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ORIGINAL PAPER

Out of the Darkness: Three Waves of Family Research and the Emergence of Family Therapy for Lesbian and Gay People

Michael C. LaSala

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Abstract Like family relationships themselves, the history and treatment of lesbian and gay people and their families is complicated. For this paper, three waves of research on the families of gay and lesbian individuals are described. During the first wave, gay and lesbian sexual orientation was seen as a disease and family dynamics were blamed for its genesis. Subsequently in the second wave it was believed that, fearing rejection many gay and lesbian people either distanced or were rejected from their own families and established friendship networks that have been described as families of choice. More recently, in the third wave, the family has been identified as a resource for lesbian and gay youth whereby open relationships with parents can help protect them from mental illness, substance abuse, and HIV risk. Furthermore, an increasing number of same-sex couples are choosing to become parents, overcoming biological and social obstacles. In this article these shifting views of the role of family in the lives of lesbian and gay people will be described along with case material that illustrates the historic influences, current developments and future directions of family treatment for this population. To be maximally effective with gay and lesbian people and their families, clinical social workers and other mental health professionals must understand how family therapy has been influenced by a progression of ideas that continue to evolve. In this paper, research examining the role of the family in the lives of lesbian and gay people will be described in three waves; as a source of blame, to an impediment to gay and lesbian happiness and ultimately a resource that can enhance lesbian and gay well-being. The influences of research on family therapy with this population will be described and case examples will demonstrate how to harness the strengths of family relationships identified in the most recent wave.

Keywords Gay and lesbian families · Family therapy · HIV prevention · Children of same-sex couples · Gay and lesbian parents · Family research · Coming out · Gay and lesbian youth

M. C. LaSala (✉)
School of Social Work, Rutgers, The State University of New Jersey, 536 George Street, New Brunswick, NJ 08901, USA
e-mail: mlasala@ssw.rutgers.edu

Wave I: Blaming the Family

The idea that a gay or lesbian sexual orientation is a disease caused by family dysfunction was firmly entrenched in the field of psychiatry a little more than half a century ago and still influences the way many parents react when they first learn a son or daughter is gay or lesbian (LaSala 2010; Norton 1998). From the mid 1800s when the term "homosexual" was coined (Norton 1998) to the early 1970s, same-sex sexual behavior, including two people of the same sex dancing together, was criminalized and stigmatized in the US (Chauncey 1994). However, in the mid-twentieth century, psychiatry reconceptualized homosexuality as a disease, and the first substantive wave of family-related empirical and clinical literature addressing gay and lesbian persons concerned itself with its etiology, diagnosis, and cure (e.g., Apperson-Behrens and McAdoo 1968; Bieber et al. 1962; Loney 1973; O' Connor 1964; Socarides 1978; Thompson et al. 1973; West 1959). As a result of studies by investigators who surveyed psychoanalysts about their patients, a gay or lesbian child was thought to be the result of a toxic combination of an overbearing and close-binding mother and detached father (Bieber et al. 1962; Gundlach 1969; O' Connor 1964; West 1959). These studies were

flawed because investigators and clinicians biased by negative societal views over generalized from clinical samples (Hooker 1969). Further, even in studies of nonclinical samples (Apperson-Behrens and McAdoo 1968; Bene 1965; Evans 1969) concern with causative parental factors blinded investigators and therapists to the possibility that the association between problematic family relationships and a child having a gay sexual orientation was causal but in the opposite direction. For example, Isay (1989) postulated that a father who had taken on society's distaste for cross-gendered behavior would distance from his developing gay son, repelled by his feminine mannerisms. The boy's mother, worried about the father's remoteness, might compensate by establishing an especially close relationship with him. Thus the dynamics of a close-binding mother and distant father might not necessarily create a gay son but perhaps be *the result* of having a gay son, and these early investigators did not consider this possibility.

Although family dynamics were implicated in the cause of sexual orientation, and there are documented examples of mothers seeking treatment for their gay and lesbian children, such treatment consisted of aversion therapy, psychoanalytic or religiously oriented therapies designed to make a gay person straight (Acosta 1975; Haldeman 1991) and no examples of family therapy from this period could be found. Since 1974, being gay or lesbian is no longer considered a disease and subsequent findings have contradicted the notion that families of lesbian and gay people are more dysfunctional (Shavelson et al. 1980; Siegelman 1974, 1981). Nevertheless, these outdated ideas linger. Until the late 1980s, two prominent family therapists, Murray Bowen and Michael Kerr, promulgated the family dysfunction-disease model of sexual orientation (Kerr and Bowen 1988). Further therapists who still practice reparative or conversion therapy to change a person's gay sexual orientation, despite widespread acknowledgment that it is ineffective and unethical (Blackwell 2008; Maccio 2011, Serovich et al. 2012; Shidlo and Schroeder 2002), focus on the distant father-son relationship and may even include the father in therapy (Borowich 2008; Nicolosi 2009). Additionally, leftover notions of blaming the family are likely to be at the root of parents' guilt when they learn their child is lesbian or gay (LaSala 2010). Thus old notions from this wave of research still wield influence.

Wave II: Avoiding the Family

The second wave of research and theory, which occurred from the 1970s to the early 90s viewed the family as an obstacle to gay and lesbian happiness Findings among presumably heterosexual samples have long indicated that having a supportive network of family and friends has a positive impact on one's mental and/or physical health (Birditt and Antonucci 2007; Cohen and Wills 1985; Levitt et al. 1992; Sarason et al.1990) and buffers the stresses of illness, divorce, aging, single parenthood, and discrimination, (DeGarmo and Martinez 2006; DeGarmo et al. 2008; Gladow and Ray 1986; Koopman et al. 1998; Lin et al. 1985). Further, heterosexual couples are known to receive considerable emotional and financial support from their families (Birditt and Antonucci 2007; Eggeben 2005; Kurdek 2005; Leopold and Schneider 2011; Levitt et al. 1992) and, not surprisingly such support is beneficial to their relationships.

In contrast, during the second wave of research on gays, lesbians, and their families, findings suggested that they mostly cut off ties with their families, either because they had been rejected or sought to avoid the inherent stresses of coming out (Harry 1988; Weinberg 1972). Weston (1991) coined the term *families of choice* to describe friendship networks of lesbians and gay men, and a body of research suggested that friends, rather than family were their primary sources of social support (Blumstein and Schwartz 1983; Griffith 1985; Kimmel and Sang 1995; Kurdek and Schmitt 1987; Tully 1989). This may explain why examples of family therapy with gay and lesbian individuals and their families of origin were scarce during this time (Clark and Serovich 1997; Ussher 1991).

Nevertheless, a small number of findings during this period foreshadowed a shift in perception of the role of family for this population. Studies began to emerge suggesting that family support, when available, may be more helpful to same-sex couples than that of friends (Caron and Ulin 1997; Smith and Brown 1997). Such findings called into question the idea that a network of friends could make up for a lack of family support and also laid the groundwork for the consideration of the family as a resource

Wave III: The Family as a Resource

From the start of the new millennium to the present, gay and lesbian people along with the empiricists and therapists who study and address their needs began to see the family as a resource rather than a source of blame or an avoided obstacle, and this perspective informs the third wave of family-oriented research for lesbian and gay individuals. Due to increasing societal tolerance young people are now realizing and disclosing their sexual orientations at progressively younger ages, often in their mid to late teens while still financially and emotionally dependent on their parents (LaSala 2010; Stone Fish and Harvey 2005; Wilber et al. 2006). There is strong evidence that out gay and lesbian youth with supportive parental relationships are less likely to experience mental health and substance abuse problems than those who are not out or whose parents are

rejecting (Eisenberg and Resnick 2006; Needham and Austin 2010; Ryan et al. 2010). In addition, family rejection may lead to high-risk sexual behavior (Ryan et al. 2009) and family connectedness may be linked to staying HIV negative (Garofalo et al. 2008; LaSala 2007).

Nevertheless, despite recent progress, societal stigma still inflicts damage on the well-being of lesbian and gay youth (Coker et al. 2010; Needham and Austin 2010; Wright and Perry 2006) and too many are still ejected from their homes by parents who will not or cannot accept them (Ryan et al. 2010). Thus it is no wonder that the biggest fear of many children who have yet to come out is that they will be rejected by their families.

The evidence that youth are currently coming out at younger ages and that family support may shield them from societal stigma means that clinical social workers and family therapists must be ready to assist these families when things go awry. When parents first discover a child is gay, they often feel guilty, the likely residue of the disproven first wave notion that parent–child dynamics make a child gay or lesbian (LaSala 2010). They might mourn the previously perceived heterosexual image of their son or daughter. Parents may also become anxious for the child's well-being, worrying that a happy life is now out of their children's reach. Meanwhile, the child who is coming out seeks support, acceptance, and the parents' ongoing unconditional love (LaSala 2010). Thus the therapist's task is to help family members reconcile their separate but related needs in a way that leads to parental adjustment and honest connection. Because these needs can be disguised by distance or conflict, the therapist must reach below the surface to get the family members to acknowledge and communicate their fears and hopes. Family therapy with its focus on assessing and modifying relationships and interaction patterns is ideally suited to achieve these aims.

The Third Wave and Family Therapy

Structural family therapy and more specifically the techniques of *enactment* and *reframing* (Minuchin and Fishman 1981; Nichols 2013) can be especially useful in accessing the potential resources of these families identified in the third wave of research. Enactment is a technique common to most empirically supported models of family therapy during which the practitioner encourages family members to communicate to each other in his or her presence so that interaction patterns can be targeted for assessment and modification (Johnson 1996; Nichols 2013). Family members are directed to talk to each other, and the therapist observes and evaluates their interactions, and then coaches members to replace unhelpful communication patterns with those that are functional and productive.

When family interaction consists of accusations, angry attacks, or emotional shut downs, as it often does for families of coming out lesbians and gays, the family therapy technique of *reframing* is a way of recasting an interaction to make it more amenable to therapeutic modification (Nichols 2013). As a wise mother of a lesbian once told me, parents want their children to be happy, healthy, and safe—and I would add, connected to the family while children want their parents to be proud of them and love them unconditionally. This family folk wisdom is born out in the research and clinical literature on families of gay and lesbian youth (LaSala 2010: Stone Fish and Harvey 2005). Parents struggling with the child's coming out may raise their concerns in an angry, anxious way that can engender the child's defensiveness. Thus reframing such interactions and coaching parents and lesbian and gay children to communicate less combatively and more authentically is particularly useful for these families. The following case material demonstrates how reframing and enactment can access parents' underlying worries about their children along with the child's wishes for unconditional love and acceptance.

Marie, Jared, and Steve

Marie, a 45 year-old nurse and married mother of two sons, Jared, 19, a college student, and Cal, 25 an engineer who lived out of state, called the therapist after she found out that Jared was gay. During the intake she anxiously described how she still loved Jared but was having difficulty coping with the news. She was also troubled by her husband Steve's distant silence since Jared's disclosure. Steve, a police officer, had spent several years in the military and was described by friends and family as a "tough" guy who frequently stated that he did not believe in therapy which, Marie explained, was why he would not accompany her to the first session. Initially, separate sessions were held with Jared and Marie. Jared was not experiencing symptoms and relied on a network of friends and teachers for support but was impatient for his parents to adjust. Marie needed help to resolve her guilt and fear that she had "lost" her son—or at least the one she knew. After three sessions of individual counseling and education she was able to see that her son's gay sexual orientation was not her fault, that Jared was still the same bright young man she raised and loved, but that she now knew more about him. The therapist then believed the family was now ready for a conjoint session. When the therapist held what Marie had reframed as a family "meeting" as opposed to "therapy" Steve succumbed to her urging and joined the family.

> Therapist: I know I invited you all here, but what is it that you think would be a good idea to discuss as a family?

Marie: Well I know you and I have talked but something still bothers me. Jared told us he was gay, but how does he know this is not a phase? Something he will grow out of?
Jared: Oh Mom! What are you talking about? I have known about myself since I was 4!
Marie: But he is so young and he is making such a big change, how can he be sure?
Jared: Jesus, you are so ignorant Mom!
Therapist: Wait a second! Let's slow things down a bit. I can see that you are both pretty upset here. But I want to hear from each of you, so you first Marie. If I read between the lines I can see how worried you are about your son. So, tell me what's your biggest worry for him?

Marie's expression of anxious doubt leaves Jared feeling invalidated. So the therapist stops the action to reframe Marie's nervous uncertainly as deep concern. This reframe gives Marie an opportunity to discuss her fears in a softer way that will engender less defensiveness from Jared.

Marie: I am worried that he is making a big decision that will affect him the rest of his life. And it's a much harder life being gay.
Therapist: So I can see you care deeply that your son has a happy life and you're worried that he won't. Does he know this?
Jared: (Rolling his eyes) She really doesn't know anything. Mom just because I am gay doesn't mean I can't be happy. Many gay people are really happy. Why are you so ignorant?
Therapist: Hold on. I hear you really want your mother to understand what being gay is about but she doesn't know a lot. What makes that a problem for you? How would it be better for you if she knew more about gay people?

Here the therapist reaches beneath Jared's anger to identify what he is truly seeking—Mom's support.

Jared: Well, she is my Mom—I need her on my side. I am glad she and Dad didn't throw me out of the house like my friend Tyler's parents did, but I want them to understand me.
Therapist: (To the parents). Can you both understand this? It is very important (They look a bit surprised but also nod). (To Jared) I am wondering if there is a way to help Mom understand better, knowing she is worried for your happiness. Can you reassure her that you will be ok?
Jared: How can she not know this? It is 2012—after all!
Therapist: Well yes, but she needs your help to understand you are ok and going to be ok. Can you do it? Reassure her?

Now that the deeper feelings are brought to the surface, the therapist prescribes an enactment, or a chance for the dyad to discuss these issues in a way that is less combative and more healing

Jared: (After a long pause, he looks at his mother.) Mom it's not something I chose, it's who I am. Many gay people are happy. You just don't know any gay people so you don't know this is true.
Therapist: I think you are probably right about Mom. It is not uncommon for straight people not to know many openly gay people so they don't know what's possible. Maybe she needs time to get used to the idea and also to get to know some gay people, maybe even meet some of your friends.
Marie: Well, you are right about that, I really don't know anyone who is gay.
Therapist: I am guessing you probably do but don't know it. Mom, maybe it's time you got to know some openly gay people—to get an idea of what kind of life is possible for gay men.
Marie: Perhaps you are right—I am still learning all about this and I need some time.
Therapist: Jared, are you willing to be patient as Mom adjusts and learns more about gay people?
Jared: I guess so.

The reframing enables Jared and Marie to have a more personal, productive conversation. Next the therapist turns to Steve and Jared.

Therapist: Dad, I hear you have concerns about your son's safety also?
Jared: Yes, all he thinks about is the sex part
Steve: I think that's disgusting, what two men do to each other. I can't help it. I can't believe that's what you want to do!
Jared: Dad! Jeez. (Turning to the therapist) I am not going to discuss this with him.
Therapist: Ok, ok, I get it. I can certainly see why it is uncomfortable to discuss sex with Dad. But Dad, I hear that you are worried that somehow your son is going to be hurt in some way—or taken advantage of. Is that true?

Again, Dad's apparent revulsion over sex between men is reframed as worry for his son.

Steve: Yes, but I also just don't understand how he could want to do that.
Therapist: Yes, other people's sexual interests can be mysterious…hard to understand. You may never fully understand your son's sexual feelings. But tell me- how did you first learn what two men do sexually?
Steve: What do you mean?

Therapist: Often what men do in bed is learned on the school yard or in the locker room or is scrawled on public bathroom walls and seems degrading, dirty, or violent in some way, right?
Steve: I guess so.
Therapist: So it must be hard to understand that men would do these things for enjoyment or to express love or affection, no?
Steve: Hmmm…I never thought of it that way.
Therapist: Can you express to your son, right now, some of your worries for his safety and well-being—in a different way that he can hear better?
Steve: Son, I just have a hard time understanding how you could want to be with guys—and I also don't want you to get hurt. I'm worried about you.
Jared: I know Dad, but really, I have been attracted to other guys for as long as I can remember…and (softly) I can take care of myself.

In this brief example the clinician assessed family members' interactions and reached below their angry, defensive emotional expressions to uncover their hidden undercurrents of worry, fear, and wishes for love. As a result of this reframing, the family is better able to have honest dialogues about their worries and needs. As it turns out, one of Steve's primary concerns around gay male sex was the risk for HIV which is addressed in the next section.

Family-Based HIV Prevention for Young Gay Males

Another way the family can be a resource is the role it can play in the prevention of HIV, and exploration of this area has begun during this third wave of family research. Men who have sex with men (MSM) are estimated to be 5 % of the population but make up over 50 % of all HIV cases in the US (Kaiser Foundation 2010). Despite considerable efforts by HIV prevention specialists, young gay men are all too frequently engaging in risky sexual activities (Hall et al. 2007; Moyer et al. 2007) which explains why HIV infection among young gay men is rising at 12 % per year (Centers for Disease Control 2010).

Family support, open family discussion of sexuality, close parent–child relationships, directive parent communication, and parental monitoring are associated with consistent, low-risk sexual behavior among heterosexual youth (Borowski et al. 2003; Donenberg and Pao 2005; Voisin 2002; Wilson and Donenberg 2004). Several effective HIV prevention programs targeting heterosexual youth engage families in their efforts (Dilorio et al. 2006; Dittus et al. 2004; McKay et al. 2004; Pequegnat and Bell 2012). Nevertheless, up until recently, the extant literature has been largely silent on the role of the family in HIV prevention for gay youth perhaps because of the lingering idea that gay men are either rejected by or detached from their families of origin

Investigators have identified important risk factors associated with incidents of unsafe sex among gay youth including drug and alcohol use (Diaz et al. 1996; Koblin et al. 2000; Meyer and Dean 1995), and mental health problems, (Meyer and Dean 1995, Myers et al. 2003). As stated previously, strong parental relationships can protect gay youth against mental health and substance abuse problems, and such protection in turn might influence them to avoid unsafe sexual behavior. In addition, family rejection may be related to high-risk sexual behavior (Ryan et al. 2009) and family connectedness may be associated with being HIV negative (Garofalo et al. 2008) as young gay males who are close to their parents may feel obligated to stay healthy and avoid unsafe sex (LaSala 2007). Further, family discussions may influence young gay men to avoid unsafe sex (Yoshikawa et al. 2004). Thus, now is the time to harness the previously overlooked role of family influence in HIV-prevention for gay youth.

Preliminary findings from a study in-progress of young gay men and their parents suggest why families might avoid discussing this topic (LaSala 2012). Parents may fear invading their children's privacy and also believe they lack the knowledge and skills to discuss HIV. Sons, sensing their parents' reluctance might collude by remaining silent about this topic. However, in this study once children and parents were prompted to speak to each other about HIV risk and safer sex, they managed to overcome these barriers. Children asked parents to supply them with condoms and parents become reassured that their children were consistently using them (LaSala 2012).

These findings have implications for HIV prevention and family therapy. The therapist's task is to get the family to discuss this difficult issue in a way that addresses parental fears and the child's need to be seen as competent. As demonstrated below with Jared, Marie, and Steve, the family therapy technique of enactment is particularly well suited to push reluctant families to broach this difficult topic, and reframing can be used to keep members focused on their fears and wishes for love and connection.

Marie: One of the things I worry about is Jared's safety and well-being.
Therapist: OK. Tell me, what are your biggest concerns?
Maries: One of my big worries is that he will get HIV.
Steve: Yes, me too. Even though people aren't dying so quickly now, AIDS is still a fatal disease.
Jared: (Remains silent)
Therapist: So, what do you all know about HIV and how gay men get it?

Marie: I know you can get it from semen and blood. You should use condoms and be in a monogamous relationship to avoid getting it.
Steve: Yeah, and he's so young, I worry someone could take advantage of him. Also, we have all been his age … it's easy to lose your head in the heat of the moment. (Turning to his son) You know I don't understand this stuff son, but you should use condoms every time, every single time! No exceptions! This is something that can kill you. You hear me?
Jared: (Eye rolling): You guys, I know all of that. I am not stupid, ya' know!

Jared's parents' express their concerns in a preachy way that sells short his ability to care for himself so he reacts defensively. The therapist interrupts the interaction using reframing to identify the parents' concerns but also underscore Jared's competence.

Therapist: Jared, I heard you try to tell your folks that you know how to keep yourself safe, but with some irritation in your voice. What are they not getting? Can you explain it to them? Can you do it in a way that shows you can take care of yourself but that also reassures them?
Jared: They don't get that I know this stuff.
Therapist: I can see that but can you try to reassure them? Right now? Give it a try.
Jared: (In a softer tone). Mom, Dad, I am not stupid or crazy. I don't want to get sick. I learned all that stuff in health class and I always have condoms with me when I go out. I'll be ok.
Marie: Well OK, we know you are not stupid but we are your parents and it is kind of our job to worry about you (laughs softly).

In light of the third wave of research on family support and HIV prevention, it is worthwhile to explore ways that parents can assist their sons to stay safe. Note, if parents feel they have some influence over the situation, they might be less anxious.

Therapist: Is there some way perhaps your parents can help you stay safe?
Marie: You don't want us to buy you condoms, do you? Wouldn't you find that embarrassing?
Jared: Well (long pause) that would be ok. Condoms are expensive. Eric's parents buy them.
Marie: Really …? Well, OK, I am happy to do that. Now that we are talking about this … I always wondered, have you ever been tested?
Jared: I have been tested once and was negative … but it would be ok if you reminded me once in a while. That would be ok.
Steve: Really?
Jared: Yeah, sure.

Harnessing the power of the family to prevent unsafe sex among gay youth might simply be a matter of getting parents and sons to talk to each other, and coaching them to avoid angry, defensive, invalidating responses or emotional shut downs. As we await additional findings that explicate the role of parent–child communication in HIV prevention for gay youth, getting these families to productively discuss this difficult but important topic is a good place to start.

Gay and Lesbian Parents Raising Children

Another way the family is a resource for gay and lesbian individuals is that it is increasingly a context for same sex couples to conceive and raise children, and this is another area addressed in the third and most recent wave of family research. It is estimated that there are 115,000 same sex households with children in the US (US Census 2011) and this number is expected to grow. Repeated studies reveal that children raised by same sex couples are similar in intellectual and emotional development to those reared by heterosexual parents (Bos and Gartrell 2010; Tasker 2005). However, these children may face stigmatization due to their parents' sexual orientation (Bos and Gartrell 2010; Tasker 2005).

Having parents who are active in the gay community may render children less vulnerable to the impacts of stigma (Bos and Gartrell 2010). In addition, some findings suggest that gay parents can prepare their children by having open discussions with them about how to cope with heterosexism and homophobia (Litovich and Lanhout 2004; Stein et al. 2004).

Although gay men and lesbians are clearly capable of raising healthy children, such families will seek professional assistance when problems arise. Although the challenges faced by these families are distinctive from families like Jared's, enactment can give parents and their children the opportunity to discuss stigma and coping, and reframing can keep discussions focused and fruitful.

Margie, Joanie, and Sophie

Margie, a teacher and Joanie, a college administrator, had been together 20 years and conceived their daughter Sophie, now 13, through alternative insemination. Sophie was brought to therapy because she had suddenly become withdrawn and sad. She had just entered high school and found herself being teased. Joanie and Margie were initially unsure why, but they had their suspicions. Once again, the therapist used reframing and enactment but in a somewhat different manner than in the previous cases.

Therapist: I understand that Sophie is having difficulties coping with the teasing from other children.

Margie: Yes, she complained that the kids call her names. At first she didn't want to tell us.
Therapist to Sophie: I know it might be embarrassing to talk about, but can you tell me what it is they call you?
Sophie: Well um, err…..
Therapist: It's ok, Sophie, I was picked on as a kid myself and I was called awful things and it was hard for me to talk about it as well. But can you give it a try?
Margie: Yes, sweetheart, it's ok. Whatever it is, we have heard it all before.
Sophie: Yes…ok….well … they call me gay and lezzie. They think because my Moms are gay that I must be too, but I am not. (Sophie looks anxiously at her parents.)

Being bullied in school is a shattering experience (Juvonen and Graham 2001). Children are ashamed to discuss the nature of their bullying so they attempt to hide it particularly if they believe they must protect their parents from their peers' cruelty, as was the case for Sophie. Thus, such disclosures must be handled with gentle sensitivity, which was not what Joanie did, at least initially.

Joanie: Yes, but those other kids are ignorant idiots! Don't pay them any mind. Jesus Christ, I can't believe we still have to deal with this bullshit!
Therapist: Wait a second, I agree. It is really lousy that in 2012 we still have to deal with this… But let's just take a moment, take a deep breath and figure out how Sophie feels.

The teasing Sophie received is fueled by the persistent belief that parents make their children gay, either through poor parenting or being gay themselves, and the latter idea had been used in the past to deny parenting rights to lesbians and gays. So it is no wonder a mother like Joanie would feel defensive. Secondly, mothers in general are prone to guilt (Rotkirch and Janhunen 2009; Seagram and Daniluk 2002), and this tendency is no doubt attenuated when their children are being victimized because of something about themselves. Finally, lesbians like Margie and Joanie have been out for so long that they may be accustomed to emotionally insulating themselves from the reactions of others and perhaps have forgotten what it first felt like to be on the receiving end of people's prejudices and thus what it must be like for Sophie. Joanie initially has difficulty seeing beyond her own anger to recognize Sophie's needs.

Therapist: Sophie needs your help. To better understand her feelings, can either of you reflect back to what this might feel like for her? Margie, look at your daughter and tell her what you heard her say about how she is feeling.
Margie: Sweetie, I know you are upset
Sophie: (Staring at the floor) No, no it's ok.
Margie: No, it's not OK. I get it. It's not easy. I know that.
Therapist: Do either of you have experience with the kind of treatment Sophie is experiencing?
Margie: I didn't have trouble in school, but just the other day when I was crossing the street by the university, a carload of girls screamed out: "Move your ass out of the way, dyke!"
Joanie: Really? You never told me about this!
Margie: I know but you get so worked up about this kind of thing, I didn't want to upset you.
Therapist: There seems to be a lot of protecting going on in this family. It is great when people want to protect those they love, but it is also important to talk honestly and try to listen to each other so they can understand and offer help. Joanie, what have your experiences with this kind of thing been like–with homophobia and the stuff Sophie and Margie have been dealing with?

Here the therapist reframes the issue of keeping secrets in a way that underscores the family's love and caring but that is also problematic, which in turn lays the groundwork for a more productive discussion.

Joanie: This is kinda' tough for me because it reminds me of the kids who gave me a hard time in school when I was younger.
Therapist: Really? How so? Can you talk about it a bit more? I know this is probably painful to talk about, but it might help Sophie to learn about your experiences so she feels less alone.
Joanie: It was real bad when I became a teenager and could no longer pass myself off as a tomboy. They called me names like bull dyke and pushed me around in the halls.
Therapist: Wow, those memories sound painful. How did you get through those times?
Joanie: Ha! I learned to fight. And when I couldn't fight I would walk away, keep my head down and keep a low profile. I also found a group of outcast kids like myself to hang out with—you know, Goth types. I knew that one day high school would end and I would never have to deal with those jerks again. I feel like having a good life with Margie and Sophie is my way to get back at them and the rest of the homophobic losers in this world.
Therapist: There are no easy solutions to homophobia, discrimination, and bullying, we all know this and we each have to find our way through it, but I am willing to bet Sophie can learn from your experiences. I wonder what you learned–borrowing from

the wisdom you gained during those times, that you can now teach Sophie as she is coping with the kids in school.

Following this interchange, the therapist proceeded to coach the family to have a discussion about Sophie's feelings as well as how to cope with homophobia. After several such sessions, Sophie began to feel less sad and more supported as she and her family brainstormed ways she could deal with the bullies. Joanie, Margie, and the therapist approached the principal at Sophie's school to alert her to the problem of homophobic bullying in the school and as a result, a gay, straight alliance (GSA) was established and gay and lesbian concerns were added to the already established diversity training assemblies for the students. On the therapist's recommendation, the family also reached out to COLAGE (www.colage.org), a national organization that supports kids with gay and lesbian parents.

Conclusion

Three waves of family research have ultimately led to the realization that the family can be a resource for gay and lesbian individuals whose benefits can be harnessed through family therapy. It is worth noting that models of family therapy for this population that incorporate not only structural but Bowenian and strategic techniques have been explicated (LaSala 2010; Stone Fish and Harvey 2005). However, as of this writing there are no known therapy techniques or models of family therapy for gay and lesbian families that have been empirically validated. Randomized controlled trials, the gold standard of intervention development, must be undertaken to identify what interventions are most effective for these families, and hopefully such research will occur in subsequent waves of empirical investigation.

Comparative information is needed about families of diverse races and ethnicities as some of the challenges and clinical needs of various groups differ from those of their white, European-descended counterparts (LaSala 2010; LaSala and Frierson 2012; Poon and Ho 2008). In addition the clinical and empirical focus on gay and lesbian youth and their parents has overshadowed the needs of their siblings, who may share in the stigma faced by their gay brothers and lesbian sisters (Gottlieb 2005; LaSala 2010). More knowledge is needed to flesh out how to address their feelings and experiences in therapy.

Increasingly, youth with same-sex attractions are eschewing labels of gay and straight instead stating "I love who I love" (Savin-Williams 2005). Furthermore, there is good reason to believe, that sexual orientation particularly for women, is more fluid than what had been previously believed (Diamond 2008). Thus, the next wave of family therapy theory and research may need to encompass the needs of families with members who do not commit to one sexual orientation, and help families understand and support their loved ones' sexual and relationship choices, whatever they may be.

The troubling historical view of the family as cause for the "disease of homosexuality" no doubt is to blame for parents' guilt, the persistence of family-based conversion or reparative therapies as well as the widespread and persistent belief that acceptance of gay and lesbian people is incompatible with family life. It behooves clinical social workers to become students of the issues these families face around guilt shame, worry, protection, fear of rejection, and the need for unconditional love. As society's views and attitudes on issues such as same-sex marriage, parenthood, and civil rights for lesbians and gay men evolve, clinical social workers, family therapists and the investigators who inform them need to not only develop family therapy models that respond to this progress but also build knowledge that leads its onward, inevitable march forward.

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Author Biography

Dr. LaSala is MSW program director and associate professor at Rutgers University and has practiced psychotherapy for 30 years. His work can be found in his book: *Coming Out, Coming Home* and numerous academic journals. Dr. LaSala speaks internationally on LGBT clinical issues and maintains a blog for *Psychology Today*.