Psychiatr. Pol. 2025; 59(5): 783–796
PL ISSN 0033-2674 (PRINT), ISSN 2391-5854 (ONLINE)
www.psychiatriapolska.pl
DOI: https://doi.org/10.12740/PP/OnlineFirst/190770

Parental minorioty stress and symptoms of depression and anxiety in women raising children in same-sex relationships

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Summary

Aim. The purpose of this study was to examine the levels of depression and anxiety of lesbian and bisexual (LB) mothers raising children from a previous heterosexual relationship in a current same-sex relationship, on the basis of minority stress theory.

Method. 58 LB biological mothers, 33 LB co-mothers from same-sex relationships and 60 mothers from different-sex marriages participated in a questionnaire-based online survey. The groups were compared in terms of depression and anxiety severity (state and trait). In the LB groups, correlation analysis was conducted between the dependent variables and the number of encountered negative homophobic events, the expectation of rejection, self-concealment, and internalised homophobia. To examine whether the associations between these variables in LB biological mothers and co-mothers differed, moderation analysis was used.

Results. The levels of depression and anxiety were similar across the groups. Among LB mothers, anxiety (state and trait) correlated mainly with internalised homophobia, whereas depression was linked to the expectation of rejection. Notably, among biological LB mothers, as opposed to co-mothers, there was an association between both depression and anxiety (state) and negative homophobic events.

Conclusions. The lack of intergroup differences in levels of depression and anxiety, with correlations of these variables with minority stress, may indicate high resources (e.g. family resilience) of LB mothers. The cost of homophobic events is higher for LB biological mothers than for LB co-mothers. This may be attributed to the later emergence of non-heterosexual identity in LB biological mothers who have children from heteronormative relationships, leading to a heightened sense of threat when their custody rights are challenged.

Key words: minority stress, depression, anxiety

Introduction

The last half-century has seen legal recognition of family life for same-sex couples with children in many countries of the Western culture – in contrast to the former Eastern Bloc countries. In Poland, the existence of these couples, their specific needs and the challenges they encounter are reported by individual research studies [1, 2], as well as by NGOs and the media. Most of these families are female couples raising children born in an earlier relationship with a man [1].

In Poland, estimates put the number of children raised by same-sex couples at a minimum of 50,000 [3]. These are most often reconstituted families, in which children were born in an earlier heterosexual relationship, and, less frequently, planned families, in which same-sex couples use assisted reproduction or adoption methods [1]. At the same time, it should be emphasised that the level of systemic heterosexism in Poland is high. The right to family life protection does not extend to LGBTQ (lesbian, gay, bisexual, transgender, queer) individuals, and single-sex couples are not allowed to register partnerships, be married, or adopt a child. Although public support for LGBTQ rights has been increasing for the past 20 years, 56% of the public deny LGBTQ couples the right to marry and 75% deny LGBTQ couples the right to adopt children [4]. Stereotypes and prejudices against minorities are reproduced in the media and in politics, which encourages the escalation of homophobic hate speech and hate crimes [5]. According to the minority stress theory, these social conditions adversely affect the mental health of LGBTQ people.

The aim of the study was to test whether women forming reconstituted families with other women and raising children born in a previous relationship with a man are also affected by minority stress, as evidenced by depression and anxiety symptoms. These women mostly consider themselves to be lesbian or bisexual and are therefore referred to as LB mothers throughout the text.

The minority stress model for LGB people [6, 7] draws on the social stress theory, which postulates the impact of the social position and the extent of specific groups' privilege on their psychological wellbeing. It is a socially determined, chronic and unique stress – it represents an additional, specific burden on members of the underprivileged groups and increases the risk of physical and mental health deterioration. Meyer [6] distinguished between two types of stressors for LGB people: (1) distal, i.e. objectified negative events motivated by homophobia, such as inferior treatment, aggression, exclusion; (2) proximal, that is, subjectively conditioned, including: (a) expectation of rejection resulting in chronic vigilance and suspicion; (b) self-concealment related to the desire to conceal one's sexual identity; (c) internalised homophobia, i.e. negative attitudes towards non-heterosexuality resulting in self-deprecation and intrapsychic conflict between homosexual desires and beliefs about them.

The minority stress theory is supported by a diverse body of research. Depressive disorders, anxiety, substance abuse, suicidal thoughts and self-harm were more frequently diagnosed in LGB people than in heterosexual persons [7, 8]. Correlation-regression studies showed associations of minority stressors with anxiety, depression and suicidal thoughts [7, 9–11]. Experimental studies proved that exposure of LGB

people to homophobic content contributed to increasing the level of negative emotions (including anxiety, anger and shame [12]) as well as endocrine and cardiovascular physiological stress responses [13].

Research on minority stress rarely includes LGB parents. Meanwhile, parental minority stress is unique in that it stems from the desire to shield the child and the family from social rejection in addition to the worry of not having one's non-heterosexuality accepted [14, 15]. Therefore, in terms of parental minority stress, additional stressors should be included: negative events motivated by prejudice against LGB parents, including micro-aggressions and micro-exclusions in educational or medical institutions and in interpersonal relationships (in the case of families formed after the breakdown of a heterosexual relationship – resentment from the second biological parent and other family members [16]; the expectation of being rejected as a non-heteronormative parent and that of one's child being rejected because they have non-heteronormative parents; the concealment of information about one's sexual identity and family structure, especially in the social situations that expose the parental role; internalised prejudices about LGB parenting).

Previous research shows that both LGB parents and their children experienced rejection and exclusion in the school environment [17, 18], and that the fear of stigmatisation and discrimination against the child is common in these families [17, 19, 20]. A common cause of concern for LGB parents (especially in families formed after the breakup of a heteronormative relationship) is the use of information about the parents' sexual identity by third parties to undermine their parenting competence or challenge their right to custody of their child [20, 21].

Several previous correlational studies support the minority stress theory in LGB parents. For example, Goldberg and Smith [22] showed that American lesbians and gay men with high levels of internalised homophobia, residing in the states with no favourable legal solutions for LGB families, experienced the most dramatic increase in depressive and anxiety symptoms during the period of becoming a parent. In a Dutch study by Bos et al. [23], lesbian mothers from planned families who either experienced ostracism, anticipated social rejection, or had high levels of internalised homophobia were more likely to exhibit parental justification, that is, a strong and persistent presentation of themselves as good parents. At the same time, comparative studies have found no differences between lesbian mothers or gay fathers and heterosexual parents in terms of mental health disorders, including: neuroticism, depression, anxiety and psychotic disorders [24–26].

Thus, the minority stress theory of LGB parents is supported by the results of correlational but not comparative studies. Most of the latter, however, concerned planned families, in which taking on the parental role (through childbirth or adoption) requires strong motivation and determination. It is likely that parenthood is mainly chosen by those LGB persons who have high cognitive, emotional and material resources which protect them from the effects of minority stress. It is unclear to what extent this also applies to LB mothers who choose to live with a woman after the breakdown of a previous heteronormative relationship. It also seems interesting whether minority stress has the same effect for biological mothers and their partners – co-mothers.

In summary, the following research questions were formulated: (1) Do women raising children in same-sex relationships and mothers from different-sex marriages differ in the severity of depression and anxiety? (2) Is the severity of depressive and anxiety symptoms associated with minority stress in the form of: internalised homophobia, expectation of rejection, concealment and negative events motivated by homophobia? (3) Does the role that a person plays in the family – as a biological mother or a co-mother – moderate how minority stress is associated with depression and anxiety?

Material and method

Research group

The survey targeted women forming romantic same-sex relationships and raising at least one child between the ages of 4 and 21, having lived in a shared household for a minimum of one year. The research group was assembled by the snowball method as well as advertisements on websites dedicated to LGBTQ people and through the university's website. The invitation informed about the purpose of the study (to describe and understand the psychological mechanisms involved in caring for a child in diverse personal situations, in this case – in the families of women forming same-sex relationships). Those interested in participating contacted the author by email. In response, they received information about the course and duration of the study and a personalised link to a set of questionnaires posted on the research unit's online platform. Participants gave their informed consent at the outset of the study; the participation was completely voluntary and confidential. Due to the non-experimental nature of the study, the consent of the bioethics committee was not required. Participants filled out questionnaires at their convenient times. At the end of the study, as compensation for their time, they received an electronic gift voucher to a press shop worth PLN 50.

It is worth mentioning that participation in the study was an important experience for the participants, which they expressed in comments on the survey or in email contact with the author. Some women expressed interest in the results, provided additional information about their families, and stressed the need for this type of research in the hope that it would contribute to greater public awareness of parents who raise their children in same-sex partnerships. Individuals who expressed a wish to become friends with like-minded families were urged to get in touch with Rainbow Family Foundation (Fundacja Tęczowe Rodziny), an NGO that supports LGBT+ families, and relevant social media groups.

The actual group included 91 women: 58 biological mothers of children born in a previous relationship with a man and 33 women with no offspring of their own (co-mothers). The control group included 60 mothers of children born in a current relationship with a man.

Table 1. **Demographics by subgroups**

	Women in same-sex relationships		**Married women**	**Test of significance of differences**
	Biological mothers ***n*** **= 58**	**Co-mothers** ***n*** **= 33**	***n*** **= 60**	
	M (SD)	*M (SD)*	*M (SD)*	
Age	38.9 (6.98)[a]	33.8 (6.73)[ab]	39 (6.04)[b]	F (2; 148) = 7.87; p <0.001
Age of the oldest child in the family	13.5 (5.08)	12.4 (4.86)	11.8 (4.14)	F (2; 148) = 1.84; p = 0.162
Number of children per family	1.81 (0.93)	1.48 (0.62)[c]	2.12 (0.74)[c]	F (2; 148) = 6.93; p = 0.001
Seniority of the relationship	6.22 (4.63)[d]	5.95 (4.97)[e]	16.44 (5.4)[de]	F (2; 148) = 76.4; p <0.001
Sexual identity	*n (%)*	*n (%)*	*n (%)*	
Homosexual	25 (43.1%)	27 (81.8%)	0 (0%)	Chi^2 (6) = 173. p <0.001
Bisexual	29 (50%)	6 (18.2%)	0 (0%)	
Heterosexual	0 (0%)	0 (0%)	60 (100%)	
Other	4 (6.9%)	0 (0%)	0 (0%)	
Place of residence				
Village	7 (12.1 %)	6 (18.2 %)	11 (18.3 %)	Chi^2 (6) = 1.44; p = 0.963
City with up to 100,000 inhabitants	15 (25.9 %)	8 (24.2 %)	17 (28.3 %)	
City of 100,000 to 500,000 inhabitants	13 (22.4 %)	7 (21.2 %)	11 (18.3 %)	
City with more than 500,000 inhabitants	23 (39.7 %)	12 (36.4 %)	21 (35%)	
Education				
Secondary or lower	23 (39.7 %)	12 (36.4 %)	19 (31.7 %)	Chi^2 (2) = 0.826; p = 0.662
High	35 (60.3 %)	21 (63.6 %)	41 (68.3 %)	
Professional situation				
Economically inactive	6 (10.3 %)	1 (3.0 %)	7 (11.7 %)	Chi^2 (2) = 2.02; p = 0.365
Economically active	52 (89.7 %)	32 (97.0 %)	53 (88.3 %)	
Material situation				

table continued on the next page

Very good	14 (24.1 %)	14 (42.4 %)	20 (33.3%)	Ch^2 (4) = 4.88; p = 0.3
Good	41 (70.7 %)	17 (51.5 %)	39 (65%)	
Unsatisfactory	3 (5.2 %)	2 (6.1 %)	1 (1.7 %)	

[a] t_{Tukey} (148) = 3.57; p = 0.001; [b] t_{Tukey} (148) = 3.68; p = 0.001; [c] $t_{Games\text{-}Howell}$ (76.4) = 4.39; p <0.001; [d] t_{Tukey} (148) = 11.06; p = 0.001; [e] t_{Tukey} (148) = 9.64; p = 0.001

The groups did not differ on most demographic variables (Table 1). The length of the relationship and the average number of children in the family were the only differences. It is understandable as the LB women's group included individuals from reconstituted families who were compared to those living in their first marriage. In addition, co-mothers were younger than biological LB mothers and control group mothers, with the ages of the latter two groups being similar.

Measures

Depression

The *Centre for Epidemiologic Studies Depression Scale – Revised* (CESD-R) [27] was applied; a scale widely used to measure depression severity in the general population; in the study sample Cronbach's α = 0.936.

Anxiety symptoms

The *State-Trait Anxiety Inventory* (STAI-X1 and STAI-X2) [28] was used to measure the severity of anxiety and fearfulness; Cronbach's α in the study sample was 0.949 and 0.919, respectively.

Minority stress

Four partially modified subscales from the *Sexual Minority Stress Scale* by Goldblum et al. [29] (see also [30]) ("Sexual minority negative events", "Expectations of rejection", "Concealment", "Internalised homophobia") and five additional self-constructed scales taking into account minority parenting experiences were used. A total of 111 statements were included in the scales and responses were marked on Likert scales with the exception of the *Negative events scales* which were in the form of a check-list. Cronbach's *α* coefficient ranged from 0.881 to 0.941. For the analyses presented below, the results of these nine subscales were aggregated by factor analysis. Four measures of minority stress were obtained:

(1) "Internalised homophobia" – internalised prejudices about non-heterosexual identity and non-heteronormative parenting;
(2) "Expectation of rejection" – anticipating the social environment's reluctance towards oneself as a non-heteronormative parent and towards the child as raised by this parent;

(3) "Concealment" – concealing sexual identity in the circumstances of caring for a child and in other, non-care situations;
(4) "Negative events" – experiences during the year prior to the survey of being excluded, humiliated, rejected or subjected to violence due to prejudice against non-heterosexual identity and against combining it with parental role.

Statistical analyses

The SPSS 28.0 package and Hayes' PROCESS 4.2 macro were used. One-way analysis of variance for independent groups was used for intergroup comparisons. Correlation analysis was used to assess how strongly minority stress was associated with anxiety and depression. Moderation analysis was conducted to test if these associations were similar in biological mothers and co-mothers. Although the distributions of the variables were not normal, their variances were homogeneous in the compared groups, hence the decision was made to present the results of parametric tests (Student's *t*, Pearson's *r*), each time controlling for the consistency of the effects obtained with the results of their non-parametric counterparts (except for the moderation analysis based on regression equations).

Results

As indicated in Table 2, the mean scores on the depression, state anxiety and trait anxiety scales were comparable in the LB biological mothers and the control group, and lower in the LB co-mothers, but these differences were found to be statistically insignificant.

Table 2. **Severity of depression and state and trait anxiety in biological mothers (*n* = 58) and co-mothers (*n* = 33) forming same-sex relationships and mothers from heteronormative families (*n* = 60) – Fisher's test results**

Variable	LB biological mothers *M, SD*	LB co-mothers *M, SD*	Control group *M, SD*	*F*	*df1, df2*	*p*
Depression	17.1 (15.42)	13.6 (10.37)	17.8 (14.58)	998	2, 148	0.371
Anxiety-state	37.2 (13.31)	35.7 (9.79)	37.7 (13.59)	277	2, 148	0.758
Anxiety-trait	41.2 (11.68)	39.7 (9.78)	41.4 (10.53)	292	2, 148	0.747

Most correlations between minority stressors and anxiety (state and trait), on the one hand and depression severity, on the other, were statistically significant, ranging from weak to moderate (cf. Table 3). Women's efforts to conceal sexual identity and expectation of rejection correlated positively with all measures of emotional problems. The presence of negative events motivated by homophobia was linked to depressive tendencies and state (but not trait) anxiety. In contrast, anxiety – on both the state and trait dimensions – was most strongly associated with women's internalised homophobia.

Table 3. **Pearson's *r* correlation matrix of depression and state and trait anxiety with minority stress factors**

	Depression	Anxiety-status	Anxiety-trait
Internalised homophobia	0.149	0.416***	0.373***
Concealment	0.309**	0.308**	0.267*
Expectation of rejection	0.356***	0.356***	0.311**
Negative events	0.338**	0.296**	0.183
* p <0.05, ** p <0.01, *** p <0.001; N = 91			

The results of the moderation analysis demonstrated that the relationships between proximal stressors (internalised homophobia, self-concealment, expectation of rejection) and all three indicators of emotional problems were independent of the type of parent (biological mother/co-mother); the interaction effects were not statistically significant. In contrast, there was a statistically significant association between: (a) negative events and depression (b = 0.218; t = 2.518; p = 0.0136; cf. Figure 1); and (b) negative events and anxiety (b = 0.194; t = 2.071; p = 0.0413; cf. Figure 2). In both cases, the correlation coefficient between the variables was higher in the group of biological mothers compared to co-mothers. This means that negative events moti-

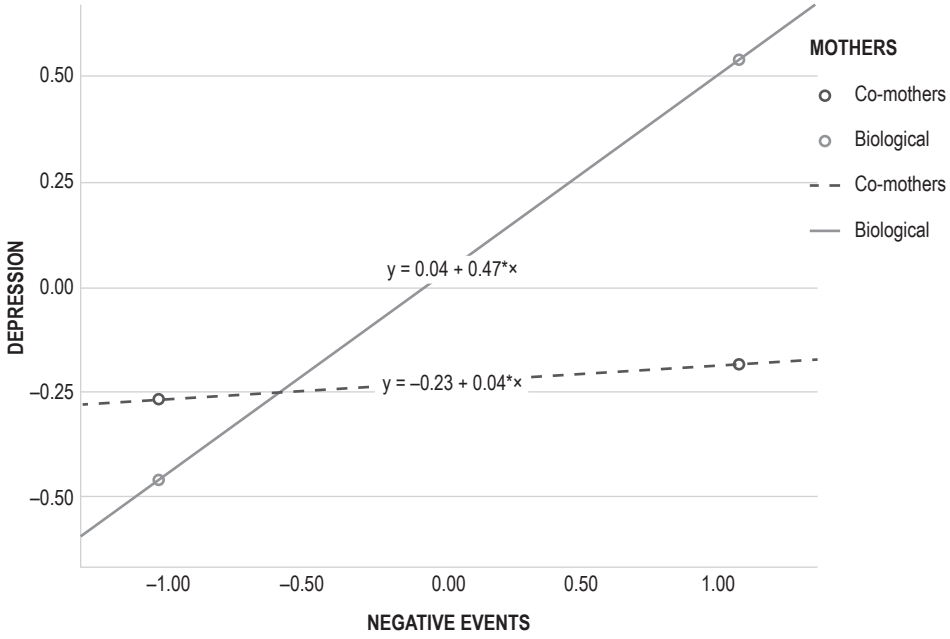

Figure 1. **Relationship between negative events and depression in LB biological mothers and co-mothers – results of moderation analysis**

vated by homophobia are positively correlated with depression and anxiety, but only in biological mothers.

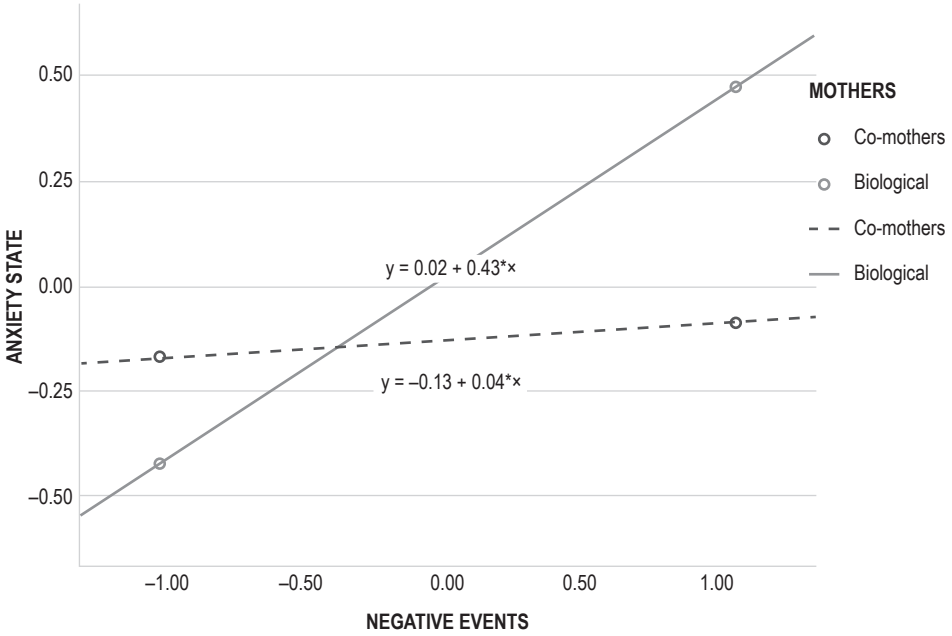

Figure 2. **Relationship between negative events and state anxiety in LB biological mothers and co-mothers – results of moderation analysis**

Discussion

As regards the first research question, it was found that the levels of depressive and anxiety symptoms in LB biological mothers or co-mothers and heteronormative mothers were comparable. In the context of the specificity of the group, it is important to stress that this finding is particularly applicable to educated individuals in good or very good financial situation. These findings are consistent with the conclusions of Anglo-Saxon studies on the mental health of LGB parents [24, 31, 32]. According to the theoretical model of family resilience [33], the lack of differences in the severity of emotional problems between the compared groups may indicate the psychological resilience and constructive psychosocial processes taking place in non-heteronormative families. The model is confirmed by the first empirical reports in the literature: lesbian mothers from Israel have higher levels of positivity than heterosexual mothers, which protects them from depressive symptoms [34].

Furthermore, as regards the second research problem it was found that all minority stressors were confirmed to be linked to mental health disruptions. The more negative events driven by prejudice the participants reported, the more they expected such

events to occur in their own and their children's life. Likewise, the more they concealed their sexual identity, the more severe the depressive symptoms were. Moreover, internalised homophobia was most strongly correlated with anxiety, both as a trait and as a state. It is possible that the persistent personality tendency to react with anxiety is a factor that promotes the internalisation of prejudices and reinforces their effect on the perceived state. It is noteworthy that anxiety status positively correlated with all stressors included in the study.

The obtained results are consistent with previous studies conducted in LGB people, both childless [6, 10] and those with children [22, 32]. Among the latter, however, associations of anxiety and depressive symptoms with stigma and discrimination and internalised prejudice have been confirmed [35], whereas the results presented in this study additionally point to the important role of other proximal stressors: self-concealment and the expectation of rejection.

Research on the relationship between self-concealment and depression or anxiety has led to inconclusive results, which has been explained by differences in the conceptualisation and operationalisation of concealment [36]. In Polish studies conducted in childless LGB individuals, this relationship was only observed in bisexual men [10]. In turn, in a meta-analysis of 193 studies, Pachankis et al. [36] found a small positive association between these variables. Although withholding the truth about oneself can be a form of self-protection against the potential hostility from other people, according to the secret preoccupation model, it can result in high cognitive activation, "intrusions" of unwanted thoughts about the hidden stigma and emotions of anxiety, shame or guilt, leading to a chronic state of lowered mood [10, 37]. This emotional state, in turn, is associated with the risk of withdrawal from social relationships, isolation, decreased sense of agency, and lower self-esteem [38].

It is worth noting that the level of openness in LB mothers may be impacted by extra contextual circumstances beyond those found in the life of childless individuals. Women's fear of having their child custody or parenting skills questioned may be key [18]. Other factors significant for disclosure are: consideration of the needs of other family members (including children) related to disclosure, the level of acceptance of women by their families of origin and by the child's father, or finally, the social climate regarding LGB rights in the child's immediate neighbourhood and school environment [20].

As for the expectation of rejection, according to Meyer's model and the research results obtained in the present study, it promotes the induction of depressive and anxiety states [10, 39]. The expectation of future rejection is likely to lower mood and exacerbate anxiety especially in a mother whose child caring skills have been undermined due to her relationship with another woman. It is noteworthy, however, that depressed mood can back influence the perception of the environment as rejecting or threatening, creating a cycle of self-regulation based on perseveration and ruminations, which is characteristic of the depressed state [40].

Regarding the third research question it was ascertained that minority stress caused deterioration in the mood of biological mothers, as opposed to co-mothers, but this was only true for negative minority events. This discrepancy might result from the distinct ways in which lesbian women without children and those who have children

from a previous relationship with a man develop their non-heterosexual identities [14], because the latter usually later realise their own non-heterosexuality [18]. Women in heteronormative relationships are not exposed to homophobic stigma and thus they get fewer chances to learn coping mechanisms [18]. When they are in a same-sex relationship and the stigma starts to influence them, they may respond in a more emotional way and experience poorer mood or more worry. Furthermore, micro-aggressions – especially those related to questioning the parenting competences or custody rights – pose a threat to women's parental identity, which finds no parallel in the experience of co-mothers. Legally and psychologically, biological mothers are in charge of their offspring, with whom they have a close emotional bond from birth. The pattern observed in biological moms may be explained by anxiety about the stability and safety of the bond with the child as well as anticipation of guilt towards the child; however, further research is needed to fully investigate this idea.

The obtained results allow us to formulate some applicable conclusions about the psychological support of LB women who raise children from previous heteronormative relationships. First of all, it is important to keep in mind that minority stress has a chronic effect on their emotional state, so the bias-free, accepting attitude of the professional providing support and the use of an affirmative approach in possible psychotherapy are invaluable [41]. Second, psychological assistance should enhance the process of developing one's sexual minority identity, which in biological LB mothers who were previously in a relationship with a man often does not occur until later in adulthood, after the birth of the child [42]. One specific area where psychological support may be needed is in the integration of a newly emerged minority identity with an earlier formed parental identity. In addition, psycho-education which debunks myths about the negative effects of raising a child by a same-sex couple, as well as accompanying the parent during the coming out process (sometimes even in front of the child), and informational support regarding the possibility of contacting NGOs or informal groups integrating LGB families are all important components of psychological assistance when working with this group of women.

Finally, it is worth emphasising that minority stress is culturally and socially conditioned and is a derivative of structural and institutional heterosexism [43]. Therefore, in addition to professionals' individual ability to support LGBT+ parents, there is a need for the professional community as a whole to be committed to normalising family life and parenting for these individuals, to counter prejudices and to make legal changes to allow same-sex partnerships or marriages.

Conclusions

1. LB women raising children from previous heteronormative relationships do not differ in their levels of depression and anxiety from married women, despite the unfavourable socio-political situation for LGBT+ people, which may indicate their adaptive and compensatory abilities.
2. The mood of LB mothers is more depressed and anxious the more severe minority stress they experience, with negative events motivated by homo-

phobia promoting the development of depressive and anxiety symptoms in biological LB mothers, but not in their female partners. Biological LB mothers are particularly vulnerable to homophobia-motivated events probably due to their lack of prior minority experience, as well as the specificity of these events targeting parental identity and relation with a child (e.g. questioning parental rights or parenting competence).

3. Some limitation of the study is the sample selection – high-functioning, mostly educated, well-off women, disclosed enough to report for the study, took part. In order to have a comprehensive grasp of the subjective experiences of minority parenting stress, future research in this area should incorporate individuals with lesser economic and social resources and employ qualitative approaches.

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