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# Lesbian, Gay, Bisexual and Transgender Families and Their Children

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## INTRODUCTION

Families headed by at least one gay, lesbian, bisexual or transgendered (LGBT) parent have become increasingly common in today's society. LGBT families present an additional family structure in society, and although there always

have been same-sex parents, estimates suggest that as many 6 million children are being raised by LGBT parents (BNA, 1987; AAP, 2002). Accordingly, these estimates represent a large population of families with specialized and idiosyncratic family structures and concomitant issues that sometimes necessitate clinical interventions from culturally and linguistically competent professionals who are knowledgeable about the needs and concerns of LGBT families.

This chapter provides an overview of some of the issues associated with LGBT-headed families, including those that may lead to seeking professional services and support that include promising practices in clinical interventions. Providing services for LGBT families requires that the helping person educate himself or herself about the needs and concerns that LGBT families are likely to present during the clinical hour (Coates & Sullivan, 2006; Israel, 2006). Because much of the limited literature available about LGBT families is focused on gays and lesbians rather than on bisexual and transgendered persons, many of the studies and associated statements included in this chapter address families headed by gays and lesbians rather than by bisexual or transgendered persons.

AU: Please revise this sentence to avoid using "including" twice, as it makes the meaning unclear.

Revision okay?

The family structure and the nature of biological, nonbiological, legal and filial relationships between the LGBT adults and the children in LGBT-headed families have substantive consequences for how the family functions and navigates in a frequently hostile societal and legal climate. LGBT families can experience stigma, prejudice and discrimination (Patterson, 2005) and may struggle with how they should function in a predominately heterosexual society rampant with images that do not include them (Coates & Sullivan, 2006). Given the lack of recognition and the sociocultural vacuum in which many LGBT families find themselves, even identifying as an LGBT family is potentially a socio-psychological-political act that can both empower and actualize and disempower and stigmatize LGBT families. Because many of the challenges LGBT-headed families experience stem from societal and sociological rather than from psychological factors (Brill, 2001; Hammersmith, 1987), this chapter is predicated on the understanding that stigma, homophobia (both societal and internalized) and discrimination are responsible for many stressors and aspects of problematic functioning that may result in LGBT-headed families seeking services.

Figure 9.1 provides a graphic illustration depicting the societal factors that interact regularly with LGBT families. These include the varied social systems that LGBT families live within and interface with as well as the larger societal perceptions of LGBT families, many of which are negative, stigmatizing and stereotypic. These generally negative societal attitudes can exist within the social systems that LGBT families exist in and interface with, emerging in unanticipated, yet pervasive, ways that affect LGBT families interactions with social systems.

## BIOLOGICAL AND GENETIC FACTORS

Several studies have examined why some individuals are gay or lesbian rather than heterosexual and have attempted to describe the phenomenon of being gay or lesbian (Bailey & Pillard, 1991, 1993; Hall & Kimura, 1994). Study results and their conclusions range from the perception that being homosexual is completely a personal decision or choice made by the individual to the belief

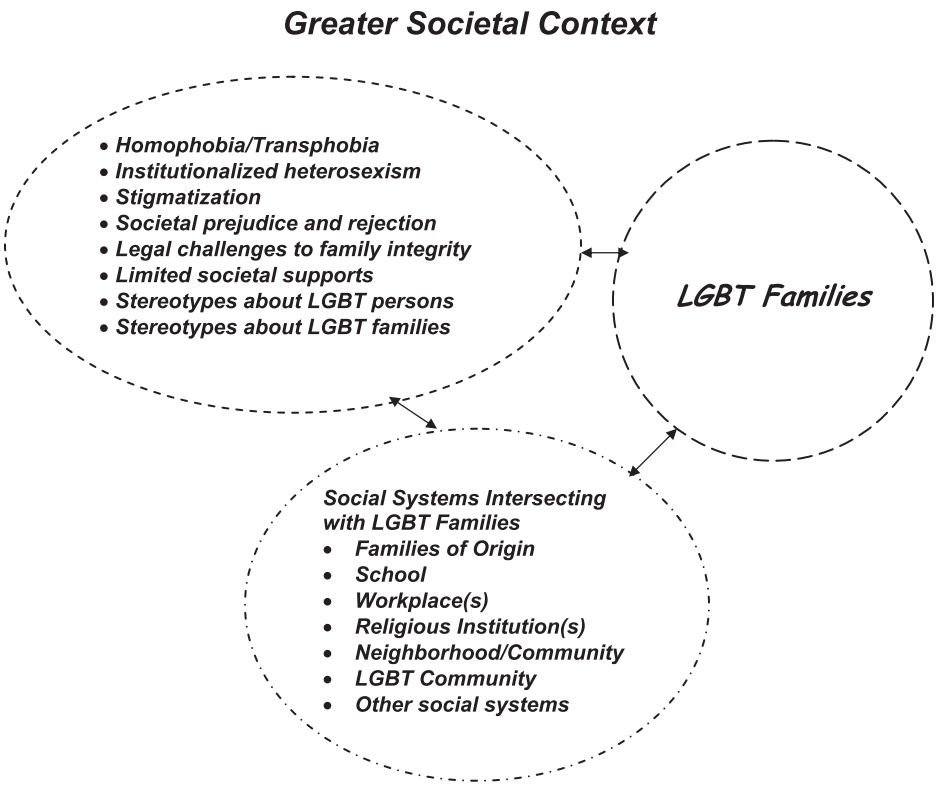


**Figure 9.1** Societal Factors Interacting with LGBT Families

that homosexuality is a biologically determined attribute in which the individual has little or no choice but to be homosexual. Some studies point to mixed causality in which biological, social and psychological factors result in an individual's having a homosexual orientation. The degree of immutability of homosexuality has also been examined in these and other studies and has been theorized about in the literature. Some theories hold that homosexual orientation is relatively immutable and virtually impossible to alter, despite extensive efforts to do so, without extreme difficulty and possible harm to the psyche of the person attempting to become heterosexual (even if he or she chooses to do so willingly). Other researchers view homosexuality as a relatively flexible attribute that can be moderated or completely abandoned through personal decision or through a mix of other difficult interventions (Bailey, Bobrow, Wolfe & Mikach, 1995; Exodus International, 2005; Falk, 1989; Forstein, 2001; Golombok & Tasker, 1996; Hall & Kimura, 1994; Hamer & Copeland, 1994).

AU: Revision ok?

There has been empirical research to suggest that homosexuality may be genetically based (Bailey & Pillard, 1991, 1993; Hall & Kimura, 1994). Several studies of identical twins examining the issue of the genetic basis for homosexuality have generated statistically significant results (Hamer & Copeland, 1994; Hamer, Hu, Magnuson, Hu & Pattatucci, 1993). For example, in one study of identical twins, a finding was obtained in which as many as 50% of identical twin pairs had both members identify as homosexual. This remarkably

high proportion suggests that there may be a genetic basis for homosexual orientation.

The American Psychological Association (APA, 2004) has developed a position statement on the issue of homosexuality:

> There are numerous theories about the origins of a person's sexual orientation; most scientists today agree that sexual orientation is most likely the result of a complex interaction of environmental, cognitive and biological factors. In most people, sexual orientation is shaped at an early age. There is also considerable recent evidence to suggest that biology, including genetic or inborn hormonal factors, play a significant role in a person's sexuality. In summary, it is important to recognize that there are probably many reasons for a person's sexual orientation and the reasons may be different for different people.

This statement is in keeping with the ideas of many professional associations and LGBT organizations that a homosexual orientation is biologically based and is relatively immutable and that relative proportions of persons with homosexual orientations in most societies are about the same, regardless of cultural differences in attitudes toward homosexuality (APA, 1994). Many of these professional associations have stated that attempts to alter sexual orientation are very difficult and may lead to unwarranted degrees of stress and possible damage to the individual seeking to become heterosexual (AAMFT, 1991; ACA, 1996; APA, 1992; American Psychiatric Association, 2007; National Association of Social Workers, 1996).

The assumption that a child is more likely to become LGBT if the child is raised by the LGBT parent (Golombok, Spencer & Rutter, 1983; Kirkpatrick, Smith & Roy, 1981) does not find support in the literature. For example, Green (1978) reported that the sexual identity of the 37 children in participating families were affected by several factors including their LGBT parents, schooling, reading, television and interactions with peers and other family members. Green noted that 36 of 37 children appeared to have typical psychosexual development, and Green tentatively concluded that children raised in LGBT families did not appear to differ appreciably from those raised in heterosexual families with respect to psychosexual development. This finding, first reported in 1978, has been reported in subsequent studies by other researchers (Patterson, 2000, 2004; Perrin and the Committee on Psychosocial Aspects of Child and Family Health, 2002; Tasker, 1999).

AU: Psychological changed to Psychosocial to match reference list. Ok?

Several studies have examined the issue of heritability of sexual orientation. A review of these studies generally supports the notion that sexual orientation is no more likely to be found commonly in families with same-sex or bisexual parents as in families with heterosexual parents (Bailey, Bobrow, Wolfe & Mikach, 1995; Golombok & Tasker, 1994). Estimates of the prevalence of a homosexual orientation in the general population vary demonstrably, ranging from 1.5% to nearly 10%, depending on the study (Bagley & Tremblay, 1998; Laumann, Gagnon, Michael & Michaels, 1994; McWhirter, Sanders & Reinisch, 1990). However, there appears to be virtually no empirical evidence to indicate that the rate at which children of gay, lesbian or bisexual parents are homosexual, bisexual or transgendered is any higher than the rate for heterosexual parents.

The theory that LGBT parents transmit their homosexuality or bisexuality to their children, either biologically or socially (Haynes, 1995), does not appear to be empirically valid, at least relative to the existence of any disproportionality in the frequency of children of LGBT parents who have a homosexual or bisexual orientation relative to the frequency of LGBT children of heterosexual parents. Gartrell, Deck, Rodas, Peyser & Banks (2005) found that children raised by LGBT parents are likely to exhibit greater degrees of tolerance toward LGBT persons and their orientation than other children. But again, these studies do not indicate there is any more prevalence of homosexual or bisexual behavior than in all families within the general population. Patterson's (2006) extensive review of research on the children of gay and lesbian parents suggests that the most important element of parenting by gays and lesbians that affect child outcomes appears to be the qualities of family relationships rather than parental sexual orientation, which has been supported by other findings (Cramer, 1986; **Dingfelder, 2005a).**

AU: Beginning in this paragraph, sometimes the T is left off this acronym. Please check throughout.

## INDIVIDUAL FACTORS INFLUENCING RISK AND RESILIENCY

There are individual factors that influence risk and resiliency in LGBT families, including the decision to be open about one's status as an LGBT person and dealing with the consequences associated with being LGBT in a fundamentally heterosexual society. *Coming out* as LGBT is defined here as being open and public about self-disclosing one's identity as an LGBT person or a member of an LGBT family (Berzon, 1988). The degree of being *out* usually occurs within boundaries or degrees of self-disclosure, ranging from coming out to oneself to being out to a small number of persons, being out to the majority of persons in one's life or being open and out to everyone in one's life, regardless of social system or how that social system intersects with the LGBT person (Gershon, Tschann & Jemerin, 1999; Savin-Williams, 1990). The coming-out process is usually a significant process for the individual and has the potential to put the individual at risk and to provide the individual with needed supports that enhance resilience (Berzon, 1988; Green, 2000; Green & Mitchell, 2002; Savin-Williams, 1990).

Coming out is also a process in that LGBT individuals continually must come out throughout their lives (Coates & Sullivan, 2006; Cohler, 2006). Although some LGBT individuals may consider the most important coming-out event in their lives to be the personal revelation, self-discovery and ultimate understanding and acceptance that many LGBT persons experience when they make the determination that they are indeed LGBT, the reality is that even self-acceptance can be a gradual and difficult process (Kurdek, 1988, 1991). In addition, coming out to others poses risks of rejection and negative consequences to the individual, while also increasing opportunities to find social supports that contribute to the individual's well-being and cultivation of resilience (Bepko & Johnson, 2000; Savin-Williams, 1990).

A number of studies and reviews have examined the mental health status of LGBT individuals. Hart et al. (1978) reviewed research comparing adjustment levels of gays and lesbians with heterosexual and concluded that gays and lesbians did not differ from heterosexuals in their degree of psychological adjustment on a wide variety of factors. Since then, Cochran (2001) identified several emerging issues in lesbian and gay mental health, includ-

ing a tendency for some gays and lesbians to manifest elevated risk levels for stress-sensitive disorders. Cochran attributed this tendency for elevated risk to stigma and discrimination that lesbians and gays experience in their daily lives and advised professionals that culturally competent care is necessary for gays and lesbians seeking mental health services. Cochran also pointed out that although affirmative therapies appear to hold promise as interventions, their efficacy has not yet been empirically investigated sufficiently to make a recommendation about their efficacy with gays and lesbians suffering the effects of stress-related disorders.

Meyer's (2003) meta-analytic review of the research evidence on the prevalence of mental disorders in lesbians, gays and bisexuals found that LGB persons had a higher prevalence of mental disorders than heterosexuals. Meyer attributed this finding to a conceptual framework of minority stress, which incorporates factors such as experienced prejudice, expectations of rejection, internalized homophobia and stigma associated with being LGB. These factors interact to create a stressful and hostile social environment that was the cause of mental health problems in LGB persons. Meyer posited that ameliorative coping processes can be implemented with LGB persons undergoing stress to help these individuals more effectively address environmental and internal stressors associated with being LGB.

An additional set of individual factors stems from the perceived role of parenting and the decision to parent by LGBT persons. Increasing numbers of studies are focusing on the reasons why LGBT persons decide to become parents, their perceptions of their own roles and how they choose to parent their children (Flaks, Ficher, Masterpasqua & Joseph, 1995; Golombok, Tasker & Murray, 1997; Patterson, 1994, 2000, 2005; Siegenthaler & Bigner, 2000). These studies generally have found that LGBT persons decide to become a parent after a relatively long decision-making process. They prefer nonphysical approaches to discipline. They are willing to go to extensive lengths to become parents and are willing to share child-care responsibilities with their partners when present. Coates & Sullivan (2006) believed that because LGBT persons must often go through a lengthy and complicated process to become parents, LGBT individuals who pursue this process may be particularly committed to the goal of becoming parents and may have extensively considered the consequences of taking on the roles and responsibilities associated with parenthood.

## FAMILY FACTORS INFLUENCING RISK AND RESILIENCY

### LGBT Families and Coming Out

Deciding whether to come out is a decision LGBT families must address on an almost daily basis as family members interface within numerous social systems, given that many of these interactions can potentially result in stigmatization and discrimination for some or all family members (Green, 2000; Green & Mitchell, 2002; Rohrbaugh, 1992; Savin-Williams, 1990). Children in LGBT families that are not out to persons in their lives may have to behave as though they themselves are closeted, operating within constraints that can impair the child's ability to make friends, to interact with others and to speak openly about their family in school, religious institutions and other venues (Coates &

Sullivan, 2006; McCandlish, 1987). Although there is little research about this issue, we hypothesize that children in this situation may experience anxiety, stress and depression due to their need to keep family secrets (Lewis, 1980; Rohrbaugh, 1992). Relationships with peers and significant adults are likely to be affected, and the child may not feel comfortable seeking external support from teachers, counselors, peers and others because of the fear of stigmatization and social censure (Gershon et al., 1999).

## Variations in Family Structure and Composition

LGBT families exhibit considerable variation in family structure and composition. LGBT family structures include donor insemination, co-parent adoption of a biological child of a second parent, stepparent arrangements, foster parenting, adoptive families (in which sometimes only one same-sex parent is allowed to adopt the minor children), hetero-gay families (in which one parent is gay and the other heterosexual, which may have been purposefully designed or which can occur when one parent comes out as LGBT) and families with more than two adults functioning in the role of parents (e.g., when a lesbian couple and a male donor whose sperm donation results in the birth of a child share parenting arrangements among all three parties). Other familial configurations include having one legally recognized parent (often the biological parent) and a second parent with no legal recognition of his or her parental role in the child's life as well as lesbian families where each lesbian mother has birthed one or more children. The nonbiological parent may or may not be a legally recognized parent of the children they did not birth themselves (Brill, 2001; Patterson, 1996a, 2000, 2005; Segal-Engelchin, Erera & Cwikel, 2004; Stacey & Biblarz, 2001).

LGBT families may have either one or two parents. LGBT single parents experience parental concerns analogous to those of heterosexual single parents regarding caring for children alone, child care, dating and relationships, limited personal time and economic and work pressures (Chan, **Brooks, Raboy & Patterson,** 1998; Coates & Sullivan, 2006). Openly LGBT single parents may encounter difficulties in securing support from other adults to ease the burden of parenting children alone (Carroll & Gilroy, 2002; Cramer, 1986). In some case, a third individual, perhaps the donor in a case-donor insemination, may have another parental role in the family; however, there is some evidence to suggest that these individuals sometimes choose to play a nominal, if any, role in the parenting process once they have donated their sperm to assist in the conception of a child (Segal-Engelchin et al., 2004).

Children of divorce in heterosexual relationships and marriages have been documented in the literature as having issues of separation, loss and custody-related issues (American Academy of Child & Adolescent Psychiatry, 2004). There is limited evidence to indicate whether children in LGBT families have similar responses to a parental breakup. A partner or spouse who comes out as LGBT after being in a heterosexual relationship or marriage may fear possible threats to custody or visitation of the minor children because of his or her LGBT status. In some states, LGBT parents can sometimes have their custody and visitation rights severely restricted or revoked altogether (Arnup, 1999; Buell, 2001; Falk, 1989).

### Social Supports Available to the LGBT Family Unit

Although all families generally benefit from supports received from extended family and other sources, supports may be more limited for LGBT-headed families resulting in the potential impoverishment of social and other opportunities for children in the LGBT family (Brill, 2001; Coates & Sullivan, 2006; Patterson, 2005; Slater & Mencher, 1991). The needs of LGBT families can be confounded with multiple concerns, including not being open about their LGBT status and withdrawing from opportunities to seek supports because of a fear of disclosure (Coates & Sullivan, 2006; McCandlish, 1987). However, Patterson (2000) pointed out that despite challenges and stigma, lesbians and gay men appear to be succeeding in creating and sustaining effective family relationships. This finding of successful family functioning is reported also by Flaks et al. (1995), Tasker (1999), and Stacey and Biblarz (2001). Several of these researchers found in their studies that there were no statistically significant differences on a number of psychological factors between children raised in LGBT-headed and those raised in heterosexual families. These studies were undertaken with a small number of participants and thus are limited in their generalizability.

### Family of Origin and the LGBT Family

Patterson (1998) conducted an exploratory study of 37 lesbian-mother families and the frequency of their young children's contacts with extended family members. They found that these children were in more contact with the grandparents and other adult relatives of the biological mother than with the nonbiological mother. This finding was replicated in another study of 80 families (55 headed by lesbian parents and 25 headed by heterosexual parents) that reported that children in heterosexual families had more contact with the parents of the biological mother than with the parents of the father (Fulcher, Chan, Raboy & Patterson, 2002). Muzio (1996) reported that having a child can significantly alter the attitudes of the family of origin toward their lesbian members, such that previously estranged relationships with the lesbian daughter improve greatly after she becomes a parent. The new grandparents appear to have more contact with their lesbian daughter and their grandchildren and to provide additional support to the family.

### Family of Choice

Kurdek (1988) reported that LGB persons tend to socialize more with friends than with members of their family of origin. *Family of choice* describes the family created by LGBT families to provide social and other support (Weston, 1992). In contrast to families of origin, families of choice are composed of individuals who comprise socially formed networks of close friends who form familial bonds that can change and develop over time. These families of choice often provide extensive social support and may serve as an important factor in promoting resilience within LGBT families.

## SOCIAL AND COMMUNITY FACTORS INFLUENCING RISK AND RESILIENCY

Slater (1995) rated social oppression associated with homophobia and heterosexism as the primary stressor in lesbian family life. Similarly, Israel (2006) pointed out the detrimental effects of societal transphobia. Couples (and their children) who are out may be criticized,

marginalized and even physically assaulted, whereas couples and children who are not out of the closet run the risk of being ignored or not recognized (American Academy of Child & Adolescent Psychiatry, 2006; Nelson, 1996; Sullivan & Baques, 1999). This balancing act can sometimes result in having LGBT families be out in some contexts but not in others, which can be confusing to all members of the LGBT family, but most especially children, who have to somehow remember who is supposed to know (or not know) about their family structure.

## Legal Challenges to the Integrity of the LGBT Family Unit

Custody issues can be complicated and detrimental to the well-being of affected children. Although there has been some improvement in terms of how LGBT parents are viewed with respect to the custody of their children (Falk, 1989; Kraft, 1983), there are jurisdictions in which the sexual orientation of the parents can be an impediment to custody and visitation rights as well as to the right to foster or adopt children. Legal issues affecting LGBT families are frequently preeminent in LGBT families seeking support or clinical assistance; helpers can isolate these issues for LGBT families, can assist them in prioritizing their legal needs and can help identify means of addressing them so that they can legalize their relationships and families to the fullest extent possible (Buell, 2001).

Arguments made in courts against custody of children with lesbian (and GBT) parents have revolved around issues including (1) the best interests of the child standard; (2) the lifestyle of the parent; and (3) the effect of the parent's lifestyle on the child. Moses & Hawkins (1982) reported that some courts have decided that lesbian mothers are less maternal than heterosexual mothers, a perception that plays a role in their custody determinations and an argument that appears to be gradually losing credence (Falk, 1989). The issue of the parent's lifestyle is often couched as a court concern that the gender role development of the child will be affected negatively if custody is granted to the LGBT parent (ibid.). A second flawed assumption is that the child is more likely to become LGBT if the child is raised by a LGBT parent (Golombok et al., 1983; Kirkpatrick et al., 1981). A number of studies have investigated these claims, and the evidence does not support these presumptions (Golombok & Tasker, 1996; Golombok et al., 1983; Kraft, 1983; Moses & Hawkins, 1982). A final claim is that children of LGBT parents will encounter trauma or stigma as a result of living with the LGBT parent. The argument here is that the negative societal ostracism on the LGBT parent will extend to the child and do irreparable harm. Falk (1989) reported that this assumption has resulted in the denial of custody to LGBT parents in some jurisdictions, whereas the perceived effects of stigma has not been recognized as an acceptable reason for denial of custody and visitation privileges to LGBT parents in others.

Because in many areas same-sex couples do not have the same protections afforded heterosexual married couples, same-sex families need to take special precautions to protect the rights and integrity of their family, including domestic partnership arrangements, drawing up of custody agreements and making arrangements to provide health-care services for minor children (Brill, 2001; Buell, 2001; **Dingfelder, 2005b**). If the nonlegally recognized same-sex partner is the only partner who is employed and the employer does not insure children who have no legal relationship to the children, then these children may be uninsured (Crespi, 2001).

Crespi (2001) reported that same-sex couples lack social constructions to guide them in family formation and in identifying significant familial milestones, which brings an added challenge to the survival and satisfactory functioning of the LGB families. He wrote that LGB families often develop their own rituals and familial paths that may only be observed by affected family members. Navigating social conventions without social signposts that address the needs of LGB families can be complicated. As the numbers and visibility of LGBT families increase, these families may develop their own social constructions that will guide other LGBT families as they develop and nurture their own families.

The availability and type of support the LGBT family receives from the extended family are important questions that helping professionals should ask to determine whether an individual or family's social support system is complicated by immediate and extended families that do not accept them (Crespi, 2001). One limitation for family development and healthy functioning stems from the lack of legal and sometimes social recognition of the nonbiological parent in same-sex couples. Several studies report that visitation with the extended family of nonbiologically related co-parents is less frequent than with that of extended families of biologically related parents (Fulcher et al., 2002; Patterson, 1996b; Vanfraussen, Ponjaert-Kristoffersen & Brewaeys 2003).

Planck (2006) reported that as more LGBT people are choosing to become parents, many are developing connections and social networks through organizations like the Family Pride Coalition and other LGBT parenting groups. These parenting groups provide social support where everyone involved can feel safe and can be open about their family status and where children can experience families similar to their own. LGBT families located in communities with more limited resources can still struggle to find other LGBT families; on-line communities and resources are available to all LGBT families with Internet access.

## EVIDENCE-BASED TREATMENT INTERVENTIONS FOR LGBT FAMILIES

### What Works

A review of the literature did not uncover any intervention that met the criteria of three successful trials.

### What Might Work

Our search of the literature yielded several promising theoretical constructs worth further exploration. Among these, Long and Bonomo (2002) advised professionals working with LGBT families to understand the significance that class, race, ethnicity, religion and spirituality play in LGBT families. They remark that many LGBT families are White and middle class and believe that professionals working with LGBT families need to achieve cultural and linguistic competence, including experience regarding the ways that culture, language, race, ethnicity and other variables affect the functioning of LGBT families in the larger societal context.

AU: This reference revised to match list. Ok?

Long, Bonomo, Andrews & Brown (2003) recommended family therapy approaches as a means of intervening with LGBT families to address some of the challenges LGBT families face. They and others encouraged clinicians to stretch the boundaries of existing family therapies to accommodate the specialized needs of LGBT families (Coates & Sullivan, 2006; LaSala, 2007). That said, specific recommendations about how family therapy should be adapted to serve the needs of LGBT families are limited, requiring the clinician to make these clinical determinations of his or her own accord and to research to assess whether family therapy is helpful is needed.

For example, LaSala (2007) reported that family therapy models often do not reflect the realities and desires of many gay and lesbian couples and stated that therapists working with this population are left to decide whether to apply these models as they are, to discard them or to attempt to modify them as they assist their clients. Although writing about couples therapy with lesbians and gays, which include issues such as intergenerational boundaries for gay and lesbian couples and the nonmonogamous relationships of gay men, LaSala's observations about how therapists can adapt family therapy models to suit the needs and preferences of lesbian and gay couples might be extrapolated to the use of family therapy models with LGBT families. Given that these adaptations are implemented effectively, LaSala's reconceptualization of family therapies augers well as a potential intervention for use with LGBT families.

Lynch and McMahon-Klosterman (2006) recommended that it is appropriate for therapists who work with LGBT stepfamilies to adopt an ally identity. Specifically, by functioning in the role of ally, the therapist can provide nonjudgmental support to members of this marginalized group, can promote trust with clients and can identify ways the stepfamily can address issues of stigma, discrimination and homophobia and can improve family functioning. Although the authors do not specifically make this recommendation, we suspect that the ally identity might be a useful model for any individual seeking to provide support to all LGBT families.

Many issues associated with LGB clients are replicated with transgendered clients, including coming out to minor and adult children, coping with prejudice and role definition problems, confronting social consternation and helping minor children address issues of stigma associated with being in a family that has a transgendered parent. Although there is little literature on transgender persons and their families available, studies generally emphasize the hostility and social censure encountered by transgendered persons (Cohler, 2006). Israel (2006) reported that transgender persons cope best with the hostile climate around them when they receive family and social support. She recommended that professionals work on facilitating even a limited support system for transgendered men and women, stating that even seemingly minimal interventions can have a positive impact on the transgendered client and can yield positive benefits that may extend to the greater family.

Coates and Sullivan (2006) offered a theoretical framework that combines complementary concepts from different theories to analyze family structures and functions in the social context of heterosexism. Elements of family systems theory, structural social work, ecological systems theory and queer theory are used to work with same-sex parents. Specific aspects of family functioning such as maintenance of boundaries around and within families, and role differentiation between parents are then explored using this theoretical frame-

work. Coates and Sullivan projected that the gradual change in social mores will make LGBT families increasingly visible and, ultimately, that family systems approaches will be developed with the needs of LGBT families at the forefront and as the focus of the intervention.

## What Does Not Work

A review of the literature did not uncover any intervention that should not be used at the present time. Despite the paucity of clinical research in the area of LGBT family therapy and interventions, a number of proscriptions are most likely to be beneficial for clinicians to consider when working with LGBT families. Therapists are advised not to apply heterosexual role models to LGBT families (Blumstein & Schwartz, 1990). Role definitions are fluid and not as clearly delineated along the lines of gender in LGBT families, and the application of heterosexual family structures and constellations is unlikely to be on target as an approach to working with LGBT families (Peplau, 1991; Peplau, Venigas & Campbell, 1996).

The same proscription applies to an understanding of the family constellation, which might include significant adults who play parenting roles (or who may have a biological relationship to the child) but who are not full-time parents. These somewhat different conceptions of the parenting role may be new to some therapists who are used to seeing more clearly defined roles for parents and parental figures in heterosexual families. These emotional and relational bonds need to be respected fully by the therapist, and these individuals should be integrated into clinical interventions as appropriate (Coates & Sullivan, 2006; Meyer, 2003; Nelson, 1996). Negating the importance of these individuals may engender suspicion and mistrust in LGBT clients and may impair the success of clinical interventions.

Another approach that is inadequate in addressing the needs of LGBT families is a minimization of the effect of societal influences on the children and the adults within the family system. The intersections (or lack of intersections) between the family system and other social systems are integral to understanding what LGBT families experience. Specifically, the sustained effects of being closeted, ostracized or having family members who function in significant roles in the family's structure not have their role recognized legally or socially by the larger society can have long-term detrimental effects on the well-being of the LGBT family and should not be ignored in therapeutic contexts (Cohler, 2006; Nelson, 1996).

Professionals working with LGBT families may be aware that therapeutic approaches exist with the purpose of converting LGB persons to a heterosexual orientation. The term *conversion therapy* is used here as an inclusive term that includes reparative therapy (Nicolosi, 1991) and a number of interventions developed by some conservative Christian groups to dissuade LGB persons from their same-sex attraction using religiously based arguments as the foundation for these interventions. Joseph Nicolosi, founder of the National Association for Research and Therapy of Homosexuality (NARTH), has conducted several studies and has written several articles that he reports provide support for the effectiveness of his reparative therapy approach to curing homosexuality (Nicolosi, 1991; Nicolosi, Byrd & Potts, 2000). The tag line for NARTH is "Helping clients bring their desires and behaviors into harmony with their values." NARTH holds an annual conference and regularly publishes newslet-

ters and pieces in support of the use of reparative therapy to cure homosexual behavior, if not a homosexual orientation. Reparative therapy has been interpreted as counter to the ethical recommendations regarding the appropriate interventions and care of LGBT persons specified by the American Psychological Association, the National Association of Social Workers and the Child Welfare League of America, among other professional groups (Forstein, 2001; Shroeder & Shidlo, 2001).

There is also an entire so-called ex-gay movement (Exodus International, 2005) that makes the claim that individuals have been able to alter their homosexual or bisexual orientation to adopt an exclusively heterosexual orientation. The claims made by members of the ex-gay movement are based largely on anecdotal information provided by individuals who claim to have exchanged their homosexual orientation for a heterosexual orientation. The ex-gay movement, however, differs from reparative therapy. Reparative therapy emphasizes the use of secular approaches to bring about change in homosexual orientation or homosexual behavior. The ex-gay movement does not oppose the use of reparative therapy but emphasizes religiously based approaches to bring about change in homosexual behavior or orientation. This controversial model of conversion therapy has yielded claims in both directions regarding its effectiveness: It has been an effective approach for some individuals seeking to alter their sexual orientation; other individuals report that this approach may have temporarily resulted in behavioral changes in sexual behaviors but that it was not an effective approach to change their sexual orientation over the long term (Shroeder & Shidlo, 2001).

There are several arguments in favor of the use of conversion therapy, including the following: (1) Homosexuality is a sickness or deviance from which the individual can be cured, particularly if the individual chooses to do so; (2) homosexuality is a sin according to certain religious faiths and therefore should be turned away from as the individual should do with all sin; (3) adopting certain religious beliefs and practices will allegedly heal the individual from homosexuality or bisexuality; and (4) the heterosexual life is socially accepted, is appropriate for all persons and should be the preferred way of life, so homosexual and bisexual persons should try to adopt a heterosexual lifestyle (Exodus International, 2005; Nicolosi, 1991; Nicolosi et al., 2000).

Some of the arguments raised against the use of conversion therapy include the following: (1) Individuals may spend considerable time struggling with their sexuality and then choose to pursue conversion therapy because of a fundamental lack of acceptance of who they are; (2) individuals are pressured by others in their environment to feel shame about their homosexual or bisexual orientation and to seek conversion therapy because of these external pressures rather than for any true personal reason or desire to do so; (3) attempting to change sexual orientation is like attempting to change a person's handedness, which is fundamentally inherent in the individual and is relatively or completely immutable, and the conversion therapy process is likely to result in untold stress for the individual; and (4) forcing under-age or young persons who identify as gay, lesbian or bisexual to undergo conversion therapy against their will may be abusive and potentially harmful to these youth (APA, 1998; American Psychiatric Association, 2007).

Professionals are advised not to encourage LGB parents to pursue conversion therapy to encourage them to change their sexual orientation, which has been shown to have inadequate and potentially harmful results (DeLeon, 1998). Reparative therapy, in particular, has been repudiated by many therapists and others who work with gay and lesbian clients, as well as several professional organizations (ACA, 1996; DeLeon, 1998; National Association of Social Workers, 1996). If an LGB individual seeks to pursue interventions to change his or her sexual orientation, it would be useful for professionals to help clarify the LGB individual's reasons for pursuing this course, which might entail necessitate value clarification. In addition, LGB individuals seeking reparative therapy would benefit from being informed about reparative therapy success rates and the variable effectiveness of conversion therapies in eliminating a homosexual orientation. It is unclear whether or how the children of LGB parents are likely to respond if their parent changes their sexual orientation. The consequences of LGB parents completing conversion therapy on their children are also unknown; therefore, this approach is not recommended (Forstein, 2001; Shroeder & Shidlo, 2001).

## PSYCHOPHARMACOLOGY AND LGBT FAMILIES

A review of the literature did not uncover any intervention that should be used.

## THE PREVENTION OF STIGMA AND DISCRIMINATION IN LGBT FAMILIES

### What Works

Prevention in this context is synonymous with health promotion, and this chapter emphasizes ameliorating the negative effects of stigma and discrimination toward LGBT families and nurturing coping strategies that LGBT families can use as needed. A review of the literature did not uncover any intervention that met the criteria of three successful trials.

### What Might Work

The prevention of negative societal influences associated with homophobia is difficult to achieve and requires multisystemic interventions at the individual, family and societal level using prevention's available technology (Gullotta & Bloom, 2003). Education, community organization and systems intervention efforts have been successful in some states in making others aware that LGBT families exist and want to be considered families in every sense of that word. In other states, these efforts have encountered significant resistance and the struggle for recognition continues (Arnup, 1999; Buell, 2001; Falk, 1989).

At the microlevel, using the prevention tool of education, interventions with schools, religious institutions and workplaces can be undertaken to raise the visibility of LGBT families and their needs. Educational activities include in-house training sessions, meet-and-greet events with LGBT family members and traveling photographic displays of LGBT families that provide an honest portrayal of life in LGBT families.

Also at the microlevel, the U.S. court system has not yet fully developed a body of law applicable to the LGBT family. As such, the LGBT family needs to take the necessary legal steps to ensure that their wishes are fulfilled. This educational action is referred to as *anticipatory guidance* in the prevention literature. We make specific note of this as there is anecdotal evidence to support the damage done to LGBT families who did not take the appropriate legal steps to reinforce the sustainability and efficacy of their families (Cohler, 2006; Sullivan & Baques, 1999). Many of the negative outcomes that can result from threats to the LGBT family can be prevented if thoughtful planning and foresight are pursued by the LGBT family to ensure the protection of its members.

At the macrolevel is Children of Lesbians and Gays Everywhere (COLAGE), a national, nonprofit organization run by and for children who have one or more LGBT parents (Kuvalanka, Teper, and Morrison, 2004). The mission of COLAGE is to use the prevention tool of community organization to engage, to connect and to empower people to make the world a better place for children of LGBT parents and families. COLAGE has chapters in many large urban areas across the United States, maintains a Web site of activities and topics of interest to the children of LGBT parents and conducts several retreats and family events throughout the year.

COLAGE maintains that children of LGBT parents love their parents and are happy being in their families. COLAGE acknowledges the complex and sometimes difficult emotional and sociopolitical challenges and unique experiences that children of LGBT parents face and encourages multiple opportunities for peer support, interactions and networking. Accordingly, COLAGE uses prevention's technology of natural caregiving, of competency promotion, of community organization and of systems change to build networks, to empower youth and to promote societal recognition and validation of all families.

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### What Does Not Work

A review of the literature did not uncover any prevention or health-promotion intervention that should not be used at the present time.

## RECOMMENDED BEST PRACTICE

When working with LGBT families, it is advisable to consider the following issues. First, LGBT families are likely to manifest concerns about the opinions, attitudes and clinical judgments of prospective helpers when seeking counsel. LGBT families seek acceptance of their lifestyle choices and family arrangements and do not want their family structure to be viewed in a prejudicial manner or as inherently in need of clinical intervention because of the presence of one or more LGBT parents. LGBT families are likely to seek assistance from helpers who understand that their family structure is unique and can present unique challenges. Individuals seeking to assist LGBT families are advised to consider their own long-held beliefs, attitudes and subconscious assumptions about LGBT individuals and LGBT families before working with LGBT families (Ariel & McPherson, 2000; Laird & Green, 1996; Turner, Scadden & Harris, 2004).

Second, therapists are encouraged to identify external supports available to the LGBT family. For example, is there an extended family that the fam-

ily can rely on for needed assistance and encouragement? Does the immediate and extended family accept the family and integrate them into the larger family's culture? Early evidence suggests that this is an important source of support for the LGBT family. When grandparents, other relatives and families of choice (frequently composed of friends and extended family members) are available, accessible and able to be relied on for supports, the to-be-expected stresses are reduced substantially, and the LGBT family is less likely to be isolated (Fulcher et al., 2002; Kurdek, 1988, 1991). It is very likely that these additional supports can serve as protective factors to bolster the effective functioning and satisfaction of the LGBT family (Brill, 2001; Coates & Sullivan, 2006).

Third, same-sex couples do lack social constructs to guide them in family formation (Ariel & McPherson, 2000; Coates & Sullivan, 2006; Crespi, 2001). This challenge does put additional burden on the LGBT family seeking to delineate and to recognize pivotal milestones in the life of the family. Accordingly, professionals working with LGBT families can help promote the development of satisfactory social networks that encourage their clients to network socially with other LGBT families who also must deal with stigma and societal prejudice. This is often easier to do in large metropolitan areas where social and networking organizations exist that are designed to encourage positive and supportive interaction between LGBT families, whereas these outlets may be comparatively limited in more rural and isolated areas (Cramer, 1986; Long et al., 2003). As a general rule, broadening the social networks for LGBT families, as with all families, is a fruitful approach that is likely to increase the social capital available to all members within an LGBT family (Coates & Sullivan, 2006). However, when encouraging LGBT families to pursue broadening of their social networks, it is advisable that each potential interaction be evaluated on the basis of potential gain and potential risk to the LGBT family to ensure that the safety and integrity of the family is protected (Green, 2000; Green & Mitchell, 2002). Groups such as COLAGE offer children of LGBT families a safe community-based venue in which to socialize and share issues and concerns, providing them with peer support.

Fourth, professionals working with LGBT families should explore the appropriateness of encouraging LGBT families to pursue legal and social family protections as early as possible in LGBT family formation. The availability and use of legal safeguards (e.g., wills, contracts, binding agreements, powers of attorney, co-parent adoptions by nonbiological parents) can help prevent difficult crises and threats to the integrity of the LGBT family. By specifying and codifying the intentions and legal obligations of adult family members to the child and to the family's overall functioning, this form of assistance can assist the LGBT family in navigating complex legal and financial systems, can enhance family bonds and can strengthen the overall protection of the LGBT family (Arnup, 1999; Cohler, 2006).

Coates and Sullivan (2006) held that the well-intentioned therapist who generally accepts diversity is not sufficiently prepared to work with LGBT families. Instead, they advised that clinical competence rests on experience working with lesbian and gay clients and acknowledging the impact of societal factors, such as heterosexism, on parenting in the context of same-sex relationships. A challenge to the helping person working with LGBT families is to identify additional supports and interventions that facilitate the growth and

development of the LGBT family, within a culturally and linguistically competent approach that honors the integrity of the family being served (Janson, 2002). Although Coates and Sullivan's observations refer to gay and lesbian parents, they may also be applicable to bisexual and transgendered parents.

Theoretical interventions have not been developed specifically to address the needs of LGBT families, but some practitioners and researchers have made recommendations about approaches that can be adapted to LGBT families. Family therapy, structural social work, queer theory and ecological systems theory have been adapted by Coates and Sullivan (2006) to address the needs of LGBT families. The adaptation of family therapy and other theoretical and clinical practices for LGBT families is in its infancy, and considerable work remains to be undertaken to have a full complement of useful practices and interventions for LGBT families.

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