & Bos, 2010). An explanation for this difference might be that the *DSM*-oriented scale scores are more sensitive in measuring behavioral disorders than the traditional CBCL scores.

From a theoretical perspective based on an ecological approach to human development (Bronfenbrenner, 1979), one would also expect to find an effect of stigmatization on psychological well-being, especially during adolescence. In an article recently published in the *Journal of Counseling Psychology*, Goldberg and colleagues emphasized that this ecological approach “acknowledges that individuals exist within and are influenced by multiple intersecting contexts” (Goldberg, Kinkler, Richardson, & Downing, 2012, p. 73), and that it therefore might be a useful theoretical framework to study adolescents and young adult offspring. During adolescence, the influence of parents becomes less important and peers become increasingly more important (Steinberg, 2002). Furthermore, adolescents with lesbian mothers may be susceptible to what is described in the literature as “minority stress”—that is, psychological stress derived from their minority status (Meyer, 2003)—because they have been raised in nontraditional families.

We also assessed the constancy in the absolute level of *DSM*-oriented scale scores of the offspring between when they were 10 (T4) and 17 (T5) years old. We found a difference for only one scale: the NLLFS offspring had lower scores on the oppositional problems subscales when they were 10 years old. Several epidemiological studies on the prevalence of disorders in childhood and adolescence have also found higher oppositional problems scores among adolescents (see, for an overview, Costello, Copeland, & Angold, 2011). For none of the other *DSM*-oriented scales did we find a significant change in the scores between T4 and T5, or changes that were significantly associated with homophobic stigmatization. We should keep in mind, however, that most NLLFS offspring were in the non-clinical range of the *DSM*-oriented scales at T4 and remained in this range at T5, and only a few offspring moved from the normal range at T4 to the deviant range at T5. In this pattern, no differences were found between adolescents with and without experiences of homophobic stigmatization.

### Limitations and Strengths

The findings of the present study should be considered in the light of several limitations. First, regarding the comparison between the NLLFS and Achenbach normative samples, complete matching on demographic variables was not possible due to the limited demographic data provided on the Achenbach group. There was no significant difference in age of the offspring because it was possible to match the Achenbach sample on this variable with the NLLFS offspring who were on average 17 years old. There was also no significant overrepresentation by gender in either sample. However, there were more

White/Caucasian parents in the NLLFS sample, and there were significantly more parents with an upper-middle SES in the Achenbach normative sample. Future research should try to include more equivalence samples with respect to demographic variables in order to examine whether differences or similarities in psychological functioning of offspring are associated with family composition.

Another limitation for the comparison between the NLLFS and the Achenbach adolescents is the relatively small total sample size. However, a post hoc power analysis found that the power (1- beta error probability) was .77 and as such the sample was sufficient in size.

Furthermore, the findings are based on checklists completed by the mothers about their offspring's behavior. A more complete indication of the adolescents' *DSM*-oriented scale scores could have been obtained by asking the adolescents to fill in the Youth Self-Report (Achenbach & Rescorla, 2001), or by obtaining reports from other important people in their lives, such as their teachers (Achenbach & Rescorla, 2001).

It should also be mentioned that the NLLFS is based on a convenience sample. This may have resulted in the selection of mothers who were more interested in the topic under investigation, namely the development of lesbian offspring conceived by donor insemination. Another limitation is that homophobic stigmatization was measured in such a way ("Have you been treated unfairly because of having [a] lesbian mom[s]?"), that we do not know when or in which specific contexts these experiences occurred, or how stressful the experiences were for the NLLFS adolescents.

However, compared with other studies on the adolescent offspring of lesbian mothers, our study does have several strengths, notably that it was based on a longitudinal study, which made it possible to explore developmental changes over time. Another strength is that we used the *DSM*-oriented scale scores; because these scales are more sensitive in measuring problem behavior, they may be more effective in assessing the negative effects of homophobic stigmatization.

## Practical Implications

Our findings have several implications for practitioners working with adolescents in same-sex-parent families. First, on the *DSM*-oriented scales of psychological functioning, adolescents reared in planned lesbian families are comparable to age-matched teens reared in traditional families. This finding has practical implications for health care practitioners who are consulted by same-sex couples considering parenthood in a heteronormative society.

On the other hand, we also found that experiences of homophobic stigmatization by peers can negatively impact well-being for some adolescents with lesbian mothers. This finding underscores the importance of asking about stigmatization when counseling youths with same-sex parents.



Clinicians should be alert to the potential for distress that homophobic bullying might engender. In studies on younger children in lesbian families, two factors were found to be protective against the negative influences of homophobia: (1) attending schools with LGBT curricula and (2) having classmates whose parents were also LGBT. In addition, Branscombe, Schmitt, and Harvey (1999) found that higher levels of identification with their minority group helped individual members avoid the adverse effects of discrimination against that group. Drawing on social identity theory (Tajfel & Turner, 2004), one could argue that the offspring of lesbian mothers might cope with rejection by identifying or strengthening bonds with their in-group (Crocker & Major, 2003), and that such bonds could be influential in promoting well-being. As such, counseling psychologists might consider introducing the families of stigmatized offspring to advocacy groups for same-sex parents and their offspring.

Another strategy counselors might employ to help stigmatized adolescent offspring of same-sex parents is to teach them how to depersonalize the homophobia. This could be achieved, for example, by explaining how the painful experiences fit into the sociopolitical context of cultural heterosexism (Short, 2007). Russell and Richards (2003) reported that LGB women and men who were confronted with anti-LGBT politics appeared to benefit from such a cognitive strategy. Finally, counselors could remind targeted youths that peers who insult or mock them with homophobic comments are not really their friends.

## CONCLUSION

The present study has contributed to the literature on lesbian families and their adolescent offspring by measuring the adolescents' problem behavior with the *DSM* scales of the CBCL, which are more specific than the broadband and small-band syndrome scales. The results indicate that although the adolescent offspring of lesbian families do not differ on *DSM* scale scores from their age-matched peers in a national sample, and although most of the offspring do not show scores in a clinical range, some of them are suffering from their experiences of homophobic stigmatization.

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