THERAPY WITH LESBIAN AND GAY PARENTS AND THEIR CHILDREN

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This article explores some of the social and clinical issues facing the many different kinds of gay and lesbian families that are becoming increasingly visible in the United States. Research findings are discussed that dispel popularly held myths and stereotypes concerning these families, gays and lesbians as parents, and their children. Clinical vignettes are presented to illustrate issues often encountered in the consulting room, some unique to gay and lesbian families and some common to all families.

In Boulder, Colorado, John arrived in the park with his 3-week-old daughter Susan. He sat down on a bench next to a woman and her baby and said hello. The woman said, “What a lovely baby.” She then looked at John and added, “How nice of you to take care of her. Is your wife taking some time off?” John debated whether to tell her that he and his lover Paul had just adopted the infant. This was not the first time in his short parenting career that he had been confronted with the world’s assumptions about parenting roles—assumptions that did not include gay men as fathers.

Deborah and Pam, who had been partners for 12 years, invited three of their four sons to go to the movies with them. Throughout their relationship, they had been the main parents to four sons, all of whom had been conceived in previous marriages. On their way to the film, their 17-year-old son turned to them and said with a twinkle in his eye, “Here we are. A typical Berkeley, California, family.” Everybody laughed. It had taken a long time for them to be able to have fun with this issue.

Many such lesbian and gay families are found throughout the United States, and national estimates range anywhere from two to eight million families raising three to 14 million children (Lowry, 1999). However, it is difficult to obtain an accurate count of these families and their children for a variety of reasons. For example, though these families are sometimes more easily observed in major cities where it is safer to be “out,” many lesbians and gay men have chosen to remain invisible due to the pernicious effects of discrimination, which can result in loss of employment, loss of child custody, ostracism, or antigay violence. In addition, some individuals are ambivalent or yet unaware of their homosexuality and therefore are not counted as part of lesbian and gay families. The 1998 California Republican senatorial candidate, Michael Huffington, for example, publicly announced that he is gay. Was his family a heterosexual family before the announcement? Is it now a gay family? Finally, a census of lesbian and gay families is complicated by the existence of bisexual or transgendered parents (e.g., how would a family with a bisexual parent be classified?).

Gay and lesbian parents are frequently perceived to be less stable psychologically than their heterosexual peers and to be too involved in their relationships to nurture their children appropriately. Physical custody and the right to make decisions for their children can be taken away from them in courts because they do not fit into conventional ideas of parenting, regardless of whether they are effective and caring adults. For example, a Florida court removed a child from the custody of her biological mother because the mother was a lesbian. In this case, custody was awarded to the child’s father, a man convicted of murdering his first wife. The case was under appeal when the biological mother suddenly died (Ward v. Ward, 1996).

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Legal issues pertaining to children are even more troublesome for gay men because of the commonly held beliefs that men are not as nurturing as women or that gay men, in particular, are more involved in promiscuous sex or are more apt to sexually abuse their children. None of these beliefs has any basis in research or systematic knowledge; as a matter of fact, wherever data are available, they suggested quite the opposite.

DIFFERENT FAMILY CONFIGURATIONS

Contrary to commonly held assumptions, there is no such thing as the typical gay or lesbian family. This idea belies the many ways in which these families have been created and the issues they face. As Stacey (1996, pp. 107–108) states, “Gay and lesbian families come in different sizes, shapes, ethnicities, races, religions, resources, creeds, and quirks, and even engage in diverse sexual practices. The more one attempts to arrive at a coherent, defensible sorting principle, the more evident it becomes that the category ‘gay and lesbian family’ signals nothing so much as the consequential social fact of widespread, institutionalized homophobia.”

It is valuable for clinicians, however, to become aware of two general groups of lesbian and gay families that have emerged in the latter half of the twentieth century. The first group came about as individuals in heterosexual couples began to discover or admit their homosexuality, which had not only been hidden to others but sometimes to themselves. As this awareness emerged, marriages were reevaluated and often ended in divorce, raising questions concerning child custody arrangements, spousal support, and the well-being of the children (Bigner, 1996; Bozett, 1987, 1989; Gottman, 1990).

More recently, a second group has emerged. It includes the increasing number of families created within the context of already-existing openly gay and lesbian lives. Many couples or single people are choosing to raise children conceived through various methods. They struggle with complex questions associated with insemination and, less frequently, surrogacy, and the question of parenting arrangements subsequent to it (e.g., who will be the biological parent of the child in a couple and what role—legal and emotional—will the nonbiological partner assume?). Lesbians need to decide if they want the fathers of their children to have equal custody, rights, and responsibilities or if they are willing to have limited rights and engagement. For example, arrangements must be made with the donor regarding whether he will be recognized as the child’s parent, if he will be identified only when the child reaches adulthood, or if he will remain an anonymous sperm donor. Gay men who choose to build a family through insemination or surrogacy also face questions concerning the roles and responsibilities of all involved. In some cases, lesbian and gay men create coparenting teams. This can involve two, three, or four parents, depending on partnerships.

Adoption is another route for both gays and lesbians who cannot or choose not to rear a biological child. These parents also confront many difficult issues. Adoption by lesbians and gay men is allowed in fewer than half the states in the United States (American Civil Liberties Union [ACLU], 1997). People thus either need to hide their sexual orientation and adopt initially as single parents or fight the effects of homophobia in order to try and gain parental rights or second-parent adoptions in courts. This is true with all kinds of adoptions, open or closed, foreign or domestic. In addition, decisions must be made about finding a newborn versus an older foster child, as well as whether to accept a child with special needs (e.g., children with physical and/or mental disabilities, children of alcoholic or drug-addicted biological parents, and HIV-infected children). These children are frequently the only ones made available by agencies to people who are open about their homosexuality.

The particular way in which each lesbian or gay family creates itself brings with it unique issues, pressures, and concerns. Literature pertaining to the legal, social, psychological, interpersonal, and counseling issues encountered on the different pathways to lesbian and gay parenthood has been growing (Benkov, 1994; Green, 1999; Kirkpatrick, 1996; Laird & Green, 1996; Martin, 1993; Patterson & Chan, 1996; Pies, 1985; Schulpenberg, 1985).

As mentioned above, gay or lesbian stepfamilies that are created after the divorce of a heterosexual couple are an example of one of these path ways. They encounter two potential sets of challenges and pressures. The first set concerns the usual problems facing any stepfamily; What are the loyalties to the
biological parents? What are they toward the stepparents? How will custody be arranged? What will the financial arrangements be? What is the coparenting relationship between the two divorcing parents? How are decisions made? How are conflicts resolved?

The second set of challenges concerns the issue of homosexuality in the context of the stepfamily. Depending on the age of the children involved, how and when to tell them about same-sex relationships becomes important to their well-being as does the question of how to help them deal with the effect of this knowledge on their lives outside of the family. If the children are young, adjustment to this new life can happen fairly easily over time. If they are older, the consequences can be quite profound because of the possibility of an already-established homophobic attitude or a fear of how they will be accepted in the world. Teenage children have to decide whether they will tell selective friends about their family or bring friends home where their parents’ orientation might be discovered.

Other influences also affect the adjustment of the new family, sometimes positively and sometimes negatively. How supportive is the heterosexual former spouse? How comfortable with his or her own sexual orientation is the gay or lesbian partner? What is the attitude toward children of the lesbian or gay parent’s new partner and the former spouse’s new partner, if there is one? Do the adults share their definition of family and parenting with the children or is it kept secret? How much communication is there in general between the biological parents, and how safe do the children feel to talk to either or both parents? How is the extended family involved? Should extended family members be told, and how supportive will they be? Is there a community of similar families available in their geographical area? How will the schools react? Intervened into the complex fabric of the stepfamily is the underlying fear and occasional experience of social prejudice and oppression, which have a persistent influence on individual and family tension.

Another issue raised in family therapy and in the courts is the issue of child custody when gay or lesbian relationships end, whether in conflict or through mutual agreement. Few legal precedents exist to guide solutions for legal dilemmas. When gay or lesbian couples with children separate, there are few legal protections for the nonbiological parent. Since the couple is not legally a "couple," one parent often has rights that the other does not possess. In acrimonious breakups, children can be used in a struggle for power between the biological parent and the nonbiological parent. Also, when formal marriages break up, the heterosexual parent can sue for child custody in order to protect the children from the homosexual parent and his or her "lifestyle."

In cases in which a lesbian couple has decided to have a baby, there is always the issue of the custodial rights of the biological father, whether he is a friend, an acquaintance, or an unknown sperm donor. Laws governing legal paternity differ from state to state. In California, for example, legal paternity is created if a woman is inseminated outside of a physician's office, while it is not established if insemination is performed by a licensed physician. Often, prospective lesbian parents create detailed documents outlining custody issues, visitation issues, and other issues concerning the donor. The legal validity of these documents, however, varies.

Lesbian and gay couples who have adopted children face additional problems. If there has been a second-parent adoption (possible in more than half of the states), then child-custody issues following the dissolution of a relationship take into consideration two legal parents. If second-parent adoption has not been accomplished or completed, then only one parent is considered a legal parent—a situation often rife with psychological distress and little legal or institutional recourse.

THE SOCIAL CONTEXT

Some of society's attitudes toward homosexuality have been changing radically in recent years because of the effects of the gay liberation movement. The movement has been gaining in strength and numbers, generating greater public knowledge about homosexuality. Gays and lesbians are becoming more politicized and are insisting on visibility. The HIV epidemic has necessitated talking frankly about sexuality and sexual behavior, and the current public interest in diversity has included the right to be respected for one's sexual orientation in an egalitarian society.
One of the results of these social changes is that the number of openly gay and lesbian families has been increasing, particularly in major urban settings. Children from these families are appearing in the ordinary institutions of society as they grow older. Some younger children have never experienced any other family structure, and they often believe that it is the most natural thing in the world to have two moms or two dads. When they are young, their peers are curious about the differences in families and often simply accept the alternative of two same-sex parents. Later on, as the attitudes of the external world filter into their awareness, these issues may become more complex.

Another result of increased visibility, though, has been the powerful backlash from part of the conservative religious right and right-wing organizations. Homosexuals are high on the hate list because they are viewed as threatening the fabric of “family life,” which has included only married heterosexual couples and their children. In this traditional view, children should not be exposed to homosexuality because they will be psychologically harmed. Some religious fundamentalists believe that homosexuality is against the will of God and a surrender to darker, evil forces. Even though this interpretation of God’s will is a minority view, it should be noted that it is also to be found in some mainstream religious organizations. Sexist attitudes, particularly among conservative elements of society, additionally dictate that the patriarchal form of the family remain intact with a single strong male figure in control. Further, the intense fear that can be generated by nonconformity and difference has triggered prejudice and, in some cases, unimaginable violence, as evidenced in the brutal death in 1999 of Matthew Shepard, the University of Wyoming freshman who was bound to a log fence and beaten 18 times on the head and face, or the 1997 bombing of an Atlanta gay nightclub.

In contrast, gays and lesbians in recent years have been awarded some rights in several parts of the country: joint dental and health insurance, disability and retirement benefits, bereavement or parenting leave, and various family assistance benefits and discount opportunities. They have also been welcomed by a growing number of churches and synagogues, as well as by other organizations specifically created to serve them, such as family camps, travel agencies, and vacation venues. Certainly, however, this visibility and acceptance is not universal. Powerful opposition has defeated initiatives in Colorado and Oregon, for example, that would have extended legal rights and protections to lesbian and gay citizens.

Because of this atmosphere of acceptance at best and hatred at worst, many gays and lesbians experience a need to build a safe and rich community. Holidays and other events are shared with gay friends or an extended social network. This network has often been called the “family of choice” (Weston, 1991). It functions in similar ways to those of the extended biological family and can include biological family members, friends, and past lovers, straight or gay. In therapeutic settings, it thus becomes necessary to inquire about a client’s “biological” family as well as this “functional” family. Besides the nurturing support it provides, it allows for a broader sense of community that can combat feelings of alienation and experiences of discrimination.

RESEARCH FINDINGS

Published research on lesbian and gay parents and their children first emerged in the 1970s, as more men and women of all ages realized their homosexual orientation and were encouraged to come out. Because many had been in heterosexual marriages, there was growing curiosity about the resulting gay and lesbian stepfamilies. As courts struggled with questions of custody, many of these original studies were used to refute the negative stereotypes and presumed dangers associated with homosexuality and parenthood. Scholarly research in the 1990s began to investigate the second wave of families: those who are having children in the context of openly gay and lesbian lives.

Lesbian and Gay Parents

Many early concerns surrounding gay and lesbian parents clustered around three major assumptions: That homosexuality was seen as an illness or disorder, that lesbians were viewed as less maternal than heterosexual women, and that gay men were seen as too involved with sexual partners to have the time and

Scholarly work did not confirm any of these assumptions (Falk, 1989, 1994; Patterson, 1994b, 1995a, 1996). As early as 1977, the American Psychological Association (APA) adopted a resolution claiming “sexual orientation of natural, or prospective adoptive or foster parents should not be the sole or primary variable considered in custody or placement cases” (1977, p. 432). The National Association of Social Workers (NASW, 1988) also proclaimed gay men and lesbians to be capable of effective parenthood.

More recent research has begun to investigate lesbian and gay individuals and/or couples who choose to become parents by adoption or alternative insemination. Research by Hand (1991), Osterweil (1991), and Patterson (1995a) has revealed that lesbian couples share parental duties more equally than heterosexual couples. In a study of gay male parenting couples, McPherson (1993) also found gay couples sharing parental duties more equally than heterosexual couples and also found gay couples to be more satisfied with their parental arrangements than heterosexual couples were. These results match earlier studies that refuted the myth that same-sex couples always organize their lives around traditional masculine and feminine role divisions (Green, Bettinger, & Zacks, 1996; Peplau, 1991). Although few, these studies reflect a new and positive focus of research on gay and lesbian families that departs from previous research, which examined negative stereotypes (conducted in the 1970s and 1980s) and which included only divorced lesbian and gay parents.

Children of Lesbian and Gay Parents

Another body of research has examined the children of lesbian and gay parents. Early studies were undertaken to provide a scientific basis for decisions in court cases involving the custody disputes of divorced lesbian mothers. As with the research on gay and lesbian parents, these studies tested common stereotypes: Do the children of gay and lesbian parents show impairment in sexual-identity development, personal development, and social relationships (Patterson, 1992)?

Studies in the area of gender identity (Golombok, Spencer, & Rutter, 1983; Green, Mandel, Hotvedt, Gray, & Smith, 1986), gender-role behavior (Gottman, 1990; Patterson, 1994a), and sexual orientation (Bailey, Bobrow, Wolfe, & Mikach, 1995; Golombok & Tasker, 1996) reveal no evidence of gender-identity confusion, no evidence of atypical gender-role behavior, no difficulties in sexual-identity development, and no evidence of elevated incidence of homosexuality in the children of lesbian and gay parents when compared with the children of heterosexual parents.

A number of other studies have examined other components of development in the children of lesbian and gay parents. In a review of the literature on lesbian and gay parenting published by the APA, Patterson (1995c) detected no evidence of differences between children of lesbian and gay parents and children of heterosexual parents on a variety of dimensions, including intelligence, moral reasoning, psychiatric evaluations, behavior problems, personality, locus of control, and separation-individuation.

Another group of studies assessed the assumption that children of lesbian and gay parents would be harmed by a presumed separation from the heterosexual world. Concerns were that the children of lesbian and gay parents would be teased and isolated by their peers, that they would lack experience in the heterosexual normative culture, and that they would be subject to sexual abuse from other homosexuals. Although incidents of peer-group teasing are reported, research on relationships reveals an otherwise normal and healthy picture of relationships with peers (Golombok et al., 1983; Green, 1978; Green et. al., 1986) and adults (Golombok et al., 1983; Harris & Turner, 1985/86; Kirkpatrick, Smith, & Roy, 1981). Within this presumed, separate world, children were seen as being at risk for sexual molestation. This fear overlooks the fact that sexual orientation, whether heterosexual or homosexual, is an adult attraction to others. Pedophilia is an adult attraction to children. Research shows no connection between homosexuality and pedophilia (Jenny, Roesler, & Poyer, 1994) and reveals that gay men show no more propensity for child sexual abuse than do heterosexual men (Groth & Birnbaum, 1978; Sarafino, 1979). Fearing sexual abuse from homosexual adoptive parents and not heterosexual adoptive parents would seem to be a homophobic reaction.

Of special note is a longitudinal study of children reared by lesbian parents. Tasker and Golombok
(1997) present data about 25 adult children raised by lesbian mother families. Using a comparison group of children raised by single heterosexual mothers, the study demonstrates that children from lesbian-mothered families have formed positive bonds with their mothers' partners, have enjoyed good relationships with peers, are no more likely to experience mental health problems in adulthood than are the children of heterosexual mothers, and are no more likely to identify as homosexual or bisexual than are children of heterosexual mothers.

More recent research on children reared by the second cohort of lesbian and gay parents—those who chose to become parents as openly lesbian or gay adults—has investigated the separation-individuation phase of development (Steckel, 1987) and psychological development (McCandlish, 1987) and the social competence, behavior, sexual identity, and self-concept of preschoolers (Patterson, 1994a). As with earlier studies, no major differences between children of lesbian parents and children of heterosexual mothers are reported. There is no published research thus far on children of openly gay male couples who adopted infants or had biological children with a surrogate or female coparent. Nothing in previous research suggests that findings would be different, however.

In summary, evidence does not support the notion that children raised by lesbian and gay parents will be more dysfunctional than children raised by heterosexual parents. Available research demonstrates consistently that gay and lesbian parents seem to be fully capable of providing a home environment supporting the healthy development of their children.

CLINICAL CONCERNS

Even with encouraging research findings and the social changes that are taking place today, the tension between the sometimes threatening and prejudiced outside world and the inside world of the lesbian and gay family can be very powerful. To create and maintain a warm, intimate, and loving home in the face of societal stigma can engender stress of varying degrees. Thus, the issues brought into therapy include the usual problems that any family might encounter but that are sometimes complicated with an overlap of the kind of tensions unique to lesbian and gay families described above.

A family’s ethnic or cultural origins brings with it another layer of difficulty. Different ethnic traditions view and treat homosexuality in various ways, some accepting, some unaware and fearful, and some outright hostile. These may be unsettling environments in which to live or parent. Also, there is often a painful intersection of oppressions within the lesbian and gay community. Nonheterosexual people of color, for example, must consistently confront the subtle or overt effects of racist attitudes. Many white people are ignorant of how pervasive and painful this experience can be. Differences in cultural and class backgrounds also can become potent family forces, sometimes enriching but sometimes creating power imbalances within the family that mirror the structures and attitudes of oppression in the larger society. Lesbian and gay families are not immune from the effects of racism, sexism, and classism or from the presence of these attitudes in many of its members.

In addition, the race, class, and sexual orientation of the therapist exerts a significant influence in the clinical encounter. Therapists have to be particularly aware of how their own homophobia, classism, or racism might influence their interventions, thus reenacting oppressive behavior in the consulting room, whether consciously or unconsciously. The brief discussion of this topic here and in the vignettes that follow does not do justice to its importance and complexity, and interested readers are referred to relevant book chapters (Gonsiorek, 1985; Greene, 1997; Greene & Herek, 1994; Herek, 1998; Laird & Green, 1996; McGoldrick, 1998; Stein & Cohen, 1986).

CASE EXAMPLES

A Blended Family: Virginia and June

This lesbian family called for therapy because one of the teenage daughters, Abigail, was bordering on anorexia. Virginia and June, the two active coparents, lived with Virginia’s two children, Denise, aged 11, and Abigail, 14. After a bitter divorce from her husband, Virginia was struggling with her identity as a
lesbian, which she had discovered 2 years before, when her relationship with June began. She was afraid to tell her children directly about the nature of her relationship with June. In order to maintain the secret, June had agreed grudgingly to be called a housemate.

The first session included the two lesbian coparents and the two daughters, and the time was divided among the parenting dyad, the sibling dyad, and the entire family. The father was invited by both the therapist and Virginia but was still so angry that he refused to come or even talk about the situation. In this session, it became clear that the children were confused both about June’s role in their mother’s life and about why their father was not seeing them regularly. The tension in the family was palpable, exacerbated by fear about the potential danger of Abigail’s eating behavior.

In the sessions that followed, Abigail seemed depressed. She was very upset about the divorce and the bickering and fighting between June and her mom. In particular, she felt both that June was taking up her mother’s time and that June was also often angry or in a bad mood. Both children admitted that when June tried to discipline them, they resisted because they did not consider her their parent. After the fifth session, Abigail reluctantly said that she was glad to have a place to talk and that she still was getting more used to the situation in her family. Denise maintained that she was not disturbed with what was going on and did not need to be in therapy. By this time the therapist and Abigail had fashioned an eating plan that seemed to be effective, and it was then decided that the couple would be seen alone and the children would join the therapy monthly to check in as a family.

June brought up several issues in the first session with the couple. “I’m invisible. I have no role. You won’t talk about our relationship to the kids, so I don’t fit in anywhere. They and everyone else think I’m just your friend.” Virginia responded. “I’m not ready to come out yet. You know that. It’s too embarrassing for me still. What will people think?” The therapist explored Virginia’s fears about coming out to her children, the possible projection of those fears onto her children as indications of her own internalized homophobia, and the potential connection between the family’s present tension and the maintenance of a family secret. Virginia could not accept these ideas easily. She had come from a proper upper-class family from England in which conformist behavior was expected. Homosexuality was not approved or even discussed. June had grown up in a working-class family with an alcoholic father. She and her siblings had to work hard for anything they wanted, and they lived in an atmosphere in which she had learned to speak up and take charge. She had come out to her family in her twenties and insisted that they see her for who she was.

As the differences in class and expectations between them became clearer, the therapist encouraged June to understand Virginia’s fear of revealing her lesbian identity and helped Virginia to understand June’s sense of invisibility. Each needed to suspend some of her own needs and not be reactive to the other. June began to consider allowing the children more leeway and to stop judging Virginia for “spoil[ing]” them, while Virginia began to acknowledge June’s sensitivities and to clarify their positions in the family with regard to the children. She was still not ready, however, to tell them about her lesbianism.

Subsequent sessions continued to focus on the couple’s relationship, working out issues of power, dependency, and autonomy that underlay some of the tension. Then, in a family session 4 months later, Virginia agreed to tell her daughters about the nature of the relationship. At first, the girls were quiet. Abigail looked very upset, saying that she always knew there was a secret. “I don’t understand how you can be in a relationship with a woman, Mom. Does Dad know? Is that why he’s been so strange? He won’t even come to visit our house.” She started to cry. Nobody spoke until Denise broke the silence, saying that one of her friends had two moms. “Is this like that?” she asked her mother. Virginia said that it was. June began to cry also.

In the following months, Abigail continued to express resentment about her mother’s relationship and was afraid about how it might affect her friendships. She distanced herself from June and sometimes chose not to participate in family activities, as many children her age who are in stepfamilies do. In therapy, however, she was able to talk about her fears. Denise, on the other hand, was more comfortable with her mother’s relationship and reported that she had told her closest friend, who seemed to have accepted it easily. Both Virginia and June welcomed these discussions, even though such conversations brought up feelings that were often uncomfortable for them.
A Two-Dad Family: Peter and Doug

Peter, a landscaper, and Doug, an elementary school teacher, entered therapy because they were arguing at home and they were not as sexual as they had been in the past. They had met at college and had lived together for 8 years. Peter, who is Japanese American, and Doug, who is Italian American, had been in therapy 5 years earlier with another therapist when they were deciding about having a child. They now had a 4.5-year-old biracial adopted daughter whom they had reared since her birth.

What emerged through their early reflections in therapy was that they were a couple with few external stressors. They were both open about their sexual orientation to their families of origin and their friends and neighbors and were as open as possible at work. They were both legal parents of their child and described themselves as financially comfortable, physically healthy, and generally happy. What did surface as a source of stress and tension was their search for a school for their daughter who was soon to be 5 years old.

As they described their search for a school that would educate their daughter and respect their family, a theme of isolation surfaced. Their friends and family did not fully understand the difficulty of being a gay family searching for a school. What was particularly troubling to them was the realization that their friends and family had been wonderfully supportive up to this time, but that now, through no fault of their own, they were now underestimating the struggle that Peter and Doug were experiencing. For Peter, whose tightly knit extended family had been surprisingly supportive, this awareness brought on a deep sadness.

Most of the people on school “tours” and interviewing were mothers; dads were a minority. In addition, countless stereotyping and offensive questions had been asked of them that were not asked of their heterosexual friends who were also searching for a school such as “Who cooks?”; “Whose is she?”; “Which one stays at home?”; and “How did you get her?” They described working very hard to find a school to fit their family and working even harder in the telling and retelling of their family story. They were tired of the “Excuse me for asking, but . . .” questions.

After relating their stories for almost two sessions, the therapist commented that Doug was doing most of the talking, both in the stories and in the therapy room. Each acknowledged this to be a new pattern in their relationship that they had argued about recently. After some time, Peter expressed his discomfort with the numerous “personal” questions about their family and the many times they had to tell their family “story.” Topics such as this were rarely discussed in his Japanese-American family, let alone with strangers. Peter would grow quiet when uncomfortable; Doug would fill the void by doing the talking. Doug had taken on the role of the direct one and admitted that he found this role quite consistent with his Italian-American upbringing. The couple did not like the way these roles were evolving and found them harmful to the team approach they had assumed in their relationship. At a time when they needed to be supportive of each other, this behavior was causing unwanted separation.

Doug and Peter came to six therapy sessions over a 2.5-month period. They were able to identify pressures they were experiencing in the outside world and the shift in their roles and style of communicating. These changes were not to their liking. In response, they devised ways of cooperating and supporting each other in what they grew to realize was a stressful and isolating time for them. Once they adopted this new approach, they reported they were managing their stress better and their presenting complaints were lessening. They also began to accept that as gay coparents, they would forever have to function as “ambassadors” and “educators” whenever they or their daughter first came into contact with heterosexist institutions and the specific assumption that all parents are heterosexual.

Rebecca and Maria: A Cross-Cultural Partnership

This couple came to therapy because they hadn’t been sexually active for almost a year. They had lost the passion that connected them when their relationship began 4 years earlier and seemed to be in conflict about even the smallest decisions. Maria’s family had come to California from Guatemala 20 years earlier without education or resources, while Rebecca had grown up in a middle-class Jewish family in Los Angeles. Maria’s 5-year-old biological son, Ricardo, whose Guatemalan father had never been part of his life, had been crying a lot during school for the last few months and was very dependent on his mother when he came home. Both adults feared that what was happening in their relationship was affecting Ricardo.

As the therapy progressed, certain resentments surfaced, particularly on Maria’s part. Rebecca, the daughter of professional parents, was a lawyer in a successful law firm. Maria, a legal secretary, earned less
than Rebecca and was still repaying debts incurred from financing her own college education. While Maria worked long hours to keep up her financial obligations, Rebecca worked part time and was easily able to take brief vacations. Maria also had much less support from her family, and though they liked Rebecca, they were unwilling to admit or speak about homosexuality.

In therapy, Maria talked about not being understood. As much as Rebecca tried, being a person of color was outside of her experience, as was growing up poor and being insecure about money. Also, Rebecca could not identify with Maria's loyalty to her family, which existed strongly regardless of the ways in which they were unable to support the couple because of their attitudes. The privilege that Rebecca took for granted separated the two in subtle ways.

At this point, the therapist asked Maria if it were difficult for Maria to have a therapist who is white, like Rebecca. Maria said she had been initially worried about feeling excluded and different, but actually had felt supported because the therapist seemed to understand the ramifications of what it meant to be a person of color facing continual marginalization. The therapist invited Maria to speak out if at any time she felt misunderstood or marginalized in the therapy.

Maria began to express a strong desire to become more identified with her culture. This was both for her own sense of belonging and self-esteem and for Ricardo; she wanted him to understand his roots as he grew older. Rebecca did not enjoy or feel part of Maria's friendships or her way of having fun or being connected, so the two began spending less time together. This was the first time in their relationship that Maria had acted more independently, and it threatened the couple's stability. Rebecca tried to explain that she felt abandoned and as if Maria did not care about the relationship. Maria insisted that she did care and was unhappy about causing pain.

Rebecca had initially felt allied to Maria in their lesbianism. She had not understood the implications of their different backgrounds, particularly concerning the assumed privilege and power associated with being an educated, white woman. Therapy allowed each of the partners to understand the broader effects of oppression as it exists in the outside world and influences personal experience. For Maria even to become aware of what she wanted and to dare to ask for it became part of her therapeutic work. For Rebecca to understand that her personal pain could not determine how Maria should act was difficult to accept. She made every attempt to respect Maria's needs, but it was hard to remain open and not be angry. She was faced with the difficult decision of whether to stay in the relationship when her deeply felt needs were not being met.

Eventually it was Maria who decided she needed a separation of undetermined length to be able to define more clearly how she wanted to live. She arranged for her parents to care for Ricardo when she was working as well as for time for Rebecca to be with him because the relationship between Rebecca and Ricardo was one that all three of them wished to continue. She also wanted to end therapy for the time being. In the last session, it was not clear if the partners would be able to find a cooperative way to be together at some point in the future. What would happen was left an open question.

*The Insemination Process: Ellen and Allison*

Ellen and Allison came into therapy because they were having arguments that created tension and distance between them that lasted for days at a time. Ellen had wanted children from a young age, was now 40 years old, and was feeling the pressure of the biological clock. Allison had never wanted children but was willing to participate because she wanted the relationship to last. From the beginning, they had serious differences of opinions that caused exasperating conflict.

In the office, it became clear that the couple was not dealing easily with the pressure of the many complex decisions they were having to make. Allison wanted to have a father who would participate, while Ellen wanted an unknown sperm donor so there would not be any questions about legal paternity. The couple spent hours trying to hammer out a legal document that would incorporate all of their different needs. The questions about the legal rights and decision-making powers of the biological parent had to be included as well as a definition of Allison's position as the nonbiological parent.

In general, negotiating how to live together created a volatile atmosphere. Ellen liked to spend time quietly, while Allison preferred social activity. Ellen preferred a very neat house and she was resentful that

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Allison seemed not to care. Creating a family brought up extremely strong feelings for both partners, and many of the decisions were in areas for which there were few models and precedents. The couple floundered often in the process. It was not clear whether the relationship could support the tension. Also, there were difficult technical problems about conception due to Ellen’s age. When Ellen did not become pregnant after a few months, it became clear that she would have to take fertility drugs—something she opposed.

The role of the therapist was both to contain the slowly evolving process of the pregnancy and all the decisions around it and, wherever relevant, to reflect the more chronic communication and psychological problems experienced by the couple. Allison came to understand that issues she brought from childhood underlay much of her tension and that she was being excessive in some of her demands. Ellen realized that she would have resented anybody who might have different opinions about her dreams of having a child. The couple is still trying but, given Ellen’s age and the difficult interaction between them, it is not clear whether either the relationship would endure the stress or whether the pregnancy would be successful. Statistics for women becoming pregnant at age 40 are not very encouraging, and the rate of miscarriage is >40%. Ellen’s waiting until near age 40 to become pregnant and her resistance of adoption as a possible means to parenthood were issues explored in therapy, yet they remained issues beyond Ellen’s interest at the time. In any case, the complexities of this situation made it almost impossible for this couple to manage without getting professional help.

There are, of course, many lesbian or gay couples of this kind who do not appear in the consulting room at all because they, like their heterosexual counterparts, are very excited to be thinking about childbirth and manage the complex decision-making process well. There is also an expanding network of support services in major urban centers that provides legal and psychological counseling about specific issues, such as the drawing up of contracts or dealing with the threat that AIDS presents in the insemination process. The National Center for Lesbian Rights in San Francisco, for example, has done ground-breaking work in this area for the last several years and continues to protect the rights of lesbians throughout the country. Contact information for this and other relevant organizations that support lesbian and gay parents and their children can be found in Appendix A.

CONCLUSION

In their review of articles published in the marriage and family therapy literature, Clark and Serovich (1997) found that between 1975 and 1995 only .006% of articles examined in 17 journals focused on lesbian, gay, and bisexual issues. Further, it was not until 1997 that the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) included sexual orientation in its antidiscrimination clause. While the trend toward more scholarly attention to gay, lesbian, and bisexual issues is evident in recent book publications (D’Augelli & Patterson, 1995; Laird & Green, 1996; Savin-Williams & Cohen, 1996), there is still a paucity of articles in marriage and family therapy journals. This article attempts to address only a few of the topics suggested by Clark and Serovich (1997). Limited by space constraints and our experience, we have presented research findings and several vignettes that illustrate the more common themes encountered in the consulting room with gay and lesbian families. It by no means addresses the issues involved in working with other sexual minority families, such as bisexual or transgendered families, nor does it address in depth such issues as the influence of the gender, race, class, sexual orientation, and attitudes of the therapist on the therapy.

Each family is unique in its particulars. Each also exists in the larger social framework where, like every other family, it has to struggle with defining its place and power, sometimes in the face of racism, sexism, and class differences and sometimes in the face of personal or historical demons. One of the most remarkable aspects of working with gays and lesbians is the continual awareness of two realities. The first is the universal reality of ordinary human beings struggling together to create intimate bonds that allow both individual freedom and family cohesion. The second is the particular reality of societal prejudice: at any moment, a gay or lesbian family can become the object of hate or derision that powerfully affects self-esteem and the level of stress within the family. Being able to hold both of these realities is primary to intervening effectively with any oppressed group.
Often, lesbian and gay families enter therapy for guidance, support, and recognition that they do not experience in the broader social arena. They can be exquisitely attuned to any uninformed or judgmental attitude. A couple and family therapist thus has a profound responsibility to obtain the training, education, and experience necessary to understand the lived experience of lesbian and gay parents, their children, their extended families, and their families of choice.

REFERENCES


