

Donor-Conceived Adult Offspring of Lesbian Parents: Stigma, Coping and Mental Health

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ABSTRACT

This study examined how established adult offspring born to lesbian parents cope with the renewed anti-LGBTQ+ oppression in the United States. The study included 75 adults in their early thirties ($M = 30.93$, $SD = 0.92$; 49.33% female, 48.00% male and 2.66% gender non-binary; 90.67% White, 9.33% people of colour) from Wave 7 of the National Longitudinal Lesbian Family Study. Even though the majority of the offspring (68%) are heterosexual and no longer live at home, their awareness of homophobic discrimination against their parents may have a negative effect on their mental health. We hypothesised that coping strategies, such as educating others about discrimination or actively resisting it, could reduce the negative impact of perceived stigma on their mental health. Surprisingly, the results showed that adult offspring who coped through educating reported lower life satisfaction when they perceived higher levels of stigma. There were no significant findings relating to psychological distress. The results indicate the importance of studying families with minoritised sexual identities during a time of anti-LGBTQ+ laws and policies.

1 | Introduction

Stigmatisation has mental health consequences, causing psychological distress and life dissatisfaction (e.g., Emmer et al. 2024). Moreover, stigmatisation is often uncontrollable and unpredictable (e.g., Pascoe and Smart Richman 2009). In addition, awareness of hostile attitudes (i.e., perceived stigma) can negatively affect psychological well-being (e.g., Mickelson 2001). The current climate of the United States is characterised by a reactionary backlash against LGBTQ+ people. The stigmatisation associated with this backlash could impact the mental health of offspring whose parents have minoritised sexual identities (PMSI).

1.1 | Homophobic Stigmatisation of PMSI Offspring in Different Developmental Contexts

Homophobic stigmatisation refers to the harmful social or cultural process by which individuals or groups are marginalised, discriminated against or subjected to negative stereotypes and attitudes based on their perceived or actual sexual orientation. This stigma can take various forms, such as verbal harassment, physical violence, exclusion from social groups or institutions, denial of rights and opportunities and perpetuation of harmful stereotypes (e.g., Herek 2004; Meyer 2003). Homophobic stigmatisation is not limited to individuals with minoritised sexual identities but can include individuals who do not conform to

Summary

- This study is one of the first to examine adults who were conceived and raised by parents with minoritised sexual identities, particularly during a time of increased anti-LGBTQ+ discrimination.
- The study explored how educating people about discrimination or resisting discrimination can help or hinder adult offspring in such an environment.
- The research found that educating people about discrimination may be a less effective strategy in the current highly-polarised anti-LGBTQ+ climate.

heteronormative stereotypes (Farr et al. 2022). PMSI offspring may also experience homophobic stigmatisation due to the sexual identity of their parents.

Numerous studies have reported that PMSI children experience bullying and teasing. Farr et al. (2016) found that 57% of the school-aged children adopted by same-sex parents in the United States experienced microaggressions related to their parents' sexual orientation, such as teasing, heterosexism and public outings by others. Carone et al. (2022) conducted an Italian study on school-age children born to lesbian or gay parents through assisted reproduction. The study found that between 66% and 70% of the children reported experiencing peer microaggressions. Even in the Netherlands, which is considered one of the most accepting countries for LGBTQ+ people (Flores 2023), children between the ages of 8 and 12 with lesbian-identified parents reported that their peers often made jokes (60%), asked annoying questions (56.7%), used abusive language (45.2%) or gossiped (30.6%) about their mothers' sexual orientation (Bos and van Balen 2008).

In a recent Canadian study, almost half of adolescents and young adults with lesbian and gay parents reported experiencing homophobic stigmatisation (Bédard et al. 2023). Kuvalanka et al. (2014) conducted interviews with emerging adults who were reared by lesbian-identified parents; nearly half reported being subjected as adolescents to derogatory comments about their mothers' sexual orientation. Another survey of emerging adult PMSI offspring found that the most common form of homophobic stigmatisation was being asked annoying questions (72.8%) or having jokes made (58.2%) about their parents' sexual orientation (Koh et al. 2019).

1.2 | The Moderating Role of Coping in the Association Between Perceived Stigma and Mental Health

Coping strategies—the thoughts and behaviours used to handle difficult situations—can impact how stress affects mental health (Folkman 1992; Folkman and Moskowitz 2004). Adaptive coping strategies, such as weighing one's options or forming a plan of action (e.g., problem-solving coping), can reduce the impact of stress on mental health by increasing positive emotions and decreasing negative emotions (Amirkhan 1990; Nezu 1987). In contrast, maladaptive coping

strategies, such as avoiding social interactions or stressful situations, can have deleterious effects over time (e.g., Caudwell et al. 2024). There is little research examining the impact of coping strategies on the relationship between discrimination, victimisation and perceived stigma on mental health outcomes, especially among sexual minorities (Ngamake et al. 2014; Pascoe and Smart Richman 2009).

Research on the effects of coping in individuals with a minority status has primarily evaluated responses to general stressors or adverse events (e.g., Ridder 1997; Manne 2003). However, general coping measures may not fully capture how stigmatised individuals cope with stigma-related stressors, by, for example, educating others about stigma and its harmful impact or confronting individuals who discriminate (e.g., Choi et al. 2011). Consequently, Wei et al. (2010) developed the Coping with Discrimination Scale (CDS) that was validated with racial minority populations. This scale was used in research on sexual minorities (Ngamake et al. 2014, 2016), but has not been employed in studies of the offspring of lesbian parents.

1.3 | Coping Strategies of PMSI and Their Offspring in Different Developmental Contexts

Several studies on lesbian-parent families focused on how parents coped with stigma. Coping strategies included being active in the LGBTQ+ community, attending events such as Pride parades, engaging in other social justice activism and modelling values of acceptance and inclusivity for children (e.g., Mendez 2022; Oswald et al. 2020). Parents' participation in LGBTQ+ community and family networks protected their children against the negative effects of stigma (Bos and van Balen 2008).

Whereas studies of young PMSI children have shown that the children have positive feelings about their family (Farr et al. 2016, 2024), coping strategies become more complex in adolescence. One commonly mentioned coping strategy for adolescents with lesbian parents was that they kept their parents' sexual orientation a secret from their peers (Kuvalanka et al. 2014; Van Gelderen et al. 2012). Conversely, another common approach was to take a positive approach, such as refusing to let the stigma force them into the closet, confronting or educating others about stigmatisation and advocating on behalf of their PMSI (Clarke and Demetriou 2016; Kuvalanka et al. 2014).

1.4 | Purpose of the Current Study

There is little research about how PMSI children are affected by homophobic stigmatisation in adulthood. The U.S. National Longitudinal Lesbian Family Study (NLLFS) is the longest-running prospective study of lesbian-identified parents who conceived children via donor insemination in the 1980s. As adults, the NLLFS offspring, who are mostly heterosexual, may face less direct homophobic stigmatisation because they no longer live with their parents (Carone et al. 2024; Gartrell et al. 2019). However, their awareness of negative attitudes

(perceived stigma) towards sexual and gender minorities, and their own parents in particular, may have a negative effect on their mental health.

The present study is focused on how established adult NLLFS offspring (Wave 7) coped with the current anti-LGBTQ+ climate, and how their coping strategies affected their mental health. More specifically, we investigated whether the relationship between perceived stigmatisation and mental health (life satisfaction and psychological distress) was influenced by strategies for coping with discrimination (i.e., coping by educating people about discrimination, or coping by resisting). We hypothesised that coping through educating or resisting would moderate or buffer the impact of perceived stigma on mental health problems. Because of the longitudinal design of the NLLFS, it was possible to control for experienced stigmatisation and coping strategies from the Wave 6 NLLFS data collection when the offspring reached emerging adulthood.

2 | Methods

2.1 | Participants

The study included 75 adults (sex assigned at birth: 39 female and 36 male) aged 30–33 ($M=30.93$, $SD=0.92$), whose parents had participated in the U.S. NLLFS. All participants were conceived through assisted reproductive technologies (ART), had been born in the United States and lived independently of their parents. A majority lived in California, Massachusetts or New York.

Most participants identified as White (90.7%, $n=68$). The remaining 9.33% ($n=7$) identified as African American/Black ($n=3$), Latina/o or Hispanic ($n=1$) or other/mixed ($n=3$). Seven (9.3%) of the participants had attended some college, about half (50.7%, $n=38$) had completed a college or registered nurse degree and an additional 40% ($n=30$) had completed more than college. Seventy-three (97.3%) identified as cisgender, and two (2.7%) identified as transgender, although they indicated on a follow-up question that they were non-binary. The majority of participants identified as heterosexual (68.0%, $n=51$), with 32.0% ($n=24$) reporting a sexual minority orientation (lesbian gay: $n=3$, bisexual: $n=7$, queer: $n=13$, other: $n=1$).

2.2 | Procedure

Prospective NLLFS parents were recruited between 1986 and 1992 through announcements distributed in lesbian communities in the U.S. cities of Boston, Washington, D.C. and San Francisco. In the first wave (when the intended parents were inseminating or pregnant), 84 families participated, and the pregnancies resulted in 85 index offspring, including one set of twins. Parents were subsequently interviewed or surveyed when their children were aged 2, 5, 10, 17, 25 and 30–33 (Waves 2–7), and offspring were surveyed beginning at age 10 (Wave 3). At the seventh wave of the NLLFS, 75 families still participate, yielding a 90% family retention rate (see Gartrell 2020 for more details about the NLLFS procedure during all the assessment periods).

The participants were requested to complete an online survey, which was secure and anonymous. Upon completion of the survey, each participant received a \$60 gift card as compensation. The NLLFS study was designed longitudinally, allowing for the assessment of participants' experiences with stigmatisation and coping strategies from Wave 6 (when they were 25 years old). Therefore, offspring who took part in both Wave 6 (data collection in 2017) and Wave 7 (data collection in 2021 and 2022) were included in this study's analyses. The Institutional Review Board at Sutter Health approved the study (SHIRB no. 20.070-2; IRBNet no. 348911-23).

2.3 | Measures

2.3.1 | Perceived Stigma at Wave 7

Perceived stigma was evaluated using a scale consisting of three statements, developed by Herek (2009). Each item (e.g., 'Most people where I live think less of a person who is gay') is rated from (1) *strongly disagree* to (5) *strongly agree*. Mean scores are used, with higher scores indicating a greater feeling or awareness of stigma ($\alpha=0.67$).

2.3.2 | Mental Health at Wave 7

Measures consisted of both positive (satisfaction with life) and negative (psychological distress) aspects of mental health.

The Satisfaction with Life Scale (SWLS; Diener et al. 1985) was used to measure participants' overall satisfaction with life. It consists of five questions, such as 'In most ways, my life is close to ideal', which are answered on a scale from 1 (*strongly disagree*) to 7 (*strongly agree*). Mean scores are used, with higher scores indicating a greater satisfaction with life. The reliability of the scale is high ($\alpha=0.92$).

The Kessler-6 Psychological Distress Scale (K6; Kessler et al. 2002) was used to measure psychological distress. Participants were asked to rate six different feelings they experienced in the prior 30 days (e.g., 'worthless') on a scale of 1 (*none of the time*) to 5 (*all of the time*). Summed scores were used, with higher scores indicating more frequent experiences of depressive feelings ($\alpha=0.87$).

2.3.3 | Coping by Educating and Resisting at Wave 7

The CDS (Ngamake et al. 2014), which measures two different coping strategies, was utilised in this study. The two strategies were coping by educating (five items, e.g., 'I try to educate people so that they are aware of discrimination', $\alpha=0.91$) and coping by resisting (three items, e.g., 'I directly challenge the person who offended me', $\alpha=0.85$). Participants were asked to rate each item on a scale from 1 (*'never'*) to 6 (*'always'*) to indicate how frequently they used each coping strategy when faced with discrimination. A mean score was calculated for each subscale; higher scores indicated more frequent use of that coping strategy. The internal consistency of the items was high ($\alpha=0.91$ for coping by educating $\alpha=0.85$ for coping by resisting).

2.3.4 | Covariates: Experience With Homophobic Stigmatisation and Coping Styles at Wave 6

The following variables from Wave 6 (when participants were age 25) were used as covariates: (1) experience of homophobic stigmatisation and (2) adaptive and maladaptive coping strategies.

Experiences of homophobic stigmatisation consisted of six items (e.g., 'Peers asked annoying questions') about how often they had been stigmatised as an adult for being raised by (a) lesbian mother(s) (0 = *never* to 4 = *very frequently*) (Bos et al. 2020). Because of the distribution and small cell sizes, the answer categories 1 = *rarely*, 2 = *sometimes*, 3 = *often*, and 4 = *very frequently* were collapsed for each item. After this, each item was recorded as 0 (*no experience of homophobic stigmatisation*) and 1 (*experience of homophobic stigmatisation*). The scores on the six items were then summed; higher scores indicated multiple stigmatisations associated with having lesbian parents.

Items of the Brief COPE (Carver 1997; Carver et al. 1989) were used to assess the use of adaptive and maladaptive coping strategies. Participants were asked to indicate how often they used a particular strategy, with answer options ranging from 1 (*not at all*) to 4 (*frequently*). For this study, 13 items, consisting of six problem-focused and seven active emotional coping strategies, were combined to measure adaptive coping strategies. An example of a problem-focused coping strategy is 'I focus my efforts on addressing the situation I am in' and an example of an active emotional coping strategy is 'I try to view the situation differently to see it in a more positive light'. Higher scores on the adaptive coping strategy scale ($\alpha=0.71$) indicate that participants more frequently used these coping strategies. The measurement of maladaptive coping strategies was conducted using 10 items that were related to avoidant emotional coping strategies (e.g., 'I criticize myself'). A higher score on this scale ($\alpha=0.66$) indicated more frequent use of this maladaptive coping strategy while dealing with stressful situations.

2.3.5 | Demographic Information

Participants were asked to provide their age, sex assigned to them at birth, gender identity, sexual orientation and level of education. The participants' race/ethnicity was based on the information collected during Wave 6.

2.4 | Statistical Analyses

All statistical analyses were performed using IBM SPSS (version 29). We performed several preliminary analyses by calculating the mean scores and standard deviations of the variables measured at Wave 7: (1) perceived stigma, (2) coping through educating and resisting and (3) mental health (life satisfaction and psychological distress). A paired *t*-test examined whether the scores on coping through educating differed significantly from coping through resisting. In addition, mean scores and standard deviations were calculated for the covariates (experienced stigmatisation, and adaptive and maladaptive coping strategies) measured at Wave 6. Pearson *r* correlations between perceived

stigmatisation, coping through educating and resisting, mental health and the covariates were also conducted.

Finally, for the preliminary analyses, we analysed whether the demographic variables were associated with perceived stigmatisation, coping through educating and resisting and mental health (life satisfaction and psychological distress). The association between age and these variables was calculated with a Pearson *r* correlation. For sex assigned at birth, education and sexual orientation, analyses of variance (ANOVA) were used. Non-parametric tests (Mann-Whitney *U*) were employed to assess the association of race/ethnicity because the cell sizes for the categories were too small to use standard ANOVAs or *t*-tests. The cell sizes for the categories of educational level were also too small for standard ANOVAs or *t*-tests. As there were three educational levels, we used the Kruskal-Wallis *H* test as a non-parametric test. We could not perform statistical tests on gender identity because there were only two participants who identified as non-cisgender. Due to the multiple tests conducted on perceived stigmatisation, coping through education and resistance, as well as life satisfaction and psychological distress in relation to the demographic variables, a correction for multiple testing was conducted to control the risk of a Type I error. A Bonferroni correction was applied, adjusting the significance level to $p < 0.003$ (based on $\alpha = 0.05/20$ comparison).

To find out if the educating and resisting coping styles had an impact on the association between perceived stigmatisation and mental health (as measured by life satisfaction and psychological distress), moderation analyses were performed using PROCESS. This is a macro that is designed to analyse the interaction effects within a multiple linear regression analysis (Hayes 2013). Two moderation analyses were conducted with life satisfaction as the outcome variable: one with coping through educating as the moderator and one with coping through resisting as the moderator. We used the same procedure (separate analysis for each moderator) in a second set of moderation analyses with psychological distress as the outcome variable. In all moderation analyses, we entered perceived stigmatisation as a predictor. Experienced stigmatisation and adaptive and maladaptive coping strategies, measured at Wave 6, were included as covariates in these analyses. When demographic variables were significantly associated with life satisfaction, psychological distress, coping through educating or coping through resisting in the preliminary analyses, additional moderation analyses were conducted to investigate whether the findings were consistent with the first set of moderation analyses.

A Bonferroni correction was applied because of the multiple tests conducted. Since the study's primary focus was on the interaction effects across four distinct regression models, the correction was based on these four interaction terms. This resulted in an adjusted significance threshold of $p < 0.013$ (i.e., $\alpha = 0.05$ divided by four tests).

When an interaction effect between perceived stigmatisation and a moderator variable was significant in a moderation analysis after the Bonferroni correction, PROCESS established the value(s) of the moderator when the point of linearity of the association was no longer statistically significant (e.g., regions of

TABLE 1 | Means (*M*) and standard deviations (SD), observed minimal and maximal scores and Pearson *r* correlations of Wave 7 variables and Wave 6 covariates.

Variable	<i>M</i> (SD)	Observed scores		1.	2.	3.	4.	5.	6.	7.
		Minimal	Maximal							
Wave 7										
1. Perceived stigma	1.51 (0.65)	1.00	3.33	—						
2. Satisfaction with life	5.20 (1.44)	1.00	7.00	−0.15	—					
3. Psychological distress	12.36 (4.13)	6.00	25.00	0.07	−0.50***	—				
4. Coping through educating	3.75 (1.28)	1.00	6.00	0.14	0.18	0.00	—			
5. Coping through resisting	2.50 (1.21)	1.00	6.00	0.17	0.10	0.26*	0.47***	—		
Wave 6 covariates										
6. Experienced homophobic stigmatisation	2.32 (1.81)	0.00	6.00	0.35***	−0.02	0.12	0.24*	0.10	—	
7. Adaptive coping strategies	2.99 (0.39)	2.23	3.77	−0.18	0.32**	−0.17	0.42***	0.15	0.04	—
8. Maladaptive coping strategies	1.89 (0.37)	1.20	2.90	0.04	−0.27*	0.39***	0.06	0.16	0.19	−0.01

Note: Absolute scores: perceived stigma = 1–5, satisfaction with life = 1–7, psychological distress = 5–30, coping through educating = 1–6, coping through resisting = 1–6, homophobic stigmatisation = 0–6, adaptive coping strategies = 1–4, maladaptive coping strategies = 1–4.

p* < 0.05, *p* < 0.01, ****p* < 0.001.

significance) with the Johnson–Neyman technique (Hayes and Matthes 2009). These regions of significance were used for the interpretation of the significant interaction instead of probing two specified levels (1 SD above and below the mean) and calculating a simple slope (for a more comprehensive discussion of the use of the Johnson–Neyman technique above the simple slope analysis, see Dearing and Hamilton 2006). We used the statistical programme R to create a plot showing the regions of significance.

resisting were 3.75 (SD = 1.28) and 2.50 (SD = 1.21), respectively. A paired *t*-test showed that participants more often reported coping through educating than through resisting when confronted with stigmatisation or discrimination; *t*(74) = 8.45, *p* < 0.001, 95% CI: [0.96–1.55]. The mean scores on the covariates measured at Wave 6 for experienced homophobic stigmatisation, adaptive and maladaptive coping strategies were respectively 2.32 (SD = 1.81), 2.99 (SD = 0.39) and 1.89 (SD = 0.37).

3 | Results

3.1 | Preliminary Analyses

Table 1 shows the descriptive and bivariate Pearson *r* correlations of perceived stigma, coping through educating and resisting and life satisfaction and psychological distress as measured at Wave 7 of the NLLFS, and the covariates experienced homophobic stigmatisation and adaptive and maladaptive coping strategies measured at Wave 6.

3.1.1 | Mean Scores and Standard Deviations on Studied Variables

At Wave 7, the participants reported low levels of perceived stigma (*M* = 1.51, SD = 0.65), high levels of life satisfaction (*M* = 5.20, SD = 1.44) and low levels of psychological distress (*M* = 12.36, SD = 4.13). The mean scores on coping through educating and

3.1.2 | Bivariate (Pearson *r*) Correlations Between Studied Variables

Pearson *r* correlations showed that three out of the seven associations between the studied Wave 7 variables were significant. Participants with higher scores on psychological distress had lower scores on life satisfaction (*r* = −0.50, *p* < 0.001) and higher scores on coping through resisting (*r* = 0.26, *p* = 0.026). Those with higher scores on coping through resisting had higher scores on coping through educating (*r* = 0.47, *p* < 0.001). None of the covariates measured at Wave 6 were significant.

Participants with higher scores on adaptive coping strategies at Wave 6 had higher scores on the Wave 7 variables of life satisfaction (*r* = 0.32, *p* = 0.005) and coping through educating (*r* = 0.42, *p* < 0.001), and those with higher scores on maladaptive coping strategies at Wave 6 reported lower scores on life satisfaction (*r* = −0.27, *p* = 0.019) and higher scores on psychological distress (*r* = 0.39, *p* = 0.001). Participants who reported more homophobic

TABLE 2 | Participant characteristics and bivariate associations of Wave 7 variables and Wave 6 covariates.

Variable	Age		Sex assigned at birth						Race/Ethnicity			
			Female (n=39)			Male (n=36)			People of colour (n=7)		White (n=68)	
	Pearson <i>r</i>	<i>p</i>	<i>M</i> (SD)	<i>M</i> (SD)	<i>F</i>	<i>p</i>	Cohen's <i>d</i>	<i>M</i> (SD)	<i>M</i> (SD)	<i>p</i>	Mann- Whitney <i>U</i> test	Cohen's <i>d</i>
Wave 7, <i>M</i> (SD)												
Perceived stigma	0.17	0.145	1.58 (0.70)	1.42 (0.59)	1.06	0.306	0.25	1.67 (0.67)	1.49 (0.65)	174.00	0.218	0.29
Satisfaction with life	-0.08	0.500	5.30 (1.49)	5.09 (1.41)	0.39	0.537	0.14	4.89 (1.59)	5.24 (1.44)	197.50	0.460	0.20
Psychological distress	0.09	0.452	12.54 (4.28)	12.67 (4.01)	0.15	0.700	0.03	10.71 (2.29)	12.53 (4.25)	186.00	0.340	0.20
Coping through educating	-0.10	0.417	4.06 (1.06)	3.41 (1.41)	5.14	0.026	0.26	3.91 (1.29)	3.73 (1.28)	213.50	0.665	0.09
Coping through resisting	-0.02	0.876	2.59 (1.23)	2.39 (1.20)	0.47	0.496	0.11	2.81 (1.25)	2.47 (1.21)	192.50	0.404	0.19
Wave 6 covariates, <i>M</i> (SD)												
Experienced homophobic stigmatisation	-0.12	0.318	2.72 (1.79)	1.89 (1.75)	4.09	0.047	0.47	2.43 (2.07)	2.31 (1.80)	228.50	0.861	0.00
Adaptive coping strategies	-0.11	0.347	3.10 (0.37)	2.87 (0.37)	6.55	0.013	0.62	2.87 (0.43)	3.00 (0.38)	200.00	0.487	0.16
Maladaptive coping strategies	-0.09	0.461	1.91 (0.37)	1.87 (0.37)	0.23	0.632	0.11	1.79 (0.36)	1.90 (0.37)	205.50	0.552	0.13
Educational level												
More than college degree (n=30)												
Variable	Some college degree (n=7)		College degree (n=38)		<i>M</i> (SD)		<i>M</i> (SD)		Kruskal-Wallis <i>H</i> test		<i>p</i>	
	<i>M</i> (SD)	<i>p</i>	<i>M</i> (SD)	<i>p</i>	<i>M</i> (SD)	<i>p</i>	<i>M</i> (SD)	<i>M</i> (SD)	<i>M</i> (SD)	<i>p</i>	<i>F</i>	<i>p</i>
Wave 7, <i>M</i> (SD)												
Perceived stigma	1.67 (0.77)	1.42 (0.64)	1.58 (0.64)	1.09	0.353	0.25	1.50 (0.63)	1.51 (0.70)	0.00	0.948	0.02	
Satisfaction with life	4.74 (0.92)	5.12 (1.53)	5.42 (1.43)	3.26	0.196	0.13	5.55 (1.13)	4.47 (1.76)	10.32	0.002	0.73	
Psychological distress	15.00 (3.79)	12.03 (3.87)	12.67 (4.42)	4.92	0.550	0.54	11.82 (3.72)	13.38 (4.82)	2.17	0.145	0.36	
Coping through educating	3.89 (1.01)	3.56 (1.30)	3.97 (1.30)	1.19	0.246	0.26	3.65 (1.27)	3.97 (1.28)	1.03	0.315	0.26	
Sexual orientation												
Heterosexual (n=51)												
Variable	Sexual minority (n=24)		<i>M</i> (SD)		<i>M</i> (SD)		<i>M</i> (SD)		<i>M</i> (SD)		<i>p</i>	
	<i>M</i> (SD)	<i>p</i>	<i>M</i> (SD)	<i>p</i>	<i>M</i> (SD)	<i>p</i>	<i>M</i> (SD)	<i>M</i> (SD)	<i>M</i> (SD)	<i>p</i>	<i>F</i>	<i>p</i>
Perceived stigma												
Satisfaction with life												
Psychological distress												
Coping through educating												

(Continues)

TABLE 2 | (Continued)

Variable	Educational level						Sexual orientation		
	More than college degree (n=38)		College degree (n=30)		Kruskal-Wallis H test		Cohen's <i>d</i>	<i>p</i>	Cohen's <i>d</i>
	<i>M</i> (SD)	<i>M</i> (SD)	<i>M</i> (SD)	<i>M</i> (SD)	<i>n</i> (n=30)	<i>n</i> (n=51)			
Coping through resisting	2.90 (1.33)	2.47 (1.12)	2.43 (1.31)	1.15	0.563	0.25	2.39 (1.05)	2.74 (1.49)	1.38
Wave 6 covariates, <i>M</i> (SD)									
Experienced homophobic stigmatisation	3.00 (1.73)	2.42 (1.88)	2.03 (1.73)	2.09	0.351	0.34	2.47 (1.90)	2.00 (1.59)	1.11
Adaptive coping strategies	3.00 (0.43)	2.91 (0.36)	3.09 (0.40)	3.37	0.185	0.44	3.00 (0.40)	2.97 (0.37)	0.10
Maladaptive coping strategies	2.07 (1.98)	1.88 (0.42)	1.84 (0.31)	2.86	0.240	0.40	1.86 (0.35)	1.95 (0.40)	1.15

Note: After applying the Bonferroni correction, the threshold for significance was set at $p < 0.003$.

stigmatisation at Wave 6 reported higher scores on perceived stigma ($r=0.35$, $p=0.002$) and higher scores on coping through educating ($r=0.24$, $p=0.041$) at Wave 7 (Table 2).

3.1.3 | Demographic Differences on Studied Variables

Non-heterosexual participants reported lower life satisfaction scores compared to heterosexual participants, $F(1, 73)=10.32$, $p=0.002$, with a Cohen's *d* effect size of 0.73 (Cohen 1988). None of the other demographic factors showed a significant relationship with the variables measured at Wave 7.

3.2 | Moderation Analyses on the Association Between Perceived Stigma and Mental Health

3.2.1 | Life Satisfaction

Regarding the analyses using coping through educating as a moderator variable, after controlling for the covariates measured at Wave 6, the interaction between perceived stigma and coping through educating was significantly associated with life satisfaction, $b=-0.49$, $SE=0.18$, 95% CIs $[-0.85, -0.12]$, $p=0.010$. The interaction between coping through resisting as a moderator and perceived stigma was not significantly related to life satisfaction after entering the covariates, $b=0.05$, $SE=0.19$, 95% CIs $[-0.33, 0.43]$, $p=0.786$ (Table 3).

The Johnson–Neyman technique showed that when the scores of coping through educating were outside the interval 0.71–4.42, the slope of perceived stigma was significant at $p < 0.05$. Given that the range of observed values of coping through education was 1.00–6.00, for participants with higher scores on this coping style, higher levels of perceived stigma were associated with lower levels of life satisfaction. This was the case for 34.67% of the participants (see Figure 1).

When we included sexual orientation and sex assigned at birth as covariates, along with other variables from Wave 6, the results remained consistent, showing that the interaction between coping through educating and perceived stigma significantly impacted life satisfaction ($b=-0.45$, $SE=0.18$, 95% CIs $[-0.80, -0.10]$, $p=0.012$).

Sex assigned at birth was not significantly associated with coping through resistance; therefore, we did not include it as a covariate in this additional analysis involving coping through resistance as a moderator. Because sexual orientation was significantly associated with life satisfaction, it was included as a covariate in the additional analyses with the variables measured at Wave 6, and the results remained consistent, showing that coping through resistance \times perceived stigma did not significantly impact life satisfaction ($b=0.00$, $SE=0.18$, 95% CIs $[-0.36, 0.36]$, $p=0.989$).

3.2.2 | Psychological Distress

Table 4 shows the two separate moderation analyses (coping through educating and coping through resisting as moderator variables) with psychological distress as the outcome variable.

TABLE 3 | Moderation analyses on life satisfaction, separately for coping through educating and coping through resisting with Wave 6 covariates.

Variable	R^2	<i>p</i>	ΔR^2	<i>p</i>	<i>b</i>	SE	<i>p</i>	95% confidence intervals (CIs) for <i>b</i>								
								Lower	Upper							
Coping through educating as moderator																
Wave 6 covariates																
Experienced homophobic stigmatisation					0.02	0.09	0.812	-0.16	0.21							
Adaptive coping strategies					0.79	0.45	0.083	-0.11	1.68							
Maladaptive coping strategies					-1.06	0.42	0.013	-1.89	-0.23							
Wave 7																
Perceived stigma					-0.22	0.26	0.389	-0.73	0.29							
Coping through educating					0.12	0.14	0.367	-0.15	0.39							
Perceived stigma \times coping through educating					-0.49	0.18	0.010	-0.85	-0.12							
	0.27	0.001	0.07	0.010												
Coping through resisting as moderator																
Wave 6 covariates																
Experienced homophobic stigmatisation					0.05	0.10	0.592	-0.14	0.24							
Adaptive coping strategies					1.04	0.42	0.017	0.19	1.88							
Maladaptive coping strategies					-1.17	0.45	0.011	-2.07	-0.28							
Wave 7																
Perceived stigma					-0.31	0.28	0.259	-0.86	0.24							
Coping through resisting					0.15	0.14	0.279	-0.12	0.42							
Perceived stigma \times coping through resisting					0.05	0.19	0.786	-0.33	0.43							
	0.20	0.016	0.00	0.786												

Note: After applying the Bonferroni correction, the threshold for significance was set at $p < 0.013$. Post hoc power analyses—coping through educating as moderator: $1 - \beta$ error probability = 0.918 and $f^2 = 0.27$ ($N = 75$, $p < 0.05$); coping through resisting as moderator: $1 - \beta$ error probability = 0.981 and $f^2 = 0.37$ ($N = 75$, $p < 0.05$).

In both moderation analyses, after controlling for the covariates measured at Wave 6, the interaction between coping by educating and perceived stigma was not significant ($b = 0.64$, $SE = 0.55$, 95% CIs $[-0.45, 1.73]$, $p = 0.245$). This non-significant association was also observed for the interaction between perceived stigma and coping through resisting on psychological distress ($b = 0.13$, $SE = 0.54$, 95% CIs $[-0.94, 1.20]$, $p = 0.806$).

In our additional analysis, we included sex assigned at birth as a covariate in the original analysis because it was significantly associated with coping through educating. The results consistently showed that the interaction between this coping style and perceived stigma was not significant ($b = 0.72$, $SE = 0.56$, 95% CIs $[-0.39, 1.83]$, $p = 0.204$) when sexual orientation and the other Wave 6 covariates were included in the analysis.

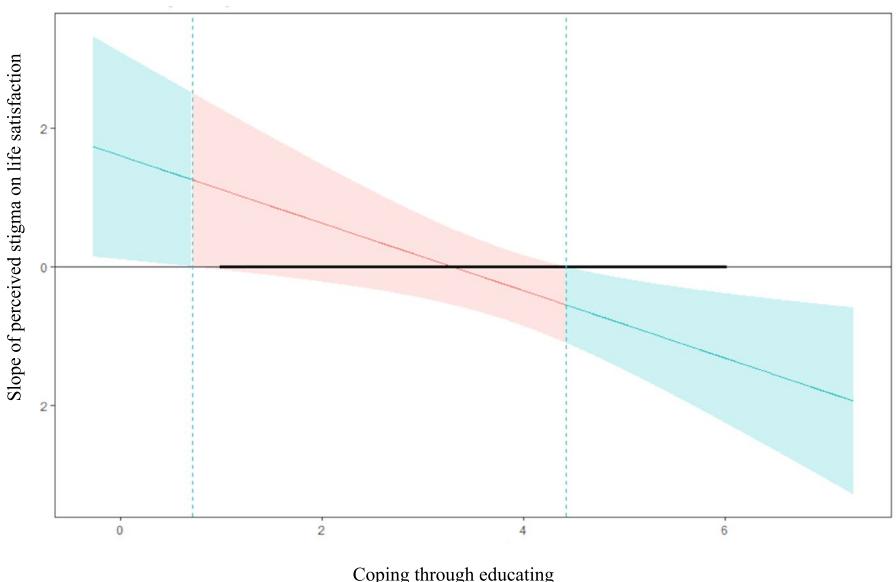


FIGURE 1 | Johnson–Neyman plot (the area on the left of the first dashed line and on the right of the second dashed line is significant at $p < 0.05$).

4 | Discussion

The current study focused on adult offspring in the United States who were conceived and raised by parents with minorised sexual identities. The study aimed to understand the offspring's coping strategies in the current climate of LGBTQ+ stigmatisation. Specifically, we were interested in finding out if strategies such as educating others about discrimination or resisting discrimination could decrease the possible negative impact of perceived stigma on mental health. The study used data from the latest wave of the NLLFS, and its longitudinal design allowed us to account for previous experiences of stigmatisation and coping strategies in the analysis.

4.1 | Coping Through Educating and Resisting as Moderators in the Association Between Perceived Stigma and Mental Health

We hypothesised that there would be a positive association between perceived stigmatisation and low levels of life satisfaction, as well as high levels of psychological distress, for NLLFS adult offspring with lower scores on educating others about discrimination or resisting discrimination. To test this hypothesis, we used the CDS, which was initially designed for racial minority populations (Wei et al. 2010), but has also been validated with sexual minorities (Ngamake et al. 2014, 2016). The advantage of this scale is that it focuses on how participants deal with discrimination, such as by educating others about stigma and its harmful impact, or confronting people who discriminate. This contrasts with more traditional coping measures that evaluate responses to general stressors or adverse events (e.g., Ridder 1997; Manne 2003).

Contrary to our hypothesis, there was a significant association between perceived stigma and low levels of life satisfaction for adult NLLFS offspring with high levels of coping through educating. This suggests that coping through educating about the impact of discrimination may not have been an effective strategy

for NLLFS offspring. We did not find a significant association between coping through resisting and life satisfaction, nor between coping strategies, mental health and perceived stigma.

One possible explanation for the significant association between perceived stigma and low levels of life satisfaction for adult NLLFS offspring with high levels of coping through educating could be that constantly explaining the impact of discrimination may have been exhausting and emotionally draining. The continuous effort to clarify and defend their experiences might have made them more aware of stigma and discrimination, leading to reduced life satisfaction. In other words, although educating others is an active coping strategy, it might not offer the emotional relief or support needed to lessen the negative effects of feeling stigmatised. It is possible that educating others about the discrimination associated with being a child of sexual minority parents may be an added stressor. In a similar vein, two qualitative studies found that non-binary college students and adults experienced cognitive and emotional exhaustion from constantly having to educate, defend or prove their identity, which negatively impacted their well-being (Goldberg and Kuvalanka 2018; Matsuno et al. 2024).

The NLLFS offspring had relatively high scores on life satisfaction and low scores on psychological distress. Additionally, their reported levels of perceived stigma were relatively low, and there was also no bivariate association between perceived stigma and life satisfaction or psychological distress. The low levels of perceived stigma could be attributed to the fact that most NLLFS offspring resided in California, Massachusetts or New York, states known for being more progressive (Goldberg 2024). In the United States, there has been an increase in anti-LGBTQ+ laws during the years 2021–2022 when the NLLFS offspring were surveyed, but these discriminatory laws are less common than in politically conservative U.S. states such as Florida, Georgia, Texas, Arizona and Wisconsin (e.g., Goldberg 2024; Sosin 2022; Strauss 2022). As a result, NLLFS offspring living in progressive states may experience stigmatisation less frequently than those who reside in more politically conservative regions of the

TABLE 4 | Moderating analyses on psychological distress, separately for coping through educating and coping through resisting with Wave 6 covariates.

Variable	<i>R</i> ²	<i>p</i>	ΔR^2	<i>p</i>	<i>b</i>	SE	<i>p</i>	95% confidence intervals (CIs) for <i>b</i>								
								Lower	Upper							
Coping through educating as moderator																
Wave 6 covariates																
Experienced homophobic stigmatisation					0.13	0.28	0.637	-0.42	0.68							
Adaptive coping strategies					-1.79	1.34	0.187	-4.46	0.89							
Maladaptive coping strategies					4.15	1.25	0.001	1.66	6.63							
Wave 7																
Perceived stigma					-0.10	0.77	0.896	-1.63	1.43							
Coping through educating					0.13	0.41	0.743	-0.68	0.94							
Perceived stigma \times coping through educating					0.64	0.55	0.245	-0.45	1.73							
	0.20	0.017	0.02	0.245												
Coping through resisting as moderator																
Wave 6 covariates																
Experienced homophobic stigmatisation					0.14	0.27	0.602	-0.40	0.68							
Adaptive coping strategies					-2.20	1.19	0.068	-4.58	0.17							
Maladaptive coping strategies					3.74	1.25	0.004	1.24	6.24							
Wave 7																
Perceived stigma					-0.32	0.77	0.680	-1.86	1.22							
Coping through resisting					0.79	0.38	0.041	0.03	1.55							
Perceived stigma \times coping through resisting					0.13	0.54	0.806	-0.94	1.20							
	0.23	0.006	0.00	0.806												

Note: After applying the Bonferroni correction, the threshold for significance was set at $p < 0.013$. Post hoc power analyses—coping through educating as moderator: $1 - \beta$ error probability = 0.894 and $f^2 = 0.25$ ($N = 75$, $p < 0.05$); coping through resisting as moderator: $1 - \beta$ error probability = 0.946 and $f^2 = 0.30$ ($N = 75$, $p < 0.05$).

United States. A prior study found that NLLFS offspring did not experience more victimisation, mental health problems or issues related to their social well-being than matched participants of a U.S. probability sample (Bos et al. 2024).

4.2 | Strength and Limitations of the Current Study

This study has several notable strengths. The NLLFS is the first longitudinal and prospective study of offspring born to and raised by PMSI in the United States. Second, the study is also one of the first to focus on established adult PMSI offspring, with data collected during a time characterised by renewed

anti-LGBTQ+ oppression. A third strength is that the longitudinal design enabled us to control for experienced stigmatisation and coping styles when the offspring were younger. Finally, the study's measures helped us to understand the offspring's coping strategies related to perceived stigma.

It is important to note that the findings of this study may be limited in their generalisability because the NLLFS offspring are predominantly White and highly educated. When the NLLFS began in the mid-1980s, ART were primarily utilised by individuals with significant financial resources. Additionally, at that time, there were few, if any, population-based studies that inquired about sexual orientation, resulting in a convenience sample.

Another limitation of this study is that it investigated whether the relationships between perceived stigmatisation and life satisfaction or psychological distress are influenced by coping strategies using a cross-sectional design. As a result, we must be cautious in interpreting the causal direction of these relationships.

4.3 | Future Directions

Due to the limitations of this study's cross-sectional design, further research is necessary using a longitudinal approach. This would allow for a deeper exploration of the impact of coping strategies, such as educating individuals about discrimination and empowering LGBTQ+ families and their children to resist microaggressions when they experience them.

While the power analyses for the four moderation regression analyses showed adequate power ($1 - \beta$ error probability ranging from 0.894 to 0.981), it is important to acknowledge that this study has a relatively small sample size. Consequently, our conclusions should be interpreted with caution, particularly regarding the non-significant interactions in the moderation analysis. Future research on the effects of coping through education and resistance in the face of homophobic stigmatisation—especially concerning the well-being of adult offspring of lesbian parents—should aim to include a larger sample size.

Furthermore, in light of the current backlash against LGBTQ+ communities, families and their children, it is important to focus future research on the impact of anti-LGBTQ+ laws on parents with marginalised sexual identities and their children throughout the developmental lifecycle (childhood, adolescence and adulthood). Mental health professionals need to understand the most effective ways for families with PMSI to cope during difficult times. Future research should also focus on politically conservative U.S. states and other nations where recent anti-LGBTQ+ laws and policies have been introduced. Additionally, it is important to study more diverse family groups based on their demographic backgrounds.

Author Contributions

Henny M. W. Bos: conceptualization, data curation, formal analysis, investigation, methodology, writing – original draft, writing – review and editing. **Esther D. Rothblum:** conceptualization, investigation, methodology, writing – original draft, writing – review and editing. **Nicola Carone:** conceptualization, formal analysis, investigation, methodology, writing – original draft, writing – review and editing. **Audrey S. Koh:** conceptualization, methodology, writing – original draft, writing – review and editing. **Nanette K. Gartrell:** conceptualization, investigation, methodology, project administration, supervision, writing – original draft, writing – review and editing.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Due to the sensitive nature of the survey questions, all respondents were assured that raw data would remain confidential and would not be shared with others.

Peer Review

The peer review history for this article is available at <https://www.webofscience.com/api/gateway/wos/peer-review/10.1002/icd.70026>.

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