Child: care, health and development
Original Article
doi:10.1111/cch.12180

The health perspectives of Australian adolescents from same-sex parent families: a mixed methods study

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Accepted for publication 20 June 2014

Abstract

Background Research involving adolescents from same-sex parent families provides an important contribution to the evidence base on their health, well-being and the impact of stigma. To date reports on the perspectives of adolescents with same-sex attracted parents have been limited. This study aimed to describe the multidimensional experiences of physical, mental and social well-being of adolescents living in this context.

Methods A mixed methods study of adolescents with same-sex attracted parents comprising of an adolescent-report survey of 10- to 17-year-olds and family interviews with adolescents and their parents. Data were collected in 2012 and 2013 as part of the Australian Study of Child Health in Same-Sex Families.

Results The findings from qualitative interviews with seven adolescents and responses to an open-ended survey question ($n = 16$) suggest four themes: perceptions of normality, positive concepts of health, spheres of life (including family, friends and community) and avoiding negativity. The quantitative sample of adolescents with same-sex attracted parents ($n = 35$) reported higher scores than population normative data on the dimensions general health and family activities within the Child Health Questionnaire (CHQ) as well as higher on the peer problems scale on the Strengths and Difficulties Questionnaire (SDQ). Perceived stigma correlates with lower health and well-being overall.

Conclusions Positive health outcomes are informed by the ways adolescents conceptualize health and how they construct their spheres of life. Peer relationships, and community perspectives of same-sex families, inform perceived stigma and its correlation with poorer health and well-being. Although adolescents see their families as essentially normal they are negatively affected by external societal stigma.

Keywords
adolescent health, family health, same-sex families, sexuality, social stigma

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Introduction

Previous studies that have considered the health of adolescents with same-sex attracted parents suggest that these children are doing well in most aspects of their lives (Stacey & Biblarz 2001), including a recent large-scale cross-sectional study from Australia (Crouch et al. 2014). However, there are residual concerns about the negative and potentially harmful impact of stigma and discrimination (Bos *et al.* 2008). Unfortunately, despite the contemporary societal interest and need for evidence, few research studies have considered adolescent's perspectives of their health and well-being.

Self-report is the gold standard approach to assessment of subjective aspects of health (Hays *et al.* 1995). The use of appropriately designed instruments and interviewing techniques with adolescents provides a rich source of health and well-being information. Furthermore, situating interviews and other techniques in contexts preferred by adolescents provides a safe setting to express themselves and establish a more accurate account of lived experiences (Punch 2007).

Mixed methods allow the use of well-designed measurement techniques to be integrated with qualitative, interview-based data collection. The rationale for the use of mixed methods is grounded in a post-positivist perspective in which it is understood that unobservable factors may impact on observable phenomena (Clark 1998). Post-positivism allows a more complex positioning of adolescent health, as attributed by adolescents themselves to their own specific circumstances, and is informed by the social and historical contexts in which same-sex parented families live (Crouch *et al.* 2013). This can be captured by family interviews through a social constructivist lens, drawing on queer theory which suggests that 'an understanding of virtually any aspect of modern western culture must be not merely incomplete but damaged in its central substance to the degree that it does not incorporate a critical analysis of modern homo/heterosexual definition' (Sedgwick 1990). In articulating social constructivism (Harre 1986) and queer theory with the post-positivist perspective, this study sought to enable a way of 'examining the ways in which families and their members respond in formally similar fashion to similar events, yet each with their own marvelous variations' (Fraenkel 1995).

The overall aim of this study was to understand the multidimensional experiences of physical, mental and social well-being of adolescents with same-sex attracted parents. The objectives were to measure adolescent perspectives of physical, mental and social well-being in the setting of same-sex parent families and as it relates to population-level data; and to capture the ways adolescents understand this health context themselves.

Methods

This was a mixed methods study nested within the Australian Study of Child Health in Same-Sex Families (ACHESS) (Crouch *et al.* 2012). This paper reports on the data from the adolescent reported survey and adolescent perspective from family interviews. The study received ethical approval from the University of Melbourne Health Sciences Human Ethics Subcommittee (Ethics ID number 1136875, approved 5 April 2012).

Study participants

Adolescents whose parents had completed the ACHESS parent-report survey (Crouch *et al.* 2012) and had then consented for their children to be approached by the study team were recruited. Fifty-eight adolescents were contacted in the first instance and invited to complete the ACHESS adolescent survey. Two reminders were sent. The survey was distributed between May and December 2012 to children aged between 10 and 17 years and was available both online and in paper form. Returning the survey implied consent to participate.

Adolescent perspectives were also gathered from family interviews. Families who participated in the parent survey were selected purposively and invited to participate in interviews, providing candidates from all states and territories in Australia, with the exception of the Northern Territory. A diverse sample of same-sex parent family types with a range of child health and well-being experiences were selected. Parents were contacted, in the first instance, and adolescents were invited to the interviews with parental consent. Family was defined by the index parent who invited additional family members to take part. Written consent was obtained from all adolescents who took part in family interviews, as well as their parents.

Data collection

Adolescent survey

Self-reported adolescent health was measured using a cross-sectional survey composed of validated instruments which measure multidimensional aspects of health and well-being. Preparation for the parent and adolescent reported quantitative survey instrument comprised a scoping review of the literature (Crouch *et al.* 2012), consultations with same-sex attracted parents and adult children with same-sex attracted parents, and the selection of psychometrically validated and

reliable measures of child health and well-being (Crouch *et al.* 2012).

Adolescent health was measured using two scales. The Child Health Questionnaire (CHQ) was used to measure multidimensional aspects of functioning and health-related quality of life (Landgraf *et al.* 1996; Waters *et al.* 2000). This instrument produces scores from 0 to 100 for child and adolescent health across a number of scales, with higher scores representing better health and/or well-being.

The Strengths and Difficulties Questionnaire (SDQ) was used to measure behaviour as a brief behavioural screening questionnaire with five scales (Hawes & Dadds 2004). Individual scale scores range from 0 to 10, with a total difficulties score ranging from 0 to 40 (excluding the prosocial scale). A lower score indicates better health, with the exception of the prosocial scale where a higher score indicates better health.

Measures of perceived stigma were based on the stigmatization scale for lesbian-parent families developed by Bos *et al.*, the Bos Stigmatization Scale (BSS) (Bos *et al.* 2004). This was adapted to represent adolescents from all types of same-sex parent families. Adolescents were asked to indicate how often in the past year their family had experienced stigma related to their parents' same-sex attraction (e.g. have people gossiped about you and your family, have people excluded you and your family?). Each of the seven items is scored from 1 (never) to 3 (regularly) with the final score being the mean of all items. A higher score represents more frequent experiences of perceived stigma. Internal consistency of the adapted scale was good (Cronbach's $\alpha = 0.91$).

One open-ended question was included in the adolescent survey: 'If you have been treated unfairly or bullied due to your parents' sexual orientation please describe what happened, how this affected you and your family, and what you did about it.' Responses from this question was analysed and included as part of the overall data upon which qualitative findings were based.

Online survey responses were automatically recorded into a database during survey completion and then exported into Microsoft Excel for Mac, version 14.0.2. Paper completed surveys were double entered into the spreadsheet for cleaning and scoring. Mean scale scores for the CHQ and SDQ were compared with published population means using independent sample *t* tests (Waters *et al.* 2001; Mellor 2005). Correlation coefficients were used to examine the relationship between adolescent health measures and stigma. Missing values were omitted and a significance level of two-sided $P < 0.05$ was used. All statistical analyses were performed using STATA version 12.0.

Family interviews

Interviews were conducted at the family home with all members of the family present. The interview followed an interview schedule, which guided open-ended questions. Interview themes included family, health and well-being, social attitudes and discrimination.

Focused discussions with adolescents were built on three key tasks in order to build rapport. First, adolescents were asked to talk about two pictures of their family that they had brought to the interview. Adolescents were then guided through an iPad application that showed a number of pictures relating to locations or activities in which young people might partake. Adolescents were encouraged to describe what the pictures meant to them and how they related to their family. Finally, adolescents were given the introduction to a story about an adolescent with same-sex attracted parents and they were asked to complete the story. Some older adolescents, not residing with the index parent, were interviewed by telephone. For these children it was not possible to use pictures, and interviews more closely followed the interview schedule used for parents. In all cases however, the adolescents were given space free from parental contribution for at least some part of the interview.

All interviews were recorded and then transcribed, replacing any identifying information with pseudonyms. Transcribed interviews were analysed using HyperResearch 3.5.2 to apply codes and develop themes. Thematic analysis was used, based on a social constructivist paradigm and drawing on elements of queer theory. As the same researcher conducted both the data analysis and the interviews, data immersion began at the start of the first interview. The context in which interviews took place and the interactions with participants informed the data immersion process, which was built upon by reading and re-reading transcripts after the interview itself.

Coding was conducted by one researcher (SRC) in the first instance with a second researcher (RM) reviewing a small selection of codes to ensure appropriate labelling. Themes were developed that responded to the key research questions and provided a context for, and a broader understanding of, the quantitative findings.

Results

A total of 35 adolescents returned completed surveys (60%), while 22 adolescents provided data from family interviews ($n = 7$) and the open-ended survey question ($n = 16$) for qualitative analysis (Tables 1 and 2).

Table 1. Selected child demographic characteristics for both qualitative and quantitative data

Demographic characteristic	Number of children per data type (total number of children)†	
	Qualitative (22)	Quantitative (35)
Child gender		
Male	14	22
Female	8	13
Mean age	13 years	13.2 years
Same-sex parent's gender		
Male	5	1
Female	17	33
Geography		
Lives in a metropolitan area	15	22
Family context		
Lives full time with same-sex parent	14	26
Born in same-sex parent's current relationship	6	10
Born in same-sex parent's previous heterosexual relationship	8	13
Same-sex parent currently in a relationship	20	3
Socioeconomic context		
Same-sex parent completed tertiary education	19	26
Same-sex parent's household income over AUD $100 000	16	23

†Includes three children who provided both quantitative and qualitative data.

Table 2. Family contexts of interviewed adolescents

Child name	Description
Leanne†	8-year-old girl from the inner suburbs. Raised since birth by gay male parents.
Xavier†	10-year-old boy from the inner suburbs. Raised since birth by gay male parents.
Caroline	13-year-old girl from the country. Born in a heterosexual context and currently lives half time with biological mother and her mother's female partner, and half time with biological father and her father's female partner.
Claire	14-year-old girl from the outer suburbs. Born in a two-female-parent household. Parents separated and currently lives with biological mother and her mother's female partner.
Joel	15-year-old boy from the outer suburbs. Born to a heterosexual mother with donated sperm from a gay male father. Lives most of the time with heterosexual mother who is currently single, and some times with biological father and father's male partner.
Kevin‡	17-year-old boy from the inner suburbs. Born in a heterosexual context and lives most of the time with biological father and father's female partner, and some times with biological mother and mother's female partner.
Sam‡	18-year-old boy from the inner suburbs. Born in a heterosexual context and lives most of the time with biological father and father's female partner, and some times with biological mother and mother's female partner.

†Children from the same family.
‡Children from the same family.

Good general health

On most of the scales from the CHQ and SDQ there was no difference between adolescents with same-sex attracted parents and adolescents from the general population (Table 3). This finding from the survey is reflected in a general theme of *perceived normality* that adolescents often described. Their own normality is viewed as *no different* when compared with other families, and they stressed that their parents' sexual orientation was *irrelevant* to their health. In fact, adolescents with same-sex attracted parents report that their friends often view their families as being quite normal:

> Sam (male, 18 years old): Yeah, my friends do know about my family background and the fact that my mum is gay. They don't really mind. They don't really find it all that different.

In terms of their general health, the adolescents with same-sex attracted parents from our sample scored significantly higher than the general population. In describing their general health adolescents considered a range of health concepts but often focused on positive physical aspects of health and well-being, the absence of injury, and the importance of diet and exercise. Beyond this most adolescents described a relatively straightforward interpretation of emotional well-being that involves having fun and being happy. For adolescents who had been through a family transition a key element to health and well-being was family stability, although this was not

Table 3. *T* test comparisons between the Australian Study of Child Health in Same-Sex Families (ACHESS) youth Strengths and Difficulties Questionnaire (SDQ) and Child Health Questionnaire (CHQ) scale scores and population mean scores†

	Diff. in mean	SE	95% Confidence Interval	P
SDQ				
Emotional symptoms	−0.06	0.35	−0.75, 0.62	0.85
Conduct problems	−0.31	0.30	−0.90, 0.26	0.29
Hyperactivity/inattention	−0.03	0.40	−0.81, 0.76	0.94
Peer problems	0.76	0.28	0.21, 1.31	0.0071
Prosocial	0.46	0.30	−0.12, 1.05	0.12
Total difficulties	0.29	0.98	−1.64, 2.22	0.77
CHQ				
Physical functioning	0.51	1.77	−2.95, 3.97	0.77
Role emotional	3.82	3.28	−2.62, 10.26	0.24
Role behavioural	−1.57	2.77	−7.01, 3.87	0.57
Role physical	2.25	2.62	−2.89, 7.38	0.39
Bodily pain	1.47	3.78	−5.96, 8.89	0.70
General behaviour	3.56	3.00	−2.33, 9.44	0.24
Mental health	2.72	2.79	−2.75, 8.18	0.33
Self-esteem	4.48	2.96	−1.33, 10.29	0.13
General health	14.21	2.28	9.74, 18.67	0.0000
Family activities	7.52	3.67	0.32, 14.71	0.04
Family cohesion	0.05	4.42	−8.63, 8.72	0.99

†Population data for SDQ scales from Mellor (2005) and for CHQ scales from Waters and colleagues (2003).

as important to young people raised in the same family context from birth.

Social families

In relation to family, the adolescents from our sample with same-sex attracted parents reported significantly higher scores than the general population on the family activities measure of the CHQ. Adolescents relate different *spheres of* life to their health, of which *family* is one, along with *friends* and *community*. At times these categories would be clearly demarcated but some adolescents, like 16-year-old Joel, would blur the distinction as they described social families and contexts where friends are seen as part of the family, being just as important as, or in some cases more important than, biological ties.

> Friendships and relationships have always been really, really important to me. I think far more than anything else. But I think that those friendships and relationships, they're more important than having a stable family life. It would be fantastic to have a mum who treated me like I wanted to and, you know, didn't kick me out so often. I really think I deserve that but I don't have it and I do think the other relationships are more important and if I did have a stable family I would still feel that.

This concept of social family, which includes personal friends, step parents and adult friends of parents, is echoed by a number of adolescents and suggests a definition of family that goes beyond purely biological ties. Building on this concept, many of the young people reflected on the health benefits of multiple parent figures and highlight the contexts where family activities take place, as described by Sam, an 18-year-old male who has spent time living with both his heterosexual father and his father's partner and his lesbian mother and her partner:

> Interviewer: And you see having four parents as a positive thing not as a negative thing?
> Sam: Yeah, definitely.
> Interviewer: In what way?
> Sam: You have, not more options but you've got more people to back you up and more opinions and more people to talk to when you need it.

Although this multiple-parent construct appears beneficial, some adolescents described the conflict that arises between parent figures and the 'irritation' that multiple 'prying' parents can create. The development of this construct, and the potential for resultant conflict between parents, often appeared to be a consequence of children being born into a heterosexual relationship that subsequently separated. This family transition from both heterosexual and same-sex families of origin, more than parental sexual orientation *per se*, was seen as a key factor by many adolescents in causing disruptions in their lives and impacting on well-being. Although Joel described above that friendships were more important than stability, many adolescents appeared to seek stability in their family lives while at the same time recognizing the benefits of experiencing different

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Table 4. Correlation between health scales from the Child Health Questionnaire (CHQ) and the Strengths and Difficulties Questionnaire (SDQ) with scores on the Bos Stigmatization Scale

Scale	*r*	*P* value
SDQ		
Emotional symptoms	0.32	0.06
Conduct problems	0.57	0.0004
Hyperactivity/inattention	0.42	0.01
Peer problems	0.38	0.03
Prosocial	0.10	0.56
Total difficulties	0.56	0.0004
CHQ		
Physical functioning	−0.42	0.01
Role emotional	−0.44	0.008
Role behavioural	−0.29	0.09
Role physical	−0.45	0.007
Bodily pain	−0.32	0.06
General behaviour	−0.50	0.002
Mental health	−0.31	0.07
Self-esteem	−0.35	0.04
General health	−0.27	0.12
Family activities	−0.55	0.007
Family cohesion	−0.31	0.07

household contexts, and many enjoyed the growing relationships with stepparents.

Peer responses to same-sex parented family structure

Even for those adolescents who appeared to not view friends as family, but as a separate and distinct sphere of life, the importance of close friendships is clear, and throughout the interviews adolescents recounted mostly positive reactions to their parent's sexual orientation from their friends.

The adolescents from our sample with same-sex attracted parents did score higher on peer problems when compared with population mean data however; and increased perceived stigma correlated to worse health outcomes on almost all scale measures (Tables 3 and 4). While adolescent reports were positive in relation to family and close friendships, perceptions of the broader community's reaction to same-sex families was not always positive. Most young people interviewed indicated a lack of personal negative experiences, but as Kevin, a 17-year-old boy describes, adolescents were aware that negative attitudes exist in the *community*:

> Interviewer: How do you think that people in society generally view same-sex families or same-sex attracted parents?
> Kevin: Well I guess I generally view that most are accepting but there's always some people that have got their own views and that they are against it. Generally I've seen that most people are accepting and you can generally pick out the ones that aren't already anyway.

These negative attitudes were often garnered through the media and mixed in with debates around marriage equality, something that all the adolescents considered important, if not specifically for their own family then in terms of wider acceptance.

Stories of personally experienced stigma did surface, particularly from the open-ended survey question, reflective of the less favourable peer problems outcomes. These stories were independent of parental gender and clearly had a significant impact on some adolescents, as described in response to the survey by this 16-year-old girl living in semi-rural Australia:

> I have been teased since the age of eight about having same-sex parents and as I got older the comment (sic) become a lot worse. I never told my parents as I did not want to upset them, but instead I kept it to myself until it was all to (sic) much and I then took my anger and frustration out on my family. I have been greatly affect (sic) and have lied and made up I did not have gay parents so people would like [me] and this really has affected me.

This girl had a significant experience and internalized the negativity. Children in inner metropolitan areas were not immune to negative comments but they appeared less emphatic, as described by this 10-year-old girl, from the survey:

> I've been teased about my family and the members of it. It has made my family proud of how I reacted. What I did about [it] was I said that they were wrong, so when they got no reaction, they gave up on teasing me.

Although this girl describes a proactive approach, a clear theme emerged around *avoiding negativity*, a common protective strategy employed by adolescents, perhaps a strategy to reinforce their own *perceived normality* in the face of stigma. This is in contrast to the internalization seen by the 16-year-old girl above and is described here by Caroline, a 13-year-old girl:

> I don't really give that much thought to it. I know some people at school are homophobic but I don't really care and I don't really know them that well so I don't really listen.

Discussion

This research found that our sample of adolescents with same-sex attracted parents scored well on multidimensional measures of health and well-being. It provides further evidence of the ways in which they define their concept of health in a positive

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way and explores ways in which they relate health to the different spheres of their lives, while maintaining a perspective of their own normality. However experiences of perceived stigma impact on reports of health and well-being and the way they interpret community attitudes towards same-sex parent families.

Through their *perceived normality* adolescents from this study mirror findings from previous research (Perrin *et al.* 2002), but they are also perhaps less aware of some small but important differences that can be both beneficial and detrimental to their health. As Stacey and Biblarz explain these families provide an interesting context for understanding family difference and in particular issues around gender and parenting structure (Stacey & Biblarz 2001). The finding that these adolescents scored well overall on general health reflects the parent reports from the ACHESS (Crouch et al. 2014). Viewing health in a positive light, focusing on diet and exercise, is unlikely to explain this outcome as there is no clear evidence that adolescents with same-sex attracted parents would adopt this perspective any more than other adolescents (Woodgate & Leach 2010). Perhaps this outcome is engendered by same-sex attracted parents who, alert to the possibility of rejection for their families, prepare their children for an abundance of negativity that does not always eventuate (Ray & Gregory 2001), reflected in a general lack of negative personal interactions. An alternative hypothesis might suggest that same-sex parents are focused on building resilience in their children allowing them to focus on positive health outcomes.

When considering the *spheres of life* that adolescents describe we see that their concept of family can be quite broad. The idea of 'social family' builds on Weeks *et al.*'s idea that same-sex families are testing new ways of family formation, but emphasizes a move beyond this 'trial' phase to a real lived experience (Weeks *et al.* 2001). This is augmented by Weston's description of 'families of choice' where gay and lesbian adults have sought the right to choose and shape their families outside of mainstream heterosexually driven biological concepts (Weston 1991). Perlesz *et al.* previously commented on how children with lesbian parents might view 'doing family', linking their perspectives to the heteronormative world (Perlesz *et al.* 2006), but this adaptation of ideas drawn from queer theory has not previously been applied to children with a broad range of same-sex parents and family contexts, particularly as it relates to their health and well-being. We can see that the adolescents from the ACHESS are constructing their own reality, or choice, of family in the same mould that their homosexual parents may have done previously, and benefitting from different contexts in which they perform *family activities*. Care should be taken however in attributing this difference to the same-sex attraction of their parents. While they may be modelling family construction on social foundations built in the queer community it is difficult to separate out these experiences from aspects of family transition, something that can be further explored when more children raised from birth in same-sex families have reached adolescence. A positive perspective was presented by adolescents themselves around multiple parents, and even shared households, leading to the adaptability necessary to construct lives in varying contexts. Achieving this necessary acceptance outside the traditional heterosexual family construct could be due to an eschewing of heteronormative dictates but may be more broadly a product of family transition *per se*. Furthermore, the willingness to seek advice from multiple parents, something that adolescents are not always good at (Darling *et al.* 2006), reflects similar findings from the National Longitudinal Lesbian Family Study (NLLFS) where 17-year-olds describe the benefits of confiding in their mothers (Gartrell *et al.* 2012).

The importance of difference is evident in the impact that stigma had on almost all aspects of health, and the peer problems these adolescents faced. While they described few direct incidents of stigma, particularly from close friends, when they did occur they had a significant impact. By emphasizing the positive aspects of their family life they appear to employ a resilience building strategy, similar to their parents, which can be quite deliberate. Disapproving peers are pushed to the periphery, outside of their friendship circle. However, despite this, there are some negative impacts on these children in that they are reporting peer problems. There is a constant interplay between trying to present their family in a positive light while negotiating their response to the negative attitudes around them. Where Australian children with same-sex parents have previously been described as being silenced in the school context in an attempt to avoid bullying (Ray & Gregory 2001), this study suggests that this may be changing. This silencing was not described by any of the children here, reinforcing the positive outcomes that disclosure can generate, as described by Gershon and colleagues (1999). In other work, American and Australian research has demonstrated the health benefits of lesbian, gay, bisexual and transgender (LGBT) visibility in school contexts for both adolescents with same-sex attracted parents and LGBT adolescents themselves (Hillier *et al.* 2010; Gartrell *et al.* 2012).

Limitations

The mixed methods employed by this study allow the quantitative findings to be strengthened by qualitative insights.

However, the sample size and convenience nature of the sample requires that the quantitative data be interpreted with care. Broadly speaking the quantitative findings reflect previous results from the large sample of parent reports from the ACHESS, particularly in areas of general health and the 'no difference' outcomes across most scales. This helps to support the validity of the adolescent data. Furthermore, interviewing adolescents in the contexts of their families provides a safe setting where they are comfortable to express themselves and provides more accurate accounts of lived experiences (Punch 2007); however, it might limit some insights as it is not clear how the presence of parents would affect adolescent's willingness to be open.

Conclusions

As the exploration and study of children and adolescents with same-sex attracted parents continues to evolve it is important to remember that the voices of the children themselves are a valuable and essential contribution to the discussion and this study allows these young people to speak in the broader context of multidimensional research. While these adolescents with same-sex attracted parents are doing well in terms of their health and well-being, strategies must be sought to ensure a broader societal acceptance of same-sex families *per se*, and all families of difference in general. Despite close immediate friendships, wider peer relationships for adolescents with same-sex attracted parents still require attention and it is in the school context that these can be tackled. There is increasing work internationally to tackle negativity in schools towards LGBT youth (Foundation for Young Australians 2012). Perhaps this needs to have a broader focus to incorporate the experiences and needs of adolescents whose parents are same-sex attracted so that their overall health and well-being does not suffer.

Key messages

- Adolescents with same-sex attracted parents report positive aspects of health, particularly in areas of general health and family activities.
- Overall they view themselves as no different from other adolescents.
- They do experience stigma however, and this has an impact on their well-being.
- Adolescents with same-sex attracted parents would benefit from positive school policies that combat homophobia.

Funding

This work was funded by an Australian Government National Health and Medical Research Council Postgraduate Scholarship.

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