International Journal of Nursing and Health Care Research

Tuovila T, et al. Int J Nurs Health Care Res 7: 1575

www.doi.org/10.29011/2688-9501.101575

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Research Article

Experiences of Young People From LGBTQ-Headed Families of School and Student Health Care Services in Finland: A Qualitative Study

Tuovila Tiina[1*], Åstedt-Kurki Päivi[2], Kylmä Jari[3]

[1]MSc, PhD Candidate, Nursing Science, Faculty of Social Sciences, Tampere University, Tampere, Finland

[2]PhD, Professor Emerita, Nursing Science, Faculty of Social Sciences, Tampere University, Tampere, Finland

[3]PhD, Professor Tenure Track, Nursing Science, Faculty of Social Sciences, Tampere University, Tampere, Finland

[*]**Corresponding author:** Tuovila Tiina, MSc, PhD Candidate, Nursing Science, Faculty of Social Sciences, Tampere University, Tampere, Finland

Citation: Tuovila T, Åstedt-Kurki P, Kylmä J (2024) Experiences of Young People From LGBTQ-Headed Families of School and Student Health Care Services in Finland: A Qualitative Study. Int J Nurs Health Care Res 7: 1575. DOI: https://doi.org/10.29011/2688-951.101575

Received Date: 03 September, 2024; **Accepted Date:** 13 September, 2024; **Published Date**: 20 September, 2024

Abstract

The diversification of family structures has increased, but the young people from LGBTQ-headed families may still face pressure at school from their family being perceived as different. Despite this, research that combines the well-being of these young people with school and student health care services is limited. The aim of this study was to describe the experiences 15-28-year-old young people from LGBTQ-headed families have had of these services in Finland. An inductive qualitative design with a descriptive approach was used. In total 11 participants wrote anonymously in narrative form about their experiences on an electronic form guided by open-ended questions. The data was analysed using inductive content analysis. The results indicate that these young people received appropriate care from the services for their health-related needs: preventative health care, medical treatment, mental health related issues and personal social issues. Still, they faced heteronormativity and shortcomings around LGBTQ topics. It is vital to be aware that support and acceptance of LGBTQ-headed families, on both individual and institutional levels, enhance the well-being of young people from these families.

Keywords: LGBTQ-headed families; Young people; School health care services; Student health care services

Introduction

LGBTQ is an acronym that refers to individuals who identify as, lesbian, gay, bisexual, transgender or queer. In LGBTQ+, plus sign depicts also sexual and gender minorities not specified in the acronym [1,2]. In LGBTQ-headed family at least one parent belongs to a sexual or gender minority [3]. Research on young people from LGBTQ-headed families is topical due to the diversification of family structures, and the increase in the number of such families and young people being raised in them [4-6]. However, only little research has been conducted on these young people and especially their long-term welfare to date, both internationally [5,7] and in Finland [4]. Particularly studies focusing on the point of view of these young people are sparse [7]. Research on the context that combines the well-being of these young people with school and student health care is limited. We know that young people aged 13-18 in Finnish LGBTQ-headed families can face positive, neutral, and prejudiced attitudes or confusion from school and student health care workers toward their families. They may need to explain their family structure, or health care worker falsely assume their issues be caused by them having been raised in an LGBTQ-headed family. In addition,

some seem to be left without support from school with their family issues, such as break-ups of their parents. Finnish young people from LGBTQ-headed families appear to require more support in different family-related situations in both compulsory school and later studies compared to their peers from other family structures [4].

In Finland, school, and student health services' goal is to contribute to the health and well-being of students and school communities. These services are part of the national public healthcare in Finland, with a comprehensive reach to all students [8,9] These services include health care and medical treatment services provided by nurses, physicians, mental and dental health professionals among others [8].

In Finland, school health care refers to the health services provided to 7-15 years old students in compulsory education [8-10]. Student health care refers to the health services provided to students studying at upper secondary education and higher education levels [8,9]. Upper secondary education refers to general education establishments and vocational schools with students aged 16-19. Higher education refers to universities and universities of applied sciences with students over the age of 19 [10].

The current study is the first in Finland to delve into the experiences 15-28-year-old young people from LGBTQ-headed families have had of school and student health care services.

LGBTQ-Headed Families in Finland

There are approximately 10 000 children and young people living in families with at least one parent of a sexual or gender minority [11]. This number is expected to grow strongly [4,12]. This growth is aided by the Act on Fertility Treatments of 2007, which made it possible for female same-sex couples to apply for assisted fertility treatments [13]. Situation was further improved by the equalizing Marriage Act of 2017 [14].

However, most Finnish LGBTQ-headed families are still lesbian or gay stepfamilies or other blended family arrangements formed post heterosexual relationships [15]. The growing number of LGBTQ-headed families appear to follow the trends of other western nations [5,16].

The Well-Being in School Life

Many young people from LGBTQ-headed families are treated well at school [17,18]. Some, however, face pressure from their family being perceived as different [18-20]. They may get called names or excluded [4,20]. Bullying may even take the form of physical violence [19,20].

These young people may feel that adults fail to intervene when they face mistreatment [4,21]. They have been asked confusing questions about their family, used unpleasantly as an example case when discussing the rights of sexual minorities, or had their family ignored by their teachers. They have also described their schools' heteronormative assumptions [17,18].

The young people from LGBTQ-headed families and their parents hope for support from schools for their family identity, a safe environment to be open about family, and for active, efforts from schools to improve their inclusivity [11,17,22]. An inclusive atmosphere and anti-discriminatory action from schools serve to improve both the general well-being of young people from LGBTQ-headed families as well as their feeling comfortable at school [23,24].

Earlier research sheds ample light on the significance the school situation has on the well-being of young people from LGBTQ-headed families. As school and student health care services are an integral part of everyday life for students, it is worthwhile to study the experiences young people from LGBTQ-headed families have of these services.

Aim of the Study

The aim of this study is to describe the experiences of young people from LGBTQ-headed families of school and student health care services in Finland. The research question is: What kind of experiences young people from LGBTQ-headed families have of school and student health care services in Finland?

Methods

An inductive qualitative design with a descriptive approach was used to capture the experiences of young people from LGBTQ-headed families about school and student health care services. This approach was selected to gain a deeper understanding of a little researched topic [25]. Within the process was strived to stay close to the data, where the experience is described from the viewpoint of the participants. This offered the opportunity to gather a rich depiction about a phenomenon which little be known about [26].

Participants

The participants were young people between the ages 15-28 from LGBTQ-headed families. The minimum age limit for participants was set at 15 years of age, when they are considered able to decide for themselves whether they wish to participate in research [27]. The maximum age limit of 28 years is based on the Finnish Youth Act [28]. This large age scale made it possible to reach the highest number of participants from a minority group [29].

There were eleven participants in this study. This is in line with the usual number of participants in inductive qualitative research, [25,30] where rich material can be produced even with a small sample size [30]. Also, when studying a hard-to-reach minority

population, this number of the participants can be considered justified and useful to get more systematic information [29]. Four of the participants were under 18 years old, and seven of them were over 18 years old. In both groups were male and female participants. The young people described their gender with the terms: girl, woman, and man. Most participants were female, however, to protect the anonymity of the participants, accurate numbers are not shared [29]. Correspondingly, quotes do not reveal the participant's exact age in the results section [29].

Data Collection

The participants were recruited in cooperation with partners (Table 1) who were selected based on their presumable ability to reach the target group of the study. All partners were delivered a written notice on the study, and options for visual advertisement to attract the interest of the target group [31].

Rainbow Families Finland Organization
The Organization of LGBTI Rights in Finland
Union of University of Applied Sciences Students in Finland
The National Union of Vocational Students in Finland
The National Union of University Students in Finland
The project Finland for All Families
PERLA - Tampere Centre for Childhood, Youth and Family Research

Table 1: Partners to recruiting participants.

The partners advertised the study on their social media pages (Facebook and Twitter) as well as their electrical newsletters to their members several times during data collection [31]. This provided an opportunity to represent a variety of geographical locations and diverse participants in the study [29,31,32]. Data collection took 11 months in total and was done in two parts between 2018-2020: October 2018-May 2019 and October 2019-January 2020. Data collection proceeded until the saturation was reached [25].

The data was collected via an electronic form, the filling of which took approximately 30 minutes [31]. The first page of the electronic form contained information about the study, instructions for participation and an informed consent section [31,33]. Participants were also informed the option to answer via interviews either in person or over a phone call [34]. However, all participants opted for the electronic form. Thus, authors had no interview connection to the participants.

Participants' responses were anonymous because LGBTQ-headed families may experience discrimination and the topic is sensitive [29]. To ensure anonymity, the personal information asked on the form only included their age and gender to describe the participants. These were also asked on the first page of the form. Age was selected from the drop-down menu, where only ages suitable for the study were available. The gender was written in their own words to describe it in the text box reserved for it. Participants could also refuse to disclose their gender and leave the box not filled.

The questions used to collect data were split into five themes with main questions (Table 2). Each theme had further open sub-questions, for example *You can tell several cases, or one case, which is most meaningful to you*, to aid the participant with their answers. Each theme and question opened on its own page, but pages could be scrolled forward and backward. The length of a single answer was not limited; the spaces to write grew larger as the participants wrote. As they shared their own stories, the answers were narrative in nature.

Table 2: Themes and main questions to collect data.

Reasons for visiting school and/or student health care services Main question: What kind of matters have you visited in school and/or student health care services?
Experiences of treatment, support, and advice received Main question: What kind of aid, support or advice have you received in school and/or student health care services?
The revealing of the young person's family structure, and the health care worker's reaction Main question: How has the family structure been reflected in the use of school and/or student health care services, and what kind of effects it has had?
The visibility of LGBTQ+ topics, and the significance of that visibility Main question: How do LGBTQ+ topics appear in your school and/or student health care services, and what significance does the visibility of these topics have for you?
Activity to promote LGBTQ+ awareness, and the significance of that work Main question: How has your school and/or student health care services participated in work related to LGBTQ-headed families or other LGBTQ+ topics at your educational establishment, and what significance does such activity have for you?

Data Analysis

The data was analyzed using inductive content analysis, because previous research on the topic is scant [35,36]. The manifest content analysis [36,37] was performed close to the material to show the

diverse experiences of the participants [38]. The data were read several times to comprehend the content and identify the meaning units relevant for the aim of the study [35]. Meaning units (e.g., sentence or a whole paragraph answering to the research question) were condensed into reductions without losing information about the meaning units [36,37]. In all, there were 258 meaning units.

The reductions were then grouped into subcategories based on the similarities and differences of reductions [36,37]. The outcome of this was 29 subcategories. Subcategories with similar content were further grouped into categories. The abstraction process continued until the main category was identified by grouping categories with similar content [36,37]. This grouping brought first 7 categories and then 3 main categories. Each category was named using content-characteristic words. See Table 3 for an example of the analysis process. The first author conducted the analysis process. However, to enhance trustworthiness all the authors were involved in the evaluation and development of the analysis, in order to achieve consensus of the findings [35]. The analysis was performed by using word processing software after exporting the data from electronic forms.

One example of meaning unit / one subcategory	Condensed reductions of meaning units	Subcategories	Categories	Main category
”I’ve gone in for physicals and had my hemoglobin tested.”	Visiting physical examination Measurement of hemoglobin	Preventative health care visits	Common reasons to visit the services	Services match the need
”I visited in the school`s health care because of the wound.”	Visiting the services due to wound	Medical treatment reasons		
“In recent years, I have visited for anxiety and panic attacks.”	Visiting the services due to anxiety Visiting services due to panic attacks	Mental health related issues		
”I went to speak and got to see a psychiatrist, when studying was difficult because of the general atmosphere of the school”	Visiting the services due to study problems Visiting the services due to burdensome atmosphere of the school	Personal social issues		
”I have received guidance about the parties I can contact if I want more detailed advice, as well as information related to contraception”	Guidance for information retrieval for contracenption from other services	Health-improving aid	Requisite help from the services	
”I have atopic dermatitis, and they always give me new salves.”	Getting salves due to skin disease	Medical treatments		
”I’ve received conversational help from a psychologist and medication for anxiety”	Conversational help from a psychologist Pharmacological treatment due to mental health	Mental health support		
“The school nurses that have helped me have appeared professional and taken me, my questions and potential worries seriously, and provided real help”	Getting professional help A sense of being taken seriously Getting real help	Satisfaction with the aid		

Table 3: An example of the analysis process for one main category.

Ethical Considerations

Special attention was paid to ethics, because the study is sensitive due the young ages of the participants and their minority group status [27,29,31]. The study was conducted in compliance with the ethical principles of science [27]. Ethical approval was applied for the study (Ethical review statement 55/2018 Tampere University, Ethics Committee Tampere Region). The study complied also with the European Union's General Data Protection Regulation [39]. The participants received information about the study ethics and data management on the first page of the electronic form.

Informed consent was ascertained in this study by providing enough information about the study at the beginning of the electronic form [31,33]. After this, the participants verified their approval in a segment titled "I consent to my information being used for this study". The only way to proceed was to select the approving answer from a drop-down menu. The participants were asked again at the end, before they returned their answers, if they wish to send their filled form and consent to the use of their answers in the study. They could also cancel their consent in the middle of the form, as the answers were only saved at the end, after the participant had consciously clicked on a clearly labeled button that submitted the filled form [33].

Results

Services Match the Need

Common reasons to visit the services

The reasons for a preventative health care visit were physical examinations, sexual health questions, contraceptives, vaccinations, blood tests and dental health services:" I've gone in for physicals and had my hemoglobin tested." (15-18-year-old female).

Medical treatment reasons included upper respiratory tract infections, skin diseases, wounds and sick leave certificates:" If I have been sick and need a permission to go home, or for the regular physical examinations at school." (19-23-year-old female).

Mental health related issues included depression, anxiety, panic attacks, insomnia, and stress: "I have had insomnia/depression..." (24-28-year-old female). Participants additionally had visited clinic to discuss their psychological well-being, without describing a specific reason.

Personal social issues were related to school life, such as problems caused by the general atmosphere in school or difficulties with studying:" I have needed help for -- study problems, bullying etc." (19-23-year-old female).

Requisite help from the services

Health-improving aid included information on sexual health, weight management and other various guidance for upholding their health:" They told me it is a good idea to eat iron, calcium, and B12 vitamins. Adequate sleep and more physical activity would also be good." (15-18-year-old female). Participants had additionally received guidance for information retrieval from other services.

Medical treatments were pharmacological treatments for acute infections, minor procedures and care of long-term diseases:" I have atopic dermatitis, and they always give me new salves." (19-23-year-old male).

Mental health support took the form of conversations with nurses, public health nurses, physicians, psychologists, or psychiatrist. Treatment continuation plans and pharmacological treatments were also received:" I've received conversational help from a psychologist and medication for anxiety." (19-23-year-old female). Treatment of depression, for example, had lasted for a longer period, whereas issues such as stress management had been combated via brief guidance.

The participants were satisfied with the services and aid they had received: "I`m pleased with the services." (24-28-year-old female). The services provided by schools located in urban areas were especially viewed positively. The expertise of the health care workers was also satisfied:" The school nurses that have helped me have appeared professional and taken me, my questions and potential worries seriously, and provided real help." (24-28-year-old female).

However, impressions had been marred by individual unpleasant experiences:" [I have received] Conversational help with depression and bullying --. But sometimes they haven't taken me seriously." (19-23-year-old female).

A variety of effects due to the family structures

Revealing the Family Structure

The visibility of the family structures varied; it may have come up rarely, several times, or not at all:" My family structure has never been visible or had any effect on me." (19-23-year-old male). If family structures come up, it was variably experienced during different educational levels. The family structures had come up when discussing general family-related topics, or when a health care worker asked about it: "The nurse asked who were part of my family, and I answered them. They just asked if my mom's wife was nice and didn't show much reaction beyond that." (15-18-year-old female).

The participants had avoided revealing their family structures if not necessary. Avoiding discussing was affected by who were involved in the situation. This was not only limited to the context

of school and student health care: "…many of my acquaintances don´t know about my family structure and I haven't felt the need to advertise it. It was a big deal back when I was in compulsory education." (24-28-year-old female).

Participants also had grown tired of explaining their family structures: "But there have been some I haven't told because I just didn't have the energy to explain my family structure, for example a nurse who didn't understand me anyway." (19-23-year-old female).

Various attitudes in the services

Positive attitudes were occurred in contexts where participant had a prolonged patient care relationship with a health care worker, for example with a psychologist. It was also possible to encounter primarily positive attitudes but with some exceptions:" Generally, I've seen positive attitudes, but there have also been cases where somebody assumes my family structure is an issue for me/will cause problems for me." (19-23-year-old female).

Neutral attitudes were described for example in situations where health care workers questions about the young person's family were delivered matter-of-factly:" My family structure came up in school health care, and they mainly asked me if it has an effect on my social life, am I being bullied about it etc." (24-28-year-old female). Mild reactions were also perceived as a neutral attitude: "They have had pretty neutral attitudes to my family structure. I've seen some raised eyebrows when it comes up, but the nurses have recovered quickly from their surprise..." (24-28-year-old female).

Some health care workers had been also perceived as having negative attitudes toward sexual or gender minorities: "There was only one -- gynecologist. I didn't go -- because I had read in a student newspaper that they were out of line. They assumed their patients to be heterosexual and had a weird attitude toward lesbians." (19-23-year-old female).

The participants had additionally encountered heteronormative assumptions among health care workers:" They always assume my mom to be dating a man and my own sexual orientation." (15-18-year-old female). However, this phenomenon has likely not always been caused by assumptions but rather by thoughtlessness: "…many of them hadn't even thought about the fact that our family members may belong to these minorities. -- somehow people don't account for the possibility that somebody's parents might belong to a sexual or gender minority." (24-28-year-old female).

The sense of otherness

There was an outlook that LGBTQ-families are equal, valuable and no different from others. Highlighting the acceptability was felt important: "I'm not in any way ashamed of myself or my family." (19-23-year-old female). However, participants felt uncertainty about whether LGBTQ-headed family were perceived as acceptable by others:" When I was younger, I was ashamed of my family and afraid it wasn't okay, though." (15-18-year-old female).

Indeed, participants families had been subjected to surprise, expressions of strangeness, or interest. Experiences of acceptance in the services and generally at school were important to participants due to being often perceived as different: "In school, during some lesson -- we went through different family structures and wrote them on the blackboard. It included LGBTQ-headed families, which felt good back then. It made me feel like my family was also considered an acceptable family structure. -- I feel it was very significant for me as a teenager." (24-28-year-old female).

LGBTQ+ Education in Minor Role

Scarcity in the LGBTQ+ visibility

Visibility was missing from the health care workers' rooms, the common spaces and the encounters:" Information about LGBTQ-headed families wasn't easily available and I don't recall them ever being mentioned in school or student health care services." (24-28-year-old female). LGBTQ+ visibility might have been encountered also only at a certain level of study:" It didn't much come up in a small community's school, but I did see, for example, brochures later." (19-23-year-old male).

Instead, LGBTQ+ topics were noticed represented in other health care services: "School nurse and doctor's offices, student health care office etc. I never saw LGBTQ+ topics represented. But as an example, LGBTQ+ topics have been visibly showcased at the low threshold mental health office -- which has always made me feel welcome and made discussing my family easier." (19-23-year-old female). On the other hand, doubts about the visibility of LGBTQ+ topics in healthcare in general came up:" I don`t think LGBTQ+ topics are visible in health care services." (15-18-year-old male).

The better visibility and the inclusion of LGBTQ+ topics was hoped in everyday matters of school and student health care operations and in family-related discussions:" …when discussing contraceptive means, they could also mention LGBTQ+ couples' STD prevention. And use LGBTQ-headed families in their examples along with other kinds of families." (19-23-year-old female). Advertisements promoting the visibility were also called for: "I don't remember seeing anything in the form of posters or brochures in the health care offices of schools, that's a point for improvement. -- I would personally appreciate it if they also exhibited newsletters from LGBTQ-headed families or something similar." (24-28-year-old female).

Improved visibility was expected to lead to a more approving atmosphere: "…if LGBTQ+ topics were more visible, I would have more courage to openly be myself." (15-19-year-old female). Also, smaller things founded meaningful: "They don't need to plaster rainbows all over the walls, but even small hints toward LGBTQ+ approval make me happy." (19-23-year-old female). The visibility had also increased the feeling of being taken notice of:" …it would make me feel the services are meant for everybody if for example their brochures had LGBTQ-headed or multicultural families." (19-23-year-old female).

Equality and highlighting similarities were felt important in the context of LGBTQ+ visibility:" I don't really think there needs to be much fanfare about it, to be honest. Our families are the same as everybody else's…" (24–28-year-old female). Additionally, equality-enhancing vocabulary was hoped for:" You could just use the word parents instead of always using mom and dad." (19-23-year-old female).

The significance of visibility was also doubted:" I don't know if posters etc. could have helped because I was mostly scared about the opinions of other people." (15-18-year-old female). Excess visibility was also seen unnecessary, and ambivalent feelings toward visibility was expressed:" I don't find special visibility exactly necessary, but it doesn't hurt either." (19-23-year-old male).

Variability in the work for LGBTQ+ awareness

School and student health care services had organized interactive discussions revolving around sexuality and sexual orientations:" We had a workshop day about sexuality -- back in junior -- I found the day helpful." (15-18-year-old female).

Awareness work by parties other than school and student health care had been encountered as part of usual lessons at school or from outside organizations:" Seta [Organization of LGBTI Rights in Finland] has sent some people to talk to us once or twice --." (19-23-year-old male).

In the experiences of participants were also the standing that work for LGBTQ+ awareness is completely missing:" I don't remember ever seeing this [work for LGBTQ+ awareness]." (24-28-year-old female). Awareness work was especially nonexistent outside of cities.

Additionally, work for awareness of LGBTQ-headed families had inequalizing implementation in. Educators might have been emphasizing of minority status in the speech and actions: "LGBTQ-headed families haven't been much talked about in general, or they are mentioned -- in a marginalizing way. -- They could talk about LGBTQ-headed families at the same time as all other families, without specifically labeling anybody." (19-23-year-old female).

It was hoped that the general public would become more familiar with LGBTQ-headed families:" Increased awareness starting with school health care services would be positive. Partly because my family structure has attracted curiosity due to its "novelty" and people have never talked about it with anybody." (24-28-year-old female). Increased awareness was hoped to enhance the standing of LGBTQ-headed families as equal to other families:" Personally I think children should be taught that our families are just like theirs. But I don't think there is any point in decorating the whole school with rainbows; that would just emphasize the differences." (19-23-year-old female).

Discussion

This study provides knowledge of experiences of the young people from LGBTQ-headed families have had of school and student health care services. The study is the first in Finland to delve into these experiences from the perspectives of adolescents, but also emerging adults from LGBTQ-headed families. The findings can be used particularly to further improve the school and student health care services to answer the needs of these young people. The knowledge can also be used in research and education. However, the findings suggest that young people's experiences cannot be explained solely by the context of school and student health care, but rather have a connection to a wider social context. Altogether, the findings offer a welcome step toward a better understanding of little studied topic.

In the current study the reasons for visiting school and student health care services correspond with those of most young people in Finland [40]. Contrary to earlier studies on the well-being of Finnish young people from LGBTQ-headed families [4], in the current study did not come up the need for help with family-related problems.

Overall, the results show in this study the aid had been appropriate and professional except for some exceptions with mental health care. Correspondingly, young people from Finland are generally pleased with school and student health care services, but mental health care specifically had been perceived as difficult to access and receive treatment from [41].

The current study demonstrates also varying attitudes from health care workers toward the young people's families, as well as the young people themselves due to their families. Indeed, the current and previous studies show that LGBTQ people and their family members still face heteronormativity from health care services: heteronormative or even heterosexist discourses, assumptions of heterosexuality and gender identity as well as the fact that various types of patient information, forms, and structures often only offer heteronormative categories for families, parents, and genders, among others [42-44].

Additionally, the results from the current study match earlier Finnish research demonstrating false assumptions from school and student health care workers that coming from an LGBTQ-headed family causes problem for young people [4]. Earlier research shows, that being a child of LGBTQ-headed family is not a risk factor contributing to the development of psychological issues in young people. So, the current study strengthens the fact that challenges faced by young people from LGBTQ-headed families primarily originate from prejudices outside of the family [45,46].

However, it is also worth noting minority stress theory about the excess stress to which individuals from LGBTQ-population are exposed because of their social minority position. Prejudices, stigma, and discrimination create a stressful social environment that can lead to mental health problems [47]. It is possible that healthcare workers' assumptions are to some extent based on this broader understanding of the risk of LGBTQ-headed families and their members facing more stressors than the majority population, even if the intra-family factors do not cause problems.

Either way, the results of the current study on the encounters and prejudices these young people face seem to mirror the general attitude in the Finnish society toward LGBTQ+ people. The general attitude has improved during 2000s, yet there is still room for improvement [15,48]. LGBTQ+ people and their families are still not fully accepted and do not have completely equal rights with the majority population [49]. Based on previous knowledge, it is useful to note these underlying social and cultural structures that may relate to the experiences of young people from LGBTQ-headed families. It is known that challenges faced by minorities stemming from social processes, institutions, and structures rather than individual events [47].

The current study reinforces also previous knowledge that the visibility of LGBTQ+ topics is scarce in school and student health care services and at other contexts of educational establishments [17]. The current study shows that better visibility encourages the young people to be themselves and discuss their families. Also, in previous knowledge visibility for LGBTQ+ topics is relevant to improve the general public's attitudes and therefore support these young people`s sense of normalcy and equality in the services [15].

The current study also showed awareness work by school and student health care services is in a minor role, and occasionally with ill-considered implementation. As in previous literature, LGBTQ+ viewpoints included in education of topics such as families and action-based and inclusive education was perceived as meaningful [50].

The current study's results also confirm previous knowledge that nonexistent or inadequate education on LGBTQ+ topics by an institution may move the role of educator to young people themselves [4,17]. This suggests the young people may be tired of having to explain their family LGBTQ-structure themselves [17]. The current study also reinforces prior knowledge that young people from LGBTQ-headed families often avoid revealing their family structures to avoid negative reactions from those around them [19,21]. Based on the current study and previous knowledge, it is, therefore, beneficial to lower the barriers related to LGBTQ+ topics by making visible the means implemented by the services to ensure consideration and an equal encounter of sexual and gender minorities [24].

Further study on the topic could be conducted from the point of view of LGBTQ+ parents or guardians, as a segment of the customers of school and student health care services are underaged. To reach a more comprehensive depiction, the views of school and student health care workers should also be researched. Diverse knowledge would make it possible to further enhance the means school and student health care services have to support the well-being of young people from LGBTQ-headed families.

Strengths and Limitations

An inductive qualitative approach was suitable to explore experiences young people from LGBTQ-headed families in school and student health care [51]. The findings shed light on these experiences, which is important. The participants produced a rich body of data, which is a strength for creating a thick description of the phenomenon [32]. The data was revisited several times to ensure that the results accurately reflected the participants' responses. Credibility was increased by using the participants' direct quotations. Dependability of the study was confirmed by providing details of the data collection and analysis [35].

The first author has a professional background as a public health nurse in student health care and may have pre-understanding of the topic. Still, self-reflection and discussions with authors was ongoing to avoid affecting the results and reporting [36].

Due to the descriptive qualitative design of the study, the results cannot be generalized into all young people from LGBTQ-headed families [52]. It is also noteworthy that most participants were female [32]. However, female youth also employ school and student health care services more than their male peers in Finland [40].

The anonymity of the participants removed from the researcher the option to reach out to them to ask for further details [51]. However, anonymity may have encouraged the participants to reveal their truthful experiences [29]. This can be considered to provide trustworthiness to the results [32].

A meager description by the participants is also of note when estimating the transferability of the results onto the greater target

group of the study. Instead, descriptions of Finnish LGBTQ-headed families provide valuable aid in understanding the likely families of the target group. Additionally, sufficient descriptions of the Finnish school and student health care context help the reader to estimate the types of other contexts the results could be transferable to [37,51].

Conclusions

School and student health care services appear to match well the health-related needs of young people from LGBTQ-headed families, but these young people face a variety of attitudes toward their families and the young people themselves due to their family structures. It is vital for school and student health care services to be aware that support and acceptance of LGBTQ-headed families, on both individual and institutional levels, enhance the well-being of young people from LGBTQ-headed families. Due to this visibility and awareness-enhancing activity should be included in the everyday operation of school and student health care services. In practice, it is suggested to avoid binary divisions and heteronormative assumptions in discursions and forms to address properly diversity. To tackle inequalities, it is recommended to carry LGBTQ+ topics, for example in posters and brochures, as equals alongside other topics without elevating them to a special status. Personnel education is suggested to be continuous, as the LGBTQ+ topics are evolving and related to legal reforms, societal structures and changing attitudes.

Acknowledgements

We thank the young people for participating in this study as well as all the partners for cooperation to recruit in participants.

Declaration of Competing Interest

The authors declare that there is no conflict of interest.

Funding Sources

This work was partly supported by the Finnish Concordia Fund and the City of Tampere Science Fund. The funding agencies had no further involvement in the study.

References

1. Primeau C, Vader K, Philpott H, Xiong Y (2022) Need for greater emphasis on 2SLGBTQIA+ health among physiotherapists in Canada. Physiother Can 74: 117-120.
2. Flatt J, Cicero E, Kittle K, Brennan-Ing M (2022) Recommendations for advancing research with sexual and gender minority older adults. J Gerontol B Psychol Sci Soc Sci 77: 1-9.
3. Lev AI (2010) How queer! The development of gender identity and sexual orientation in LGBTQ-headed families. Fam Proc 49: 268-290.
4. Aarnio K, Kallinen K, Kylmä J, Solantaus T, Rotkirch A (2017) Sateenkaariperheiden lasten ja nuorten hyvinvointi ja kokemukset [The well-being and experiences of children and young people in GLBT-headed families]. Report no. D62/2017, 2017. Helsinki: Family federation of Finland, The population research institute.
5. Bos HMW, Gartrell NK (2020) Lesbian-mother families formed through donor insemination. In: Goldberg AE and Allen KR (eds) LGBTQ-parent families: innovations in research and implications for practice. 2nd ed. Cham: Springer. 25-44.
6. Fairbain C, Cromarty H, Zayed Y, Foley N, Foster D (2022) Common law marriage" and cohabitation. Research briefing Paper for Commons library, Parliament UK. Report no. 03372.
7. Patterson CJ (2017) Parents' sexual orientation and children's development. Child Dev Perspect 11: 45-49.
8. Government Decree 338/2011 on maternity and child health clinics, school and student healthcare and preventive oral healthcare.
9. Health Care Act 1326/2010.
10. European commission (2023) National education systems: Finland overview.
11. Aarnio K, Kylmä J, Solantaus T, Rotkirch A (2018) Sateenkaariperheiden vanhemmat: kokemuksia lasten hyvinvoinnista, perhesuhteista ja tuen saannista [Parents of GLBT-headed Families: Experiences of Child Welfare, Family Relationships, and Getting Support]. Report no. D63/2018, 2018. Helsinki: Family federation of Finland, The population research institute.
12. Statistics Finland (2023) Sateenkaariperheiden määrä kasvaa – osa perheistä jää tilastoissa yhä piiloon [The number of LGBTQ families is growing - some families are still hidden in the statistics].
13. Act on Assisted Fertility Treatments 1237/2006.
14. Marriage Act 234/192.
15. Kylmä J, Apiainen R, Tuovila T, Åstedt-Kurki P (2021) Sateenkaaren alla on tilaa moninaisille perheille [There is room for diverse families under the rainbow]. In: Harju E, Palonen M, Sarell N (eds) Yhdessä perheen kanssa. Perheiden ja terveydenhuollon kohtaamisia. Helsinki: Gaudeamus. 119-134.
16. Tasker F, Lavender-Stott ES (2020) "LGBTQ parenting post-heterosexual relationship dissolution". In: Goldberg AE and Allen KR (eds) LGBTQ-Parent Families: Innovations in Research and Implications for Practice. 2nd ed. Cham: Springer. 3-24.
17. Guasp A (2010) Different families: the experiences of children with lesbian and gay parents. Cambridge: Stonewall.
18. Tuovila T, Åstedt-Kurki P, Paavilainen E, Kylmä J (2018) Nuorten kuvaus elämästään sateenkaariperheessä [Adolescents' descriptions on their lives in a LGBTI family]. Hoitotiede 30: 347-360.
19. Titlestad A, Pooley JA (2014) Resilience in same-sex-parented families: The lived experience of adults with gay, lesbian, or bisexual parents. J GLBT Fam Stud 10: 329-353.
20. Rijn-van Gelderen L, Bos HMW, Gartrell NK (2015) Dutch adolescents from lesbian-parent families: How do they compare to peers with heterosexual parents and what is the impact of homophobic stigmatization? J Adolesc 40: 65-73.
21. Kuvalanka KA, Leslie LA, Radina R (2014) Coping with sexual stigma: Emerging adults with lesbian parents reflect on the impact of heterosexism and homophobia during their adolescence. J Adolesc Res 29: 241-270.

22. McDonald I, Morgan G (2019) Same-sex parents' experiences of schools in England. J GLBT Fam Stud 15: 486-500.

23. Fedewa AL, Candelaria A (2013) Creating inclusive school environments for lesbian, gay, bisexual, and transgender headed families and their children. In: Fisher E.S and Komosa-Hawkins K (eds) Creating safe and supportive learning environments: A guide for working with lesbian, gay, bisexual, transgender, and questioning youth and families. New York: Routledge/Taylor & Francis Group.175-188.

24. Prendergast S, MacPhee D (2018) Family resilience amid stigma and discrimination: A conceptual model for families headed by same-sex parents. Fam Relat 67: 26-40.

25. Curtis A, Keeler C (2022) An introduction to qualitative methods for the nurse researcher. Am J Nurs 122: 52-56.

26. Bradshaw C, Atkinson S, Doody O (2017) Employing a Qualitative Description Approach in Health Care Research. Glob Qual Nurs Res. 4: 1-8.

27. Finnish National Board on Research Integrity (2019) The ethical principles of research with human participants and ethical review in the human sciences in Finland. Helsinki: Author.

28. Youth Act 1285/2016.

29. Sydor A (2017) Conducting research into hidden or hard-to-reach populations. Nurse Res 20: 33-37.

30. Malterud K, Siersma VD, Guassora AD (2016) Sample size in qualitative interview studies: guided by information power. Qual Health Res 26: 1753-1760.

31. Guillory J, Wiant K, Farrelly M, Fiacco L, Alam I, et al. (2018) Recruiting hard-to-reach populations for survey research: Using Facebook and Instagram advertisements and in-person intercept in LGBT bars and nightclubs to recruit LGBT young adults. J Med Internet Res 20: e197.

32. Morse JM (2015) Critical analysis of strategies for determining rigor in qualitative inquiry. Qual Health Res 25: 1212-1222.

33. British Psychological Society (2021) Ethics guidelines for Internet-mediated research. Leicester: Author.

34. Mitchell G (2015) Use of interviews in nursing research. Nurs Stand 29: 44-48.

35. Elo S, Kääriäinen M, Kanste O, et al. (2014) Qualitative content analysis: a focus on trustworthiness. SAGE Open 4: 1-10.

36. Kyngäs H (2020) Inductive Content Analysis. In: Kyngäs H, Mikkonen K, Kääriäinen M (eds) The application of content analysis in nursing science research. Switzerland: Springer International Publishing. 13-21.

37. Elo S, Kajula 0, Tohmola A, et al. (2022) Laadullisen sisällönanalyysin vaiheet ja eteneminen [Steps and phases of qualitative content analysis process]. Hoitotiede 34: 215-225.

38. Sandelowski M (2010) What's in a name? Qualitative description revisited. Res Nurs Health 33: 77-84.

39. European Union (2023) General Data Protection Regulation.

40. Finnish Institute for Health and Welfare (2024) Reasons for visiting appointments and monthly recording rates in school and student health care.

41. Aalto A-M (2020) Nuorten sosiaali- ja terveyspalveluiden tarve, palveluiden riittävyys ja asiakaskokemukset [The need for social and health services of young people, the adequacy of services and customer experiences]. In: Berg B and Myllyniemi S (eds) Palvelu pelaa! Nuorisobarometri 2020. State Youth Council. Helsinki: Hansaprint. 79-97.

42. Kerppola J, Halme N, Perälä M-L, et al. (2019) Empowering LGBTQ parents: How to improve maternity services and child healthcare settings for this community -'She told us that we are good as a family'. Nord J Nurs Res 40: 41-51.

43. Laiti M, Parisod H, Sariola S, et al. (2021) LGBTQ+ students' experiences of junior high school nursing in Finland: a qualitative study. J Sch Nurs 37: 491-502.

44. Stewart K, O'Reilly P (2017) Exploring the attitudes, knowledge and beliefs of nurses and midwives of the healthcare needs of the LGBTQ population: an integrative review. Nurs Educ Today 53: 67-77.

45. Bos H, Carone N, Rothblum E, Koh A, Gartell N (2021) Long-term effects of homophobic stigmatization during adolescence on problem behavior in emerging adult offspring of lesbian parents. J Youth Adolescence 50: 1114-1125.

46. Carone N, Lingiardi V, Chirumbolo A, Baiocco R (2018) Italian gay father families formed by surrogacy: Parenting, stigmatization, and children's psychological adjustment. Dev Psychol 54:1904-1916.

47. Meyer IH (2003) Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. Psychol Bull 129: 674-697.

48. Finnish Social Science Data Archive. FSD0154 World Values Survey 2000, 2009 & 2017: Finnish Data.

49. ILGA-Europe (2023) Annual review of the human rights situation of lesbian, gay, bisexual, trans, and intersex people in Finland covering the period of January to December 2022. Brussel: ILGA-Europe.

50. Brown R (2011) Prejudice: Its social Psychology. Malden: Wiley-Blackwell.

51. Elo S, Kyngäs H (2008) The qualitative content analysis process. J Adv Nurs 62: 107-115.

52. Thomas E, Magilvy JC (2011) Qualitative rigor or research validity in qualitative research. J Spec Pediatr Nurs 16: 151-155.