Clinical Work with Children and Adolescents Growing Up with Lesbian, Gay, and Bisexual Parents

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Lesbian, gay, and bisexual people desire to parent for many of the same reasons as heterosexually oriented men and women. However, the process of considering parenting and then becoming a parent may be more complex for sexual minorities. It may involve "coming out" as a lesbian, gay, or bisexual parent at work and in the community, and dealing with familial and societal expectations and prohibitions. Also, it is difficult for parents to anticipate the unique issues their children may confront at different developmental stages. Although lesbian-, gay-, and bisexual-parent families are more visible and are increasingly accepted in today's society, they continue to be effected by societal bias on a multitude of levels. The potential impact of this bias may differ for each member of the family.

A therapist should consider both the psychological and the social issues that may have impacted the parent's development over their life course, and how those experiences may influence their parenting. Indeed, the transition to parenthood is a significant life transition and is informed by continuities and discontinuities from all previous stages of development (Engel, 1977; Halfon & Hochstein, 2002). A life course perspective emphasizes that development is lifelong and continuous. The interaction between one's life stages and experiences cannot be understood in isolation, but is influenced at each developmental stage by one's previous development, as well as the responses of the environment in which one is raised (Johnson, Crosnoe, & Elder, 2011). A life course developmental construct is used in this chapter to illuminate the importance of one's "coming out" process and how it may influence the dynamic in one's relationships with members of one's own generation, and across generations.

Growing up as a sexual minority can influence the strengths and vulnerabilities one brings to parenting. For example, based on their own experiences of discrimination and stigma, lesbian, gay, and bisexual parents may have a heightened level of anxiety around the safety and well-being of their children. This anxiety may blind them to a deeper understanding of the specific needs and feelings of their children. A therapist may be in a unique position to help the parent to understand where there may be misattunement between the feelings and needs of the parent(s) and the child(ren), and can help them to find a way to traverse those differences. The dynamics between parents and children in lesbian-, gay-, and bisexual-parent families can be understood by developing an appreciation of how their lives and life courses are interwoven, and how the narrative of their experiences may converge and diverge.

A therapist can help parents to increase their awareness of subtle issues that may be particular to children of lesbian, gay, and bisexual parents. Clinicians can also help the parents to appreciate

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A.E. Goldberg and K.R. Allen (eds.), *LGBT-Parent Families: Innovations in Research and Implications for Practice*, DOI 10.1007/978-1-4614-4556-2_17,

and distinguish between what issues may be normative developmental struggles for any child, and what may occur as a consequence of having lesbian, gay, or bisexual parents. A biopsychosocial understanding of development can help the clinician to formulate an understanding of the vulnerabilities and the strengths of each member of the family, and the family as a whole. Although research has shown that stressful life events and repeated or chronic environmental challenges can impact individual vulnerability to illness, it has also revealed that having a sense of psychological well-being and living within a supportive environment can be protective (Fava & Sonino, 2008; McEwen, 1998; Ryff & Singer, 1996).

A clinical vignette will be used to highlight how a therapist can help a family understand the influence of parents' life course on their children's lives in the context of treating an adolescent with same-sex parents.

Clinical Vignette: Melissa

Melissa is a 16-year-old Caucasian girl growing up in a city in Massachusetts. She is a little over five feet four inches, wears her brown hair down to her shoulders, and takes pride in her appearance. She loves sports and music and is a particularly gifted cross-country runner. She has many male and female friends and enjoys social activities as well as time spent alone. She volunteers for an organization that helps children who are living in poverty around the world, and she works for a community food bank once a month. She was referred to therapy due to concern about her sadness and a change in her behavior.

During the therapists' initial meeting with Melissa's parents the following information was elicited. Melissa has two mothers, Denise and Jill, who have raised her since birth. Her mothers are currently in their 40s. They first became a couple in their 20s and discussed their wish to have children early on. Their dream to each have a child was complicated by the fact that Jill was diagnosed with Lupus when she was 23 years old, and was intermittently treated with steroids for this illness. Because of this, Jill felt she would not feel safe trying to conceive a child or carry a pregnancy. Denise, on the other hand, wanted to give birth to a child.

When they were in their early 30s they began to discuss having children more seriously and explored their options. One lingering question was whether to use a donor who would agree to be known when the child was 18, or to try to find a friend who would agree to donate sperm and be known to the child from birth. In the end, their desire to have their child know the person who donated sperm led them to consider the option of identifying a friend who would agree to be the donor.

Denise had a friend at work named Robert. Denise and Robert were in the field of technology and had become friends while working together. As Denise and Robert grew closer, she began to speak to him about her wish to have children. She told him of her ambivalence about using a sperm bank, and her wish to have her children know the identity of the sperm donor. Robert later spoke with Denise and told her that he and his partner Zack had discussed the possibility of donating sperm to Jill and Denise so they could have a child. Denise was moved by this offer and arranged a meeting with Jill and Zack for the four of them to discuss in greater detail this possible means of conceiving a child. Together and separately, the two couples tried to anticipate issues that could arise.

After completing an initial evaluation, Melissa's therapist requested to meet with each couple (Denise and Jill, Robert and Zack) to get a better history of their relationships, both with Melissa and with each other. She inquired about the concerns that each couple had regarding this decision prior to Melissa's conception, their feelings about each other after she was born, and what worries still existed about their relationship with the other couple with regard to Melissa. Both couples expressed that they had felt anxiety about this arrangement throughout the process. Some of their anxieties were articulated to the other couple prior to deciding to conceive, but others were not shared, both for conscious reasons, but also because they had not been anticipated. One early

discussion Jill and Denise had with Robert and Zack was to clarify who would be the "parents" to the child. They all agreed that Denise and Jill would be the parents and that Robert and Zack would be involved in the child's life. Initially, the four of them did not deepen this discussion to include defined roles for Robert and Zack, or how the men's roles would be constructed by the child.

None of the adults knew exactly how this arrangement would take shape, but agreed that they would work it out over time and that the child would know that Robert was the sperm donor. Robert and Zack would spend time with Melissa, but the details of this were not considered at this early stage. Denise and Jill were fortunate to live in a state that allowed for second-parent adoption. They did not want to use a "known" donor unless the donor agreed to give up parental rights. Robert agreed to this stipulation. As a result, Jill would be allowed to be the second parent on the birth certificate, permitting her to have the legal rights of a second parent. It was agreed that Jill and Denise would have full legal and physical custody, and they would make all financial, physical, and school-related decisions. No specifics were written into the contract about how much time the child would spend with Robert and Zack, but all agreed that the decision to conceive with a "known" donor was intended to give the child an opportunity to know Robert, the sperm donor, and to have a relationship with him and Zack.

Denise conceived after switching from home-based insemination to a clinic for intrauterine insemination in which a doctor used a catheter to place the sperm directly into the uterus. The couple's daughter, Melissa, was born without complications. Although Robert had given up parental rights after Melissa's birth, both Denise and Jill became increasingly anxious that he would change his mind. If he did, it would mean that Jill would not be allowed to adopt Melissa and become her legal parent. While Denise and Jill tried to anticipate issues their child might face in her life due to having lesbian parents, they never considered that they would become fearful of their child being "taken away" by the men who helped to conceive her. They did not feel comfortable discussing this fear with Robert and Zack and began to pull away from them as the due date approached. When Melissa was born, all four of them were at the hospital, although only Jill was present during the delivery. Immediately after her birth Robert and Zack spent some time with Melissa, but Jill asked them to leave so she and Denise could have alone time to "bond" with Melissa. Denise and Jill's fears had begun to create a boundary between Robert, Zack, and Melissa, which Melissa would experience as a small child, but not understand until much later.

Before they began to think about how they would conceive, Denise and Jill had discussed their concern that their child might experience discrimination secondary to their sexual orientation. They knew that they wanted to raise a child in a community that was diverse with regard to race, class, and ethnicity. They had hoped that the public school their child would attend would have other lesbian- and gay-parent families, but had no way to ensure this would happen. They were very aware of the potential difficulties due to stigmatization that their child might face coming from a "different" family, but did not know how this would manifest in a school setting day to day, or if their child or others in the community would communicate with them about these incidents.

Throughout grade school and middle school, Melissa's parents listened for any difficulties she might be having with peers or with teachers as a result of having two mothers. They tried to not overemphasize this difference, but they also wanted to create a space where Melissa could talk about struggles she might encounter for any reason, including having lesbian parents. She was open with them, and other than an occasional disagreement with a friend that had nothing to do with her parent's sexuality, Melissa did not share any experiences of rejection or discrimination that they could directly relate to having two mothers. Melissa had never experienced any bullying directed toward her or her family, but she was acutely aware of, and hurt by, the comments her peers made with regards to "gay" people.

Prior to entering high school, Melissa began to share less of her day-to-day experiences with

them, and although Denise and Jill continued to be concerned, they wanted to give her the space to bring issues to them when they arose. Melissa did well socially and academically, and, as was true throughout grade school and middle school, her teachers continued to comment on her capacity as a leader. Her sensitivity and awareness of how other children were treated based on race, class, and disabilities were beyond what her teachers normally encountered in her age group.

Unbeknownst to her parents, going to high school was a difficult transition for Melissa, and slowly over time she became more withdrawn and socially isolated. Initially, she was very popular and socially active in school, and she was involved in after-school activities and community projects. She was attracted to both men and women, and as her sexual feelings intensified toward a female friend, she began to feel conflict around an unspoken pressure she felt to be a "normal" child of lesbian parents. She did not want to betray the sense of loyalty she had to both her parents and to the community to prove that children who were raised with gay or lesbian parents were just as "healthy" as children raised in heterosexual homes. She understood that mainstream society defined "healthy" as heterosexual and behaving in a way that embraced "typical" gender role expressions. She inherently rejected the notion that there was a typical way to express herself either in terms of gender or her sexuality. She, by virtue of being raised in her family and in her community, came to appreciate the spectrum of gender and sexuality that can exist across and within individuals, and she felt that she did not yet know what all of this meant to her.

As her freshman year progressed, Melissa had increasing difficulty focusing on her schoolwork, and her grades began to drop. She stopped bringing friends to her house and participating in after-school activities. When her school counselor approached her to talk to her about her deteriorating grades, she began to open up about the fact that she was struggling. Melissa agreed with the counselor that she should let her parents know that she was not doing well.

Melissa's parents called her pediatrician to get a referral. The pediatrician recommended a therapist whom she knew was comfortable doing both individual and family therapy. The therapist initially met with Melissa a couple of times and then met separately with her mothers to get a family history. Melissa told the therapist that she had two mothers, and when the therapist asked what she knew about her conception, the family's story unfolded. The therapist recognized that although she had two parents, there were other significant adults in Melissa's life. She asked to meet with Melissa's mothers as well as with Zack and Robert separately as couples, and then all together over several sessions to get a history. The therapist wanted to hear both the individual and collective narratives about the process of the decision to have Melissa, and about the roles and relationships that each of them had had with Melissa since she was born.

Melissa liked this therapist because she asked about Melissa's "family," and included questions that allowed Melissa to speak about Zack and Robert. She did not normally talk about them with her mothers, or with her friends. During the initial phase of therapy, Melissa primarily focused on her feelings of disappointment with her friends, and with a relationship she had with a boy at school that had recently ended. Issues around having a "different" family were not addressed during this phase. The therapist felt that it was important to learn from Melissa about how she perceived her relationship with her mothers, as well as with Robert and Zack before making assumptions about the significance that each one had in her life, and her relationship with each of them. The therapist did not assume that her family structure was the reason for therapy.

The therapist believed that Melissa's symptoms would likely resolve with both individual and family therapy. This therapy would include work with Melissa's parents as well as Zack and Robert as separate couples and then together. Some of these meetings would include Melissa, and others would not. The therapist referred the family to a family therapist she felt would be a good match to do this work, and continued to do individual therapy with Melissa. During the course of her individual psychotherapy, Melissa

came to understand that some of the disappointment she felt toward others for not meeting her needs was related to her resistance to expressing those needs for fear of not having them fulfilled. She also recognized her tendency to take care of others rather than herself. She felt that she "needed" a boyfriend rather than feeling that she wanted to have one. Although she felt close with friends, she had never been particularly close with anyone she had dated. She realized that it was this feeling of isolation and loneliness that was making her feel sad. She was not able to allow herself to be intimate with others in a way that fulfilled her needs. As she discussed these issues in therapy she began to feel less sad and anxious, and reengaged with her peers and school.

Over time she began, tentatively, to express her disappointment in her "family" to her therapist. In the context of her therapy, she referred to her mothers as well as Robert and Zack as her family. Her mothers were her parents, but all four of them were a part of her family. This inclusion was true of all of their parents, her parents' siblings, and her cousins, to varying degrees. She felt disappointed and angry when she thought about how her mothers, Zack, and Robert had not been particularly helpful in figuring out these relationships. She was angry with her mothers at times, but was primarily angry with both of her "dads." She was not able to articulate what prompted this anger, but she was able to say that it was not something she wanted to talk about. Over the period of almost a year she began to open up more about her feelings about growing up in her family.

She felt very close to both of her mothers. She had always referred to Denise as "mommy," and Jill as "mama." Denise and Jill had chosen those names before Melissa was born, and since she was an infant they had referred to each other as "mommy" and "mama." When friends or other adults asked her who her "real mother" was, Melissa felt intense anger and sadness. Both Denise and Jill were her "real mothers," and she felt this deeply. She could not understand the ignorance of others who felt that a biological connection made one of her mothers more "real" than the other.

Since she was young, Melissa had a sense that she needed to protect her parents' lifestyle and was frustrated that her parents' concerns were often focused on her experience of having "gay" parents. Most of the time she felt this was a nonissue in her day-to-day life. In contrast to her friends who had different-sex parents, she felt that adults, and at times her peers, were overly curious and intrusive with regards to her family. She believed that this was solely based on her parents' sexual orientation. For Melissa, her personal relationship with each of her parents was her main concern, not their sexual orientation.

She was angry and sad that she was not the one who had any say in how the relationships between the significant adults in her life were constructed. She had spent much of her life to this point confused about who was defining how she related to each of her mothers, and Robert and Zack. Her hopes that it would be spoken about more overtly were never realized. Therefore, she always tried to interpret what she was supposed to do and did not have the opportunity to explore what she wanted to do. She did not feel that her parents understood what she wanted, or that they asked her about what she needed from each of them. She felt that her parents had made assumptions about how much time she wanted to spend with whom, and she was frustrated with herself for letting her parents take the lead in defining her relationships.

Through her work in therapy, she had begun to recognize that she could allow herself to think about the question of what her wishes were for her relationship with Robert and Zack. Melissa had first been told about Robert helping Denise "make a baby" when she was five. As she got older, her mothers offered more details about "how" babies are created. It was not until she was much older that she questioned how the decision to use Robert's sperm and Denise's egg had been made. As a child, Melissa would spend several hours a couple of times a month with Robert and Zack. From an early age, she understood that they were important people but they were referred to as "Robert" and "Zack." Melissa described to her therapist what it was like for her when all four of them were together. As a small child, Melissa

could sense their anxiety but could not name it. As she got older and learned that Robert was her biological father, she began to understand more about Robert's and Zack's desire to spend time with her, but she still did not understand why her mothers seemed different when they were around. She loved her mothers, but this did not dispel her fantasies about having more time with Robert and Zack. When she was around 7 or 8 years old she would fantasize that Robert and Denise would get married and Zack and Jill would get married. She imagined that then they could all live together.

As she got older this marriage fantasy waned, but her longing to be closer to Zack and Robert continued. Robert and Zack seemed to want Melissa to initiate their time together, but her mothers did not specifically encourage her to do so. In turn, her fears that her moms would be angry if she wanted to spend time with them kept her silent. She was left feeling sad and disappointed that none of the adults were helping her to navigate this complicated family structure. She had close friends but did not share this pain with them. She was angry that Zack and Robert were not more involved in her life, and they addressed her as "Melissa." She could never recall hearing them describe her as "my daughter." She referred to Robert and Zack by their proper names but did not feel comfortable doing so. It made her feel more distant from them, and she was upset that she had never been asked what she wanted to call them. She interpreted the fact that no one spoke to her about her wishes as a statement that they had all agreed that calling them anything other than Robert and Zack was not acceptable.

Since she was young she had always thought of them as "sort of dads," and she developed secret names for them. Starting when she was seven or eight she secretly referred to Robert as "dad" and Zack as "daddy." To her they were part of her family. Melissa did not see them as often as she wished, and they were not often spoken about in the context of day-to-day family issues. She often tried to imagine ways in which she could eliminate the awkwardness between her mothers and them, but she didn't know how to accomplish this. When she was younger she made up reasons why they were not closer, and most of the fantasies included something that she had done to create this tension. Now that she was older she understood that she was not fully responsible for the tension, but she still felt in part that it was her fault. She did not have any friends who had a family that closely approximated the complexity of her family and felt as a result that none of her friends could help her with this issue; in fact, she never talked about it with them.

Over the course of therapy, Melissa began to express her sadness about Robert and Zack's limited involvement in her life. Concurrent to Melissa's individual therapy a family therapist was working with her and her family. Her mothers had agreed to work with Robert and Zack in family work to revisit their early history together. With Melissa's permission, her individual therapist worked closely with the family therapist to help guide family treatment. In family therapy, Jill, Denise, Robert, and Zack expressed appreciation for the insight Melissa had given them into how the communication—or lack thereof—among the four of them had led to misunderstandings and distortions. Denise and Jill were able to tell Robert and Zack that although their wish was to use a known donor they did not anticipate that they would be fearful that Robert and Zack would try to take Melissa away from them. They shared that these feelings had dissipated over the years as they became more comfortable with parenting and more secure in their relationship with Melissa and as a family. They realized that some of the anxiety that they felt about Robert and Zack were a projection of their early experiences coming out, and their anxiety of not knowing who might cause them or their child harm. The therapist recognized that for Melissa, the very people who could have been helpful were the same ones who were seen as potentially harmful.

Zack and Robert were able to speak to the family therapist about their deep sense of rejection and experience of anger and disappointment when Melissa was first born and they were sent away. They felt an immediate connection to Melissa that they did not anticipate when they agreed to donate sperm. As she got older and interacted with them, they were struck by how much they wanted to spend more time with her,

and spend time alone with her to build their own relationships. They then became anxious that they would be cut off from having any contact with Melissa if they requested to have more of a relationship with her and subsequently limited the time they spent with her. It appeared to the therapist that a consequence of this was that Melissa felt rejected by them, as this dynamic was never explicitly communicated to her mothers or to her prior to her therapy.

A meeting was held with Melissa's therapist, Melissa, the family therapist, her mothers, and Robert and Zack. In this meeting Melissa was able to tell Robert and Zack that she wanted them to spend more time with her. She also expressed her wish that she didn't have to refer to them solely as "Zack" and "Robert." Denise, Jill, Robert, and Zack were all responsive to this request. In a series of family meetings, the family therapist was able to help both couples and Melissa to understand the origin of some of the tensions that existed between the couples and help them to work together to renegotiate their relationships. Both couples were able to speak to their fears and wishes with Melissa, and this increased ability to openly communicate allowed them in a unified way to allow Melissa to pursue relationships with Zack and Robert in a way that met her needs.

The work that Melissa, Denise, Jill, Robert, and Zack were able to do in individual and family therapy helped Melissa to get developmentally back on track. Her inability to articulate her experience of her relationships in her family led to her sadness and anger that brought her to treatment, and that her work in individual and family therapy helped her to understand. The family therapy allowed her to engage and reengage with her family in ways that felt more satisfying for her and helped to improve her mood. Following this work with her family they terminated family therapy, but Melissa continued with individual therapy for another 6 months. She was able to focus her individual therapy on working to separate from her parents, gain a better understanding of her own identity, and reengage with her peer group. Her mood improved as did her grades. Over time she terminated with her therapist with the understanding that she could return to do individual and family work at other points in her life in which it might be useful to her and her family.

Clinical Relevance of the Intersection of Parents and Their Childrens' Life Course

To better understand lesbian-, gay-, and bisexual-parent families, it is helpful to first understand the parents' history developmentally both in the context of their family of origin and throughout their life course. When taking a history, the clinician should include biological, social, and psychological vulnerabilities and strengths of each member of the family. This information can be incorporated into the formulation of the family dynamics and the symptoms that have brought the identified patient and their family to therapy. The clinician's understanding of the issues may be reformulated as one works with the family over time. In addition to the parent's biological, psychological, and social history, the parent's developmental history should include the parents' experience of "coming out," and their decision-making process around having children.

Understanding the parent's life course in terms of the historical, social, and cultural context of each parent's path to self-identifying as a lesbian, gay, or bisexual individual will help the therapist to appreciate the parent's own developmental experiences, and how these experiences may influence his or her parenting. Some lesbian, gay, and bisexual individuals were raised in families and communities who were accepting of their sexual orientation and gender expression. But, it is not unusual to work with parents who as children and adolescents experienced emotional distancing from parents, peers, and their community due to being "different" starting at a young age. Through verbal and nonverbal communications of anger and disappointment which may have included verbal and physical harassment from parents, peers, or other members of the community, individuals may have experienced rejection and discrimination in a multitude of ways at each stage of their lives starting in childhood.

Throughout development, individuals may have experienced and understood this rejection in a variety of ways, but ultimately it may have been internalized as a rejection of their core self. It is not uncommon to work with sexual minorities who from an early age attempt to "cover" to manage the stigma of being a sexual minority and try to keep it from "looming large" (Goffman, 1963). This process of rejection may lead to a shame-based identity and result in the individual living with internalized homophobia. This internalized sense of fear and shame can have a long-term impact on individual self-esteem and may consciously or unconsciously influence one's parenting (Kaufman & Raphael, 1996).

Thinking about becoming a parent may provoke anxiety as the individual faces the possibility that his or her children may experience rejection and discrimination solely based on the sexual orientation of their parent(s). A study by Bos and van Balen (2008) revealed that one of the primary concerns of lesbians considering parenthood is the possibility of their child having negative experiences as a consequence of being raised in a nontraditional family in a heterosexist and homophobic society. The children of lesbian, gay, and bisexual parents have "membership by association of a stigmatized minority group" (Goldberg, 2007, p. 550).

Children who are born into a "different" family constellation may not feel "different" even though their parents are "different" from other parents. The children of lesbian, gay, and bisexual parents do not necessarily experience the same minority group identity as their parents. Although children and adolescents may feel protective of the LGBTQ community, and feel a part of this community by virtue of being a child with a lesbian, gay, or bisexual parent, this aspect of their lives may or may not be pivotal to their identity (Goldberg, Kinkler, Richardson, & Downing, 2012). Parents may unwittingly overemphasize this aspect of their own identity in an effort to communicate their concerns about the discrimination their child may face. The constant reference to a parent's sexual orientation may be confusing for the child who does not understand why it is an ongoing topic of conversation.

Lesbian, gay, and bisexual parents' desire to foresee struggles and protect their children from the stigma of having lesbian, gay, or bisexual parent can be consciously and unconsciously consuming. Previous experiences of their own rejection, discrimination, and verbal/physical assaults for being lesbian, gay, or bisexual may heighten their fear for their child's safety and well-being. In a study conducted in the Netherlands on lesbian mothers, Bos, van Balen, van den Boom, and Sandfort (2004) found that mothers with increased levels of perceived stigma, internalized homophobia, and higher levels of perceived rejection felt a greater need to justify their position as mother. This response to real and perceived stigmatization may impact the children as well. Bos and van Balen (2008) found that children with lesbian mothers who perceived higher levels of stigmatization for having lesbian parents had a lower sense of well-being. Girls who perceived high levels of stigma reported low self-esteem, and boys who perceived high levels of stigma were rated by their parents as being more hyperactive, which may have been a reflection of increased levels of anxiety.

The negative effects of homophobic stigmatization on children's self-esteem and behavior have been shown to be counteracted by frequent contact with other offspring of same-sex parents, being in a school that teaches tolerance, and having mothers who perceive themselves as active members of the lesbian community (Bos & van Balen, 2008). Bos, Gartrell, Peyser, and van Balen (2008) compared planned lesbian-mother families in the USA with families in the Netherlands and found that in both countries, there was a negative effect of homophobia on children's psychosocial adjustment. The extent to which socioeconomic status and stigmatization are interrelated is underexamined in research; however, one study by Tasker and Golombok (1997) did suggest that children from lesbian-mother families with lower socioeconomic status were more likely to experience peer stigma because of their mothers' sexual orientation than those from middle-class lesbian-mother families. This finding highlights the importance of considering social class in clinical work with lesbian-, gay-, and bisexual-parent

families in addition to other aspects of their identity which place them in a minority group.

The stress that lesbian, gay, and bisexual individuals experience due to being a member of a sexual minority has been understood as a type of "minority stress." Minority stress theory posits that people from stigmatized social categories experience negative life events and additional stress due to their minority status (Meyer, 1995, 2003). Meyer (2003) further described four different minority stress processes in lesbian, gay, and bisexual adults: experiences of prejudice; expectations of rejection or discrimination; hiding and concealing one's sexual orientation; and internalized homophobia, which is the process of turning societal negative attitudes toward oneself.

A secondary process that has been described is one of "microaggressions." Microaggressions are social or environmental, verbal and nonverbal, and intentional and unintentional brief assaults on minority individuals (Balsam, Molina, Beadnell, Simoni, & Walters, 2011; Sue et al., 2007). These microaggressions can take the form of microassaults, microinsults, and microinvalidation (Balsam et al., 2011). Whether or not they are intended as an aggression, children may witness or experience these types of transgressions toward lesbian, gay, and bisexual people as an assault on their parents, and secondarily on them.

Experiences of microaggressions may occur in a variety of settings and be very confusing for children and adolescents. They may experience anxiety for the safety and well-being of their parents, and subsequently for themselves. Parents in turn may have their own anxiety concerning the safety and well-being of their children. This anxiety may be expressed by maintaining a kind of hypervigilance around the child's interactions with adults and peers at school and in the community, with the hope of protecting them. It may be difficult for family members to consciously identify these microaggressions and therefore impede the ability of the family to discuss the overt and covert stress it creates for the family system.

An ongoing dialogue between parents and children that is developmentally attuned is important to help the communication between them around the child's experience of being raised in a "different" family structure than many of their peers, and the homophobia that may be misdirected toward them based on their parents' sexual orientation. Indeed, Gartrell, Deck, Rodas, Peyser, and Banks's (2005) longitudinal study of 78 lesbian-parent families with 10-year-old children found that 43% of the children in this study reported that they had experienced stigmatization due to their mother's sexual orientation.

Grade school and middle school years may be the hardest for children of lesbian, gay, and bisexual parents (Goldberg, 2010; Ray & Gregory, 2001). Children of lesbian, gay, and bisexual parents often lack a "group" at school who share a similar family structure and with whom they can identify, and for that reason, they may feel "different" themselves. During grade school, it is not unusual for children to be exposed to the stigma directed toward people who are identified as lesbian, gay, or bisexual. Children with lesbian, gay, or bisexual parents may be bullied due to the sexual orientation of their parents, and they may experience comments and jokes about nonheterosexual people as a personal affront, even when they are not directed specifically toward them or their families. Children of lesbian, gay, and bisexual parents may or may not share these comments or their experiences with their parents in order to protect their parents. Children often develop an early awareness of homophobia and the impact of stigmatization and discrimination on individuals, families, and communities (Goldberg, 2007).

In some cases, children are taught overtly or covertly either by their families, or from their experiences in school and with friends, or both, that it is not safe to talk openly to others about their family. Parents may choose to not "come out" at work, at their children's school, or in the community in which they are raising their children (Stein, Perrin, & Potter, 2002). Depending on the community in which they are raised, children may need to closely monitor what they say to friends and other adults about their lives. They learn that their safety may be dependent on the need to "hide" aspects of their family. This need to maintain secrecy can impact children's capacity to form trusting relationships where they can

openly explore different parts of themselves, and use these relationships to begin to separate from their parents.

Both family and friends can be important sources of support to buffer the children's experience of heterosexism. Based on her review of the literature, Goldberg (2010) concluded that both living in a community that was supportive, as well as having relationships with other children of lesbian, gay, and bisexual parents, can help children to feel "less vulnerable and alone" (p. 161). Goldberg (2010) also concluded what was helpful to adult children of lesbian, gay, and bisexual parents to cope effectively with heterosexism while they were growing up was open communication between parents and their children.

For lesbian, gay, and bisexual parents, having a close, positive, and meaningful connection with their children is associated with better mental health outcomes for the children (Golombok, 2000). For example, Bos and Gartrell (2010) found that although homophobic stigmatization can have a negative impact on the psychological well-being of lesbian-mother families, being raised by "loving, nurturing, supportive parents can counteract these detrimental effects" (p. 569). This finding is consistent with earlier data that showed that warm and supportive relationships between parents and their children, as well as children and their peers, may be protective for children, and may buffer them from the negative psychological consequences of real or perceived stigmatization (Bos & van Balen, 2008; Frosch & Mangelsdorf, 2001; Golombok, 2000). Close and loving relationship with one's parents through adolescence continues to have a positive influence on the well-being and healthy psychosocial development of children (Udell, Sandfort, Reitz, Bos, & Dekovic, 2010). It is also important to appreciate that undergoing stress can sometimes be a positive learning experience and lead to personal growth (Cox, Dewaele, van Houtte, & Vincke, 2011; Savin-Williams, 2008).

The developmental tasks of adolescence may bring new challenges for the children of lesbian, gay, and bisexual parents. Adolescents are often duly aware that their parents have been stigmatized for being a sexual minority, and that their own sexuality may reflect back on their parents. Based on societal prejudices, children of lesbian, gay, and bisexual parents may fear coming out as nonheterosexual themselves (Goldberg, 2010). Due to societal, peer, and developmental pressures and their desire to appear "normal," adolescents with lesbian, gay, and bisexual parents may remain more secretive with their peers about the nature of their family constellation (Perlesz et al., 2006). This secretiveness may cause them to isolate their parents away from their social worlds.

The parents' own experiences of coming out may make them more sensitive to openly discussing issues around gender and sexuality with their children and more supportive of their children's questions about sexuality (Mitchell, 1998). Although the parents may be open and accepting of their children exploring their sexuality, parents' anxiety and desire to protect their children from the stigmatization they had to deal with in their lives may complicate the messages they give their children about sexual orientation and gender expression (Bos & Gartrell, 2010).

As adults, children of lesbian, gay, and bisexual parents describe themselves as being more tolerant and open minded as a direct consequence of being raised by parents who were sexual minorities, and who socialized their children to appreciate differences (Goldberg, 2007). Additionally, they often feel that a consequence of being in a home where the parent's sexual orientation was openly discussed allowed them to think more deeply about their sexuality, and understand it more complexly (Goldberg, 2010). Further, as adolescents and adults, they often view themselves as more comfortable than children who were raised in heterosexual-parent homes to resist for themselves and others heteronormative expectations around gender and sexuality (Goldberg, 2007). An awareness of the factors that have contributed to the resilience and vulnerability in the lives of both the parents and their children will help the therapist to contextualize the issues they face and formulate a biopsychosocial treatment that takes into consideration their life course.

Core Considerations for Therapy

Each family will be unique, and the perspective of each adult and child should be taken into consideration by the therapist as one listens to the family narrative, and the narrative of each member of the family. A clinical evaluation should incorporate a standard method of assessment, formulation, and treatment planning. Since lesbian-, gay-, and bisexual-parent families are constructed in a multitude of ways, a family history should take this complexity into consideration. A developmental history of the child should include a history of conception, and the history of the individual's and couple's decision-making process around having a child, or how a new family constellation was constructed that differed from the child's family of origin.

Understanding what the child knows about his or her conception and how the family defines relationships within the nuclear family and the extended family, as well as understanding the relationship with an egg donor, sperm donor, or a gestational carrier, is important. Understanding the role of other significant adults involved in the life of the child is essential. All of these issues should be further contextualized if the child was adopted. The therapist should stay mindful of the fact that the definition of these relationships may not begin to capture the real or fantasized meaning of these relationships both for the child and for the parent(s).

Over time the therapist should inquire about how the child thinks about these varying relationships as well as the meaning of each of them to the child (Corbett, 2001). Whether the child is adopted or born with known or unknown donors into a lesbian-, gay-, or bisexual-parent family, the child's fantasies and yearnings about these people with whom they have biological ties may evolve and impact their relationships with those closest to them. It is not a reflection of the love the children have for the parents who are raising them, or their loyalty and devotion to them, but is rather a desire to know more about the people with whom they have biological ties. This desire will be different for every child and every family, but the clinician's awareness of this dynamic is important.

If transparency and the permission to talk about their biological origins does not exist between children and their parents, children may suppress their curiosity and desire to know more about these people. Foreclosing on the possibility of exploring this part of their heritage may impact both the child and the parents. In his description of a clinical case where this issue was relevant, Ken Corbett (2001) wrote:

> As opposed to their (parents') fears that their (child's) fantasies would prove over stimulating or separate them as a family, they were able to entertain the opposite—the possibility of minds opening onto and into their collective fantasies in such as a way as to bring them together in a family. (p. 610)

Helping the child speak to questions and feelings that emerge at different developmental stages about their biological origins can help the child to traverse normal developmental challenges without closing off access to real or imagined relationships. The ability of the family to openly discuss these complicated relationships may be helpful in the child's process of identity development (Ehrensaft, 2008).

Creating a therapeutic space which is safe for both the parent(s) and the child(ren) to share their individual narrative and the narrative of the family is essential. Each voice is important to understand how an individual's experience may be similar to and different from that of the other. The historical experiences of the parents, as well as the current experiences of the parents and the children in the community in which they live, should be considered during the evaluation and during the course of the treatment. The impact of internalized homophobia, stigma, shame, and heterosexism and microaggressions before, during, and after their "coming out" as lesbian, gay, or bisexual individuals may have implications for their parenting style.

The children's experiences of microaggressions, and overt and subtle experiences of homophobia and stigmatization at each developmental stage, may have implications for their ability to negotiate relationships inside the family with relationships outside of the family. The therapist should inquire about experiences of stigmatization and heterosexism and offer support

and psychoeducation. The therapist can help to separate out the parent's feelings and experiences from that of the child, and model for the parents how to discuss difficult issues with their children in a developmentally appropriate manner.

If the parents are able to manage their anxiety around heterosexism and stigma, the children are likely to feel more secure. They will be more likely to sense that the parents are willing and able to discuss experiences they are having both in the home and outside the home. By extension, if parents have difficulty with managing this anxiety, it may result in the children being more fearful and feeling that it is not permissible to discuss their worries with their parents or with others.

Young children may pick up on parents' feelings of anxiety but not have a context or the developmental capacity to understand the complex societal issues contributing to such anxiety (Telingator & Patterson, 2008). They may internalize the anxiety as being a communication of something negative about themselves, and as they get older it may result in feelings of shame and stigma similar to their parents and may impact the child's self-esteem (Fisher, Wallace, & Fenton, 2000). A child or adolescent's capacity and ability to discuss their experiences with others may be an important variable in maintaining self-esteem when dealing with some of these issues. Gershon, Tschann, and Jemerin (1999) found that adolescents with lesbian mothers who used social supports to help them to deal with homophobic stigmatization scored higher on self-esteem than adolescents who did not use such strategies. In this study, adolescents who practiced more disclosure about the sexual orientation of their parents even with high levels of perceived stigma had higher self-esteem about their ability to form close friendships.

Although parents may feel that discussing issues of homophobia and heterosexism that the child may face may not be in the child's best interest, the opposite may be true. Corbett (2001) wrote about the treatment of the son of a lesbian couple:

> We (therapist and parents) worked toward the understanding that, while we wish to protect our children from pain, anxiety, and hate, we are in fact helpless to stop those feelings from entering into our child's lives, and furthermore a life without pain and loss would be an impossibly distorted one. (p. 607)

The lesbian, gay, or bisexual parents may have experienced "hate" directed toward them or their community during the course of their lives. They may now need to help their children to live in a world where they may experience hate directed toward their parents, and may themselves experience discrimination.

It is important to gain an understanding of the community in which the family resides and appreciate the stressors the family faces. The therapist should identify individual relationships and places where the family members can talk freely about their lives and their family, and in what environments they feel that they must maintain secrecy due to fears for themselves and their family (Telingator & Patterson, 2008). An appreciation of how and where each member of the family has found support and experienced stigma is essential.

In the case of Melissa, she was born into a family with privilege, who were able to choose the school and community in which she was raised. Melissa was both comfortable with her parents' sexuality and was living in a community in which it was safe to be an adolescent with lesbian parents. Although it was a difficult process for Melissa to sort out her own sexuality from that of her parents, she was able to use her therapy to work through what she thought and felt were both parental and societal expectations of her sexuality, and to identify what her own attractions were to begin to explore this aspect of her identity.

Further, although Melissa's parents experienced anxiety about her well-being, they were living as "out" lesbians, and Robert and Zack were "out" to family, friends, at work, and in their community. They had support in the school, and were friends with other lesbian and gay families and in the community. Although the vignette did not highlight issues they had confronted in their own coming out processes, each of them had access to supportive communities, friends, and families to varying degrees from the time they were children. Each of them was able to access therapy to help with emotional distress which was interfering with functioning at different

points in each of their lives. Although they had not been able to address the anxiety and conflicts that had resulted in Melissa and her family to seek therapy, they were able to use the individual and family treatments to get back on track developmentally both as individuals and as a family. The level of family, school, and community support in this case was unusual. It is important for the clinician to stay mindful of the individual circumstances of each family they encounter, and to formulate a treatment plan that incorporates both their immediate and long term needs. Assessing the both the children's and the parent's safety in their community, and in work and school settings is essential.

The life of every family is embedded in a sociocultural framework that informs both the developmental life cycle of the parents, and the child. The societal constructs of what is "normal" and what is "not normal" are dictated by the majority. As our culture evolves and the impact of this evolution influences societal norms, we as a society will need to continue to learn how to incorporate people who are diverse in their gender expression and sexual orientation. This change over time is likely to have a positive impact on those who are part of a minority group, as well as the family members who may or may not be a part of that minority group. In the meantime, the freedom to discuss the impact of homophobia, stigma, and shame within one's family may help to improve their communication, strengthen family bonds, and ultimately strengthen the resilience of the child and the family. For the families who run into developmental challenges, therapists can ideally create a safe space in which to freely discuss these complex matters.

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