CHAPTER 18

LESBIAN AND GAY FAMILY PSYCHOLOGY

Roy Scrivner and Natalie S. Eldridge

As lesbian and gay populations become more visible, family therapists are being asked to provide specialized services to these families and to help families of origin deal with their frequently ambivalent or hostile responses to gay or lesbian family members. New family structures have been created by lesbians and gays who are raising children from previous heterosexual marriages, whereas other structures are being created through adoption, donor insemination, or surrogacy.

This chapter is about people and the relationships they form, people who exist within a society that stigmatizes them as a deviant minority group. Lesbians and gays are uniquely different from ethnic and other stigmatized groups. Unlike people of color, gays and lesbians are usually "invisible," assumed to be heterosexual members of their cultural group. Unlike children of ethnic minority parents, lesbian and gay children rarely have a lesbian or gay parent who can help them to understand their particular minority status in the dominant culture. Lesbian and gay parents usually raise heterosexual children, who will not replicate a same-sex family form. Lesbians and gay men seldom enjoy the rootedness of a multigenerational family, in which certain experiences are passed down by one generation and reflected in the next. Sometimes multigenerational lesbian and gay families with nonbiologically related extended lesbian and gay family members may be found in churches and other settings. A final way that gay and lesbian individuals differ from members of many other stigmatized groups has to do with how gender role socialization impacts the intimate relationships they form. Although norms of heterosexual relating may differ from one cultural group to another, the process of reaching across gender lines to form intimacy is a commonality. In forming same-sex relationships, however, gender plays a very different role in the dynamics of intimacy for lesbian and gay couples. What are these gay and lesbian family dynamics and structures like?

This chapter will answer this question by providing both individual and systemic perspectives on lesbian and gay family psychology. An integration of several models of lesbian/gay identity development is described, followed by widely used models of gay and lesbian couple development. The stage models summarized here are not intended to be prescriptive of developmental sequences for all. Rather, they are useful in describing particular behaviors or conflicts that an individual or couple might present in therapy and in locating these within a larger context of developmental processes. Space limitations preclude an adequate discussion of the challenging issues of bisexuality. Readers are referred to Fox (1995) and Weinberg, Williams, and Pryor (1994) for a comprehensive review of these concerns. Much of the theoretical work presented here has been based on studies of Caucasian individuals. However, research and theoretical constructs drawn from the experiences of individuals of other racial groups are included when available. The chapter concludes with a discussion of various clinical issues that may arise, as well as some specific suggestions for therapists for increasing sensitivity and effectiveness.

We emphasize that the terms *lesbian* and *gay* are much preferred to the term *homosexual*, which has been associated with a mental disorder and does not differentiate between men and women. Also, we use the term *gay* in this chapter to refer exclusively to men, whereas the term *lesbian* is used solely in reference to women. The term *homosexual* also contributes to an overemphasis on gay and lesbian sexuality, rather than portraying sexuality in the context of many other dynamics within the individual's lifestyle. Like most of the large dominant nations of the world, America is a sex-negative culture (Smith, 1975). Sex-negative cultures have a stigma against many kinds of heterosexual sexual expressions and against same-sex sexual relations. In an empirical study of sex-negative and sex-positive individuals, Berry and Marks (1969) found that sex-negative persons see lesbians and gays less positively than do sex-positive individuals. Sex-negative views in America contribute to the stigma against lesbians and gays. In lieu of referring to *sexual orientation*, many prefer the term *affectional orientation*, which designates from which gender one selects a love object.

In this chapter, we will focus on the affectional relationships between lesbians and between gays. We will also note their caring relationships with their children, members of their extended nonbiologically related families of choice, and members of their families of origin. The frequently overlooked negative effects of the stigma against lesbians and gays on all of these family members will be addressed.

INDIVIDUAL DEVELOPMENT

We live in a culture that assumes heterosexuality for all and provides little support for and many deterrents to the expression of alternative identities. It is remarkable that so many individuals have found a path for the expression and development of positive lesbian or gay identities. Others, however, find themselves stuck between their emotional and sexual yearnings and their internalized negative cultural values about gays and lesbians. Conflicts are often expressed in symptoms of anxiety, depression, substance abuse, sexual dysfunction, and the entire array of psychological concerns. As psychology has moved away from a pathological view of homosexuality and a focus on etiology, greater attention has been paid to the impact of societal stigma and to the factors that encourage healthy identity development in lesbians and gays. Models of stages in the development of lesbian and gay identities have been presented by Plummer (1975), Troiden (1979), Cass (1979), and Coleman (1982). An integration of these models (Scrivner, 1984) is summarized in Table 1.

Morales (1989) proposed a model of identity formation that incorporates the doubly stigmatized status of being from a nondominant racial or ethnic background and being lesbian or gay. This model is summarized in Table 2. He noted the tasks that may be the focus of therapy for individuals in the various stages and suggested that movement through the stages decreases anxiety and tension. An individual in Stage 3, for example, may need help in recognizing the need to establish priorities of allegiance, at least temporarily, in order to ensure adequate social support and a decrease in isolation. An individual in Stage 5, however, may work in therapy on how to personalize a multicultural identity and integrate his or her connection to various communities. This usually needs to be a creative process, calling on a commitment of the individual's energy, personal interests, and values.

FORMATION AND DEVELOPMENT OF LESBIAN AND GAY COUPLES

Lesbians and gay men are more like heterosexual women and men than they are different from them. Analogously, the development of relationships among same-sex pairs have much in common with the development of heterosexual relationships. Variations among lesbian, gay, and heterosexual couple paradigms reflect broad ecosystemic influences such as cultural biases against gays and lesbians. These cultural biases often result in invisibility. However, researchers have been able to overcome this invisibility barrier and identify some of the characteristics of these couples.

A Model of Gay Couple Development

McWhirter and Mattison (1984) conducted a 5-year study of 156 gay couples living together from 1 to 37 years and found six stages of couple develop-

TABLE 1

Stages in the Development of Lesbian and Gay Identities

Stage	Characteristics	Therapy notes
1. Sensitization	Individuals gain experiences that later may serve as sources for interpreting their feelings as being gay or lesbian. There may be gender confusion, feelings of differentness, or acts that seem not intrinsically sexual or affectional, but that can later be defined as such. Children may introject ecosystemic stigma against homosexuality even before they become aware of same-sex attractions.	This stage is quite universal, and may have more to do with the growing awareness of sexuality than with sexual orientation, per se. Therapists can work with client's fears about sexuality, and the development of self-esteem, encouraging the client to remain open as to eventual orientation. This stage may begin as early as preschool and only be identified retrospectively. It may occur later, even in late adulthood.
2. Identity confusion	Individuals begin this stage thinking of themselves as heterosexual and knowing what the word *homosexual* means. Confusion begins when the individual has feelings, thoughts, or behaviors that can be defined as "homosexual."[a] Retroactive interpretation, the reinterpretation of past events as related to having a lesbian or gay identity, may begin in this stage.	How individuals deal with their confusion depends on how they perceive the thoughts, feelings, or behaviors that precipitated this stage. Perception is affected by the socialization absorbed from the environment about diversity in general, and homosexuality in particular. Denial and repression will lead to identity foreclosure. Acknowledging confusion moves the client toward the next stage.
3. Identity comparison	The individual realizes that all the guidelines for a heterosexual identity are no longer relevant for her or him. Alienation, feeling "in a void," is common. Suicide is most likely in this stage, especially among adolescents. Any grief work related to giving up a heterosexual identity may begin in this stage.	Movement into this stage is likely to increase conflict for the individual. It is useful to provide support and encourage the client to decrease isolation by exploring the lesbian and gay subculture through reading, attending meetings, or cultural events. Finding role models and other positive aspects of the lesbian/gay lifestyle needs to be encouraged.
4. Identity tolerance	This stage is reflected by greater commitment to the thought, "I probably am gay or lesbian." Some gays and lesbians may temporarily describe themselves as bisexual, whereas others may continue to develop an integrated bisexual identity.[b] Once labeling themselves as "probably gay or lesbian," contacting others in the lesbian and gay culture is viewed as something that has to be done in order to counter isolation and alienation. Support is not typically sought from heterosexuals, including family of origin members.	In this stage, a client may actively seek a lesbian or gay therapist referred by other members of the lesbian or gay community. Referrals to such therapists might be considered. Issues of trust and acceptance will be raised in the therapy relationship, even for long-standing therapeutic alliances. Alternatively, the client may rely on the therapist as the only source for information on how to enter the lesbian or gay community in a safe way. Knowledge of the local community and consultation may be important tools for the therapist.

(continues)

TABLE 1 (Continued)

Stages in the Development of Lesbian and Gay Identities

Stage	Characteristics	Therapy notes
5. Identity acceptance	This stage is characterized by continued and increasing contact with other gays or lesbians. The person feels the impact of those features of the subculture that validate and normalize having a gay or lesbian identity. Introjected stigma and inaccurate information from the ecosystem must be confronted and changed.[c] The individual may experience a "gay adolescence" that occurs after their chronological adolescence. There is increasing need to learn to relate socially to lesbians and/or gays.	This stage usually marks a major life transition, and clients often experiment with new behaviors, experience more intense emotions, or make outer changes in clothing style, career, and so on. Otherwise very mature and successful lesbian or gay adults might find themselves becoming easily infatuated with others. Therapy can provide grounding support and promote safety, as with any major life transition or change. The words *gay* and *lesbian* may begin to be used more by clients in this stage to focus on a social identity, while the word *homosexual* is seen as a negative diagnostic label.
6. First relationships	This stage is marked by the developmental task of learning how to function in a same-sex affectional relationship. It will be affected by the individual's overall experience in intimate relationships. First same-sex affectional relationships are often characterized by intensity, possessiveness, and lack of trust. The absence of role models and a failure to negotiate earlier stages (not accepting gay or lesbian identity) make these first relationships more difficult.	Family therapists skilled in couple therapy with heterosexuals need to learn about roles of stigma and gender in same-sex couples and how these couples are uniquely different from one another and from heterosexual couples. Heterosexist bias can cause harm in therapy by reinforcing internalized stigma within these relationships. Therapists may be in the role of the only "public" recognition of the couple.
7. Identity commitment and pride	Commitment to an identity presupposes a reluctance to abandon the identity, even if given the chance to do so. In this stage a person may divide the world between the subculture of lesbians and gays, and the "straight" world of heterosexuals, devaluing the latter. Pride leads to increased candor about one's gay or lesbian identity with heterosexuals.	Growing pride in negotiating a positive lesbian or gay identity in the face of adversity may be accompanied by intense anger at the straight world, or those considered to be the oppressors. Therapists may want to help clients differentiate between those who are supportive and who may collaborate with them, versus other nonsupportive heterosexuals, for whom confrontation may be appropriate. How others, especially heterosexuals, respond to the client's openess about being gay or lesbian may influence whether the client can move into next stage.
8. Identity synthesis	Feelings of pride are still present, but the "them" versus "us" philosophy is not. One's lesbian or gay identity is seen as only one aspect of one's overall identity.	Clients rarely bring in issues of a gay or lesbian identity as a presenting problem, unless focused on handling external discrimination or harassment.

[a]Coleman (1987) is recommended for working with those who are confused about their sexual orientation.
[b]See Fox (1995) for a discussion of bisexuality.
[c]Helminiak (1994) is recommended for those who have religious beliefs that conflict with an acceptance of lesbians and gays.
[d]Savin-Williams (1995) discusses lesbian, gay, and bisexual male and female adolescents.

TABLE 2

Individual Development of Ethnic Minority Gays and Lesbians

Stage	Characteristics	Therapy issues
1.	Denial of conflicts is prevalent. Individuals minimize the discrimination against their ethnic group. There may or may not be identification as lesbian or gay. If so, they experience their sexual orientation as having limited significance.	The focus of therapy is on an increased awareness of the stigma they experience as both a member of a nondominant ethnic group and as a gay or lesbian person. The positive aspects of such a multiple identity are important to explore.
2.	Some ethnic lesbians and gays prefer to identify themselves as bisexual in an effort to maintain support in both worlds. The lesbian and gay communities may be perceived as White communities, and identification with these communities could be perceived as a betrayal of allegiance to ethnic community.	Therapy may focus on the continuing conflicts between the two identities and the ecosystemic stigma against both. The specific label or language used (e.g., *gay*, *bisexual*) is less important than the exploration of the conflict between inner awareness and the impact of social roles and expectations.
3.	Conflicts in allegiances deepen. Loyalty conflicts between one's ethnic group and the lesbian and gay community are intensified.	Therapy may focus on the need to develop priorities, rather than choose sides, in an effort to reduce conflict. Examining supportive aspects of each community tends to encourage a shift from a monocultural to a multicultural perspective.
4.	Establishing priorities in allegiances begins. Priority is often given to the ethnic group first. There may be anger and resentment toward this group for lack of acceptance as a gay or lesbian person, as well as anger toward the lesbian and gay community for discrimination against one's ethnic groups.	Therapy can focus on an examination of the anger and rage at each community and on the development of a proactive perspective, rather than a reactive one, in their relationships and allegiances.
5.	Integration of the various communities is the task of this stage. The development of a multicultural perspective is the outcome. Limited options for supports integrating both ethnic and lesbian/gay identity may be a source of anxiety or contribute to alienation and isolation.	Normalizing the conflicts can be reassuring at this point. Ways to reduce isolation can be explored such as social[a] and political organizations for lesbians and gays of the client's ethnicity.

Note: The following are recommended for a further understanding of lesbians and gays from specific ethnic groups: Greene (1994), Peterson (1992), Lockman (1984), Whitman and Mathy (1985), Balka and Rose (1989), and Tafoya and Rowell (1988). See also Morales (1989).
[a]See Jackson (1993) for addresses and meetings of groups for gays and lesbians of specific ethnic backgrounds.

ment. The stages of the McWhirter and Mattison model are based on research that was conducted on White gay couples prior to the AIDS epidemic. Later, Mattison and McWhirter (1990) conducted a study of gay couples where either one or both partners developed AIDS. For some couples in the early stages of development, the AIDS crisis propelled them through subsequent stages rapidly until they reached Stage 6. Couples in dissatisfying relationships often terminated the relationship in response to this crisis. Stages identified by Mattison and McWhirter (1984) are summarized in Table 3; a case example depicting some of the stages follows.

CASE EXAMPLE: ROGER AND JAY

Roger and Jay had been together about a year when they entered couples therapy. Roger complained that Jay, a computer analyst, was becoming excessively angry at him. Jay complained that Roger, an attorney, used his courtroom skills to intimidate Jay and win arguments. In the past, they had often tried to deal with their differences nonverbally during sex, but the frequency of sexual relations had diminished, and both were afraid the relationship was breaking up.

The therapist made an assessment of the identity development of each as a gay man, and of the stage of their couple relationship. The assessment indicated that each was in Stage 6 (see Table 1) of their individual development and in Stage 1 of their development as a couple (see Table 3). Both men had been in previous gay relationships and reported that the quality and commitment in their current relationship was much higher than in the previous relationships. Each had some lesbian and gay friends, but none in their local area, as each had recently moved to the area about the same time. The therapist suggested that part of their compatibility was due to each being at the same stage in their development of a positive identity as a gay man. Their relationship appeared to be at the end of the Blending Stage. Some of their concerns (e.g., reduced frequency of sex) were described as typical for couples after the first year of a relationship. The arguments were identified as being distancing maneuvers, and general issues of closeness and distance were discussed. Subsequently, Jay and Roger were better able to identify when they wanted to be alone and to do that without the other feeling rejected. The frequency of arguments decreased.

Through a focus on family of origin work, the couple came to realize how much of their conflict reflected unresolved issues with their families. Jay was able to identify how he sometimes misplaced his anger toward his abusive parents onto Roger. Furthermore, he was jealous of and threatened by Roger's very close-knit and accepting family. Roger, on the other hand, began to recognize how he sacrificed his own time in running family business ventures, while his brother did nothing. He had been able to displace some of his anger toward his brother during courtroom trials, but in his new job he had less opportunity for this. He recognized that he had been taking his anger at his brother out on Jay. As the couple began to work on these family of origin issues in therapy, they argued far less and became increasingly committed to the relationship. They began devoting more time and resources to furnishing their joint apartment, marking their entrance into the Nesting Stage (see Table 3, Stage 2).

A Model of Lesbian Couple Development

Clunis and Green (1988) developed a six-stage model of lesbian couple development based on both the McWhirter and Mattison (1984) model for gay relationships and the Campbell (1980) model for male–female relationship development. Stages of the Clunis and Green model are presented in Table 4; a case example depicting some of these stages follows.

CASE EXAMPLE: KAY AND BARBARA

Kay and Barbara came to therapy for help in making a decision about parenting a second child. They already had a 6-year-old daughter, Kelly, who had entered the first grade and was doing very well. Barbara gave birth to Kelly during the third year of marriage to an alcoholic man and went through a difficult divorce during Kelly's first year. Barbara and Kay began dating then, moving through the pre-relationship and romance stages (see Table 4,

TABLE 3

Gay Male Couple Formation and Development

Stage	Characteristics
1. Blending	Blending refers to an intensity of togetherness, where similarities bind the couple and differences are mutually overlooked. The couple does everything together, often to the exclusion of others. There is a feeling of being "in love with love" and a shared attitude of equality. Sexual activity varies but usually includes several encounters weekly and defacto sexual exclusivity.
2. Nesting	In the second year, attention to surroundings takes the form of homemaking activities, decorating a new home, rearranging an old one. Couples in this stage also tend to see each other's shortcomings and discover or create complementariness that enhances compatibility. The partners' decline in being "in love with love" is usually not simultaneous and is often a cause for worry and concern. This decline and lack of compatibility may lead to ambivalence.
3. Maintaining	Maintaining the relationship depends upon establishing balances between individualization and togetherness, conflict and its resolution, autonomy and dependence, confusion and understanding. A reemergence of individual differences (individualization) occurs. This is accompanied by some necessary risk taking, whether in outside sexual liaisons[a], more time apart, greater self-disclosure, or new separate friendships. These risks often result in conflicts that are dealt with either by confrontation and resolution or by avoidance. Another characteristic is relying on the relationship as if it possessed certain dependable qualities, such as steadfastness, comfort, and familiarity. Recognition and support of the relationship by family and friends often begins only after a couple has been together 3 years.
4. Collaborating	Couples in stage four may unwittingly collaborate to aid the development of boredom and feelings of entrapment. After 5 years together, couples experience a new sense of security and a decreasing need to process their interactions. On the one hand, this decline in communication frequently gives rise to making unverified assumptions about each other. On the other hand, their collaborative adjustments often lead to effective complementarity. This complementarity, combined with the coping mechanisms for dealing with conflict and boredom, yields new energy which may lead to mutual as well as individual productivity of a visible nature, such as business partnerships, financial dealings, estate building, or achieving personal gains in professional or academic worlds.
5. Trusting	Trust develops gradually for most people. As the years pass, and as they gain experience, gay couples trust each other with greater conviction. The trust of stage five includes a mutual lack of possessiveness and a strong positive regard for each other. A merger of money and possessions may be a manifestation of this trust. In the latter half of stage five, there may occur an isolation from the self as manifested by lack of feelings and inattention to personal needs, isolation from the partner by withdrawal and lack of communication and, sometimes, isolation from friends in the same ways. This type of constriction may be a result of the men's ages. The attitude of taking the relationship for granted develops as a result of the other characteristics of this stage.
6. Repartnering	The 20th anniversary appears to be a special milestone for gay male couples. Couples report a renewal of their relationship after being together for 20 years or more. Goals of financial security often have been met. Other goals reached may include business, professional, and academic success. Couples in this stage assume that they will be together until separated by death. There are personal concerns, such as for health and security, fear of loneliness, and death of partner or self. Most are struck by the passage of time and reminisce about their years together.

Note: See McWhirter and Mattison (1984) for elaboration of this material.
[a]Outside sexual liaisons are much less common now; see the section on AIDS, this chapter.

TABLE 4

Lesbian Couple Formation and Development

Stage	Characteristics	Tasks	Therapy issues
1. Prerelationship	Dating, spending time. Stage often relatively brief for lesbians due to ambiguity of defining relationship, and gender role socialization encouraging women to link sexuality with love and commitment.	Getting to know each other. Deciding whether to invest more time and energy. Deciding whether or when to be sexual.	Partners bring different sets of expectations and assumptions. If women find asking for what they want or clarifying their expectations uncomfortable or unacceptable, disappointments and misunderstandings may arise.
2. Romance	Merger, fusion, and sexuality. Partners tend to neglect their friends and focus on relationship.	Developing a sexual relationship.	Partners may minimize difficulties that could arise between them. Absence of clear rituals (e.g., dating, engagement, marriage) may augment the meaning given to beginning a sexual relationship or moving in together.
3. Conflict	Differences in partners' needs or expectations emerge, demanding attention.	Learning to negotiate conflict. Developing couple decision-making processes, conflict resolution styles, communication channels, and relationship goals. Understanding the expectations and desires of the partner.	How conflict is negotiated is based in part on how well each partner made choices in the prerelationship stage, based on knowledge of the other person. If this stage was too rushed or skipped altogether, differences now emerging may be irreconcilable.
4. Acceptance	Increasing stability.	Gaining confidence in relationship through experience in recognizing conflict and negotiating solutions. Viewing the partner more realistically, accepting the strengths and flaws they see.	Help each partner identify how she contributes to their particular conflict patterns. Bring in the perspective of past experiences, former relationships, and family of origin to understand each partner's responses to the current relationship.
5. Commitment	Defined as "the decision to make choices about the relationship and be responsible for them" (p. 23). Must be preceded by the power struggle of the conflict stage and the clarity about the differentiation between the individual and the couple that evolves in the acceptance stage.	Coming to terms with opposing needs such as the needs to be separate and to be together, or needs for freedom and for security. Commitment to the relationship becomes a commitment to continually negotiate the changing needs of the individuals and the outside environment.	Support couple in the establishment of negotiation styles and, often, in considering or planning a public ceremony or recognition of their commitment. Several religious groups now make a formal commitment ceremony or marriage available through their structures; no legal recognition yet exists.
6. Collaboration	Examples of collaborative processes: working toward a political cause together, raising a child or children collaboratively, starting a joint business, sharing their relationship experience and rituals with other lesbians.	Focusing on something beyond their relationship to share with the rest of the world.	As the couple embarks on their new project together, they may reexperience aspects of the former relationship stages. However, their history of survival and acceptance generally lends greater resiliency to the reworking of the stage.

Note: See Clunis and Green (1988) for elaboration of this material.

Stages 1 and 2). Kay felt ready to live with Barbara after 18 months, but they did not begin living together until Barbara was convinced that her ex-husband would not bring a custody suit against her because of her lesbian relationship. Barbara's reticence was a source of much conflict for the couple (see Table 4, Stage 3). Kelly was almost 3 when Kay moved in with them, and establishing a blended family was difficult over the first 18 months. In the last year, the relationship stabilized and deepened (see Table 4, Stage 4), and Kay and Barbara bought a house together, which neither of them could have afforded on their own. This move has provided an excellent school district for Kelly.

Therapy focused on clarifying and reframing the impasse between Barbara's desire to have a second child and Kay's ambivalence. Barbara had always wanted at least two children and was now approaching 40. Kay was very committed to raising children with Barbara but felt resentful about how hard she has had to work to become part of Barbara's biological family. Her main concern seemed to be the lack of recognition by Barbara's family of origin that Kay was now a co-parent to Kelly. Kelly accepted her "two mommies," even bragging about this to friends, but learned not to talk about Kay when she was at Barbara's parents' home. Kay's parents, on the other hand, completely accepted Kelly as their granddaughter, and Kelly often visited with Kay's sister and brother-in-law, who lived nearby and had a son about Kelly's age. Kay feared that having another child would increase Barbara's family's involvement with them, and thus increase Kay's invisibility and further invalidate her role in the family.

The therapist assessed that the couple was in the commitment stage (see Table 4, Stage 5) based on their decisions to buy a home together and to enter therapy. After consultation with colleagues, the therapist identified a support group for lesbian parents in a nearby city and suggested that Kay and Barbara attend together to supplement their work in therapy. The group experience stimulated their creative thinking about possibilities and provided invaluable support for both Barbara's and Kay's perspectives.

In therapy, the couple identified conflicts stemming from different expectations and family of origin experiences. Barbara realized that she was colluding with her parents by allowing Kay's invisibility. Even though the family knew Kay, they would never ask about her or would change the subject when Barbara or Kelly talked about her. Kay, on the other hand, came to understand that her "second-class status" stirred up past history with her younger sister, who Kay felt always got more attention from family and the outside world. Particular relevant examples were the sister's glamorous marriage and the excitement surrounding her having the first grandchild.

As Kay and Barbara recognized the dimensions of their conflicts and felt the support and understanding of other lesbian couples raising children, a new direction emerged. Kay and Barbara were exploring the possibility of Kay's being the biological mother to their second child, and they both realized that this would fortify her place in the family in the eyes of the outside world, especially within Barbara's family. Kelly was already very excited about having a sibling and had been asking about this as a result of her experience with other children in school. Barbara and Kay felt new possibilities that would strengthen their family commitment and had resources through their group experience to explore in terms of pregnancy through donor insemination. The therapist affirmed the collaborative process in which they were making decisions for the family's future (see Table 4, Stage 6). As they began the process of Kay's insemination, the couple ended therapy. The financial drain of the insemination process contributed to their decision, but they also felt they had overcome the impasse that brought them into therapy.

Lesbian and Gay Couples From a Life Cycle Perspective

Slater and Mencher (1991) stressed the importance of viewing the lesbian family from a life cycle perspective and of considering the myriad systems involved. These systems include (a) the lesbian family system created by a couple (with or without children); (b) the family of origin of each family mem-

ber; (c) the lesbian community within which the family is embedded; and (d) the mainstream community in which the family must function. This comprehensive view of the context of systems for lesbian family development (Slater, in press) will be broadened here to elaborate on the importance of these various overlapping systems in understanding both lesbian and gay families.

For some gay or lesbian couples, families of origin may play a positive and significant role. For others, familial rejection produces a painful void. Members of the family of origin of one partner may never acknowledge the family created and view their son or daughter as being single or a single parent, or they may not accept their offspring's partner's biological child as their kin. How a couple manages this invisibility is extremely significant and is influenced by the couple's acknowledgment in each of the other three systems.

There are myriad ways in which a lesbian or gay family might connect with the wider gay and lesbian community, ranging from fear and disavowal of any association, to friendship and work environments that are exclusively lesbian or exclusively gay. Many families are isolated from other gay or lesbian families because of the invisibility required for survival. In some geographic areas, a sense of community is strong, evidenced by social networks, gay and lesbian cultural events, and openly identified lesbian or gay leaders in politics and the professions. There, family members have access to role models, and community participation provides the lesbian or gay family with a source of positive public and social identity. Often friendships with members of the lesbian and gay community, ex-lovers, and other supportive figures may be more significant than family of origin members to family functioning (D'Augelli & Garnets, 1995; Weston, 1991).

A gay or lesbian couple's relationship with the mainstream community around it will vary according to the couple's individual and family stage of comfort with their sexual identity, the degree of risk in the community in being open about the relationship (e.g., risk of job loss or potential loss of custody of children), and the family's interests and needs. Career advances, age of children, and leisure interests may affect the family's level of contact with the mainstream community. As couples reach the collaborative stage, political and social justice commitments or spiritual pursuits may bring them into closer contact with predominantly heterosexual organizations and subgroups. Aging lesbians or gays may be forced to depend on mainstream services for survival and community (e.g., nursing homes). The additional challenges faced by interracial couples involved in various racial and ethnic support networks are discussed by Peterson (1992); Lockman (1984); Garcia, Kennedy, Pearlman, and Perez (1987); and Smith (1983).

A developmental understanding of lesbian and gay families over time is in its infancy, but useful models do exist on which to build appropriate research paradigms, expand theoretical ideas, and inform clinical practice. Family therapists must begin to identify the similarities and differences among various family forms to be effective in treatment. Issues of heterosexual bias (Morin & Charles, 1983), stigma (Herek, 1995), health (Shernoff & Scott, 1988), and legal status of gay and lesbian parenting (Curry & Clifford, 1991) are all crucial to adequate treatment of lesbian and gay families.

EFFECTS OF GENDER ROLE SOCIALIZATION ON LESBIAN AND GAY COUPLES

Gender role socialization is reflected in certain observed differences between gay and lesbian couples. Differences in emotional intimacy, sexuality, and power are highlighted here. As traditional gender roles are challenged and broadened, gender-related differences in same-sex couples are expected to diminish. Although there are these gender-related differences in lesbian and gay couples, there are few differences in overall relationship satisfaction (Kurdek, 1995).

Emotional Intimacy

Lesbian couples have reported significantly higher levels of cohesion, adaptability, and satisfaction than have heterosexual couples (Zacks, Green, & Marrow, 1988). Peplau (1991) found that, regardless of affectional orientation, women were more likely than men to value emotional expressiveness and a similarity of

attitudes between partners. Initial reports on lesbian fusion pathologized the intimacy in lesbian relationships because of its deviation from norms generated from research on heterosexual couples. However, recent theorists have seen the capacity for fusion in lesbian relationships as a strength (Burch, 1993; Mencher, 1990). It may be that intense intimacy is normative in lesbian relationships, just as enmeshment can be considered normative in Jewish and other families (Herz & Rosen, 1982). Lesbians with high ego development have consistently reported experiencing of blurred boundaries in the context of their relationships and valued this favorably (Carroll & Gilroy, 1993; Mencher, 1990). Of course, when ego development is low, fusion can become rigidified and problematic for any couple. Rohrbaugh (1992) suggested that temporary fusion may be a healthy component of all close female relationships.

As was noted previously, whereas women are socialized to value and maintain relationships, focusing their energies on the care and nurturance of others, men are socialized to value autonomy, separation, and differentiation (Elise, 1986; Pollack, 1990) and to focus on their work identities through competition and achievement. Elise (1986) noted that a common response of gay couples to systemic pressures is reactive distance rather than fusion. Because the maintenance of the relationship must be done by men in gay couples, and because many men rely on sexual contact as a vehicle for emotional intimacy, sexual relations are a significant component of gay relationships. Bergman (1991) proposed a concept of a male self that includes a focus on relationships, rather than solely on autonomy and differentiation. His concept appears to be more characteristic of gay and heterosexual men who reflect less traditional gender role socialization. As was discussed in Pollack (1990), Kohut also argued for a male "self-with-others." Chodorow (1994) argued for more attention to the development of love and passion in gays and lesbians.

Sexuality

Men are typically socialized to express sexual feelings before emotional intimacy, whereas women often are socialized to prefer affectional relationships before expressing sexual feelings (Forstein, 1986). Such socialization is reflected in the gay culture, where relating sexually often occurs at the beginning of a relationship (Klinkenberg & Rose, 1994). On the other hand, lesbians often form friendships or affectional commitments prior to sexual relationships (Eldridge, 1987). Burch (1993) reported that sexuality is much more likely to be inseparable from relational desires for women than for men.

Other results of gender role socialization were reported by Kurdek (1995), who found that gay couples have sex more frequently than heterosexual couples, whereas lesbian couples have sex less frequently than heterosexual couples. Gay men also have more sexual partners than lesbians, and the forms of gay sex are more diverse than those of lesbians and heterosexuals. Multiple sex partners are relatively common among men in the gay community. Gay extramarital sex is often casual, brief, and recreational rather than emotionally intense and may not threaten the primary affectional commitment between two men. It appears that agreement among partners on whether the relationship will be open or closed is a critical factor, and agreement on this dimension tends to increase as the length of relationship increases (Eldridge, 1987).

Both gay and heterosexual men may be more likely than women to use sex as a nonverbal means of communication. Lesbian couples may have a higher level of verbal communication and less of a need to use sex for nonverbal communication. Thus, socialization may explain a significant portion of the reported differences in frequency of sexual contact between partners in lesbian and gay couples.

Power

Peplau (1991) found that, regardless of sexual orientation, women were more likely than men to value equality between partners in an intimate relationship. Kurdek (1995) reported that lesbian couples are more likely than either gay or heterosexual couples to follow an ethic of equality. For example, when lesbians perceive a power differential in their relationship, even the most powerful partner tends to be less satisfied with the relationship than when the power is equally shared (Eldridge & Gilbert, 1990). Gender differences in egalitarian values are similarly reflected in some gay and lesbian organizations, where men

tend to value formal structure and hierarchy, and women often value informal networking and equality of power. Feminist values and consciousness are more common in the lesbian community, although they are beginning to emerge in some segments of the gay culture.

LESBIAN AND GAY PARENTS AND THEIR CHILDREN

The structure of gay and lesbian families includes many variations. A primary couple relationship between two women or two men is generally defined. Sometimes a larger unit of three or four may define the primary system, which can challenge heterosexual assumptions that stable relationships are dyadic, that friendship should be asexual and distinct from a primary relationship, and that monogamy is preferable to any of its alternatives (Goodrich, Rampage, Ellman, & Halstead, 1988).

If the gay or lesbian family includes children, there are various formations to consider. A blended family includes a lesbian or a gay man who has children from a previous relationship, that individual's children, and her or his partner, who may or may not also have children. Some lesbian or gay families involve a single parent and her or his children. In the past 10 years, there has been a great increase in the number of lesbian couples who are choosing to have children together, using a variety of sources for sperm donation (Patterson, 1995). These families may include a noncustodial father if the donor is known, or a father with joint custody. Gays have created families through adoption and surrogacy (Martin, 1993), the latter allowing a biological link between father and child.

To understand the context of any particular gay or lesbian family, it is important to understand its developmental history as well as the current structure of the family. Historically, most lesbians and gays have become parents during a heterosexual marriage. These marriages may end when the lesbian or gay spouse develops a strong same-sex affectional relationship with which the benefits of the heterosexual marriage can no longer compete (Buxton, 1994). If the sexual orientation of a gay father or lesbian mother is revealed during divorce proceedings, that parent is highly unlikely to be awarded custody of any children. Visitation rights may be denied. Because they fear losing custody, lesbian and gay parents with custody of their children tend to build strong boundaries for their families and allow few outsiders into their system. This is an example of how social stigma reinforces invisibility. Such invisibility decreases the opportunity for role modeling for other gay and lesbian families raising children and contributes to the negative stereotyping in the general population that gays and lesbians are not good parents.

Green and Bozett (1991) reported that children of lesbian and gay parents are no different than children of heterosexual parents on a variety of dimensions, including the children's sexual orientation. They also found no evidence that children experience long-term problems related to learning about the sexual orientation of their parents. Patterson (1995) reported that children of donor-inseminated lesbians are as psychologically healthy as the general population. McPherson (1994) reported that gay couples experience more satisfaction with parenting arrangements than do heterosexual parents. Martin (1993) has provided information about organizations and readings for lesbian and gay families, donor insemination programs, surrogate motherhood, and adoption by gay and lesbian parents.

THE FAMILY OF ORIGIN

Many family members have difficulties accepting a gay son or lesbian duaghter, and temporary or permanent estrangement after disclosure is not uncommon. Robinson, Walters, and Sheen (1989) have documented a five-stage grief process (shock, denial, guilt, anger, and acceptance) that parents often go through in coming to accept a gay son or lesbian daughter. Specific challenges facing the family of origin include the following: (a) internalized stereotypes and dehumanizing attitudes toward lesbians and gays, and the process of replacing these with more accurate information about lesbian and gay lives (Hammersmith, 1987; Strommen, 1989); (b) fears related to the lack of civil rights protection for their children; (c) fears related to their children's being a target of hate crimes; (d) fears that their sons may

die of AIDS; (e) the stigma in the ecosystem against those sons with AIDS; and (f) the stigma of having a gay son or lesbian daughter and the shame and guilt associated with this stigma.

In working with family members who resist accepting a gay son or lesbian daughter, it is important to assess how much of the resistance is due to the son or daughter's affectional orientation and how much is a function of the child's attempt to separate and differentiate from the family (Devine, 1984). Family members are faced with lifelong choices as to whom they will disclose that they have a lesbian or gay family member. Local groups of Parents, Families, and Friends of Lesbians and Gays (PFLAG) can be useful for families that are struggling to accept a gay son or lesbian daughter. Also, PFLAG has established a support group for heterosexual spouses married or formerly married to a gay man or lesbian. Support is also provided for children of gay and lesbian parents. (See the Appendix to this chapter for the address and phone number of PFLAG.)

AIDS

Research clearly documents that since the AIDS epidemic began, gay men have adopted safer sex practices with a resulting decrease in all types of sexually transmitted diseases and reduced use of drugs (Paul, Hays, & Coates, 1995). Many gay couples no longer have sex outside their relationships. Single gays are increasingly limiting their sexual relationships to one partner and giving increased consideration to establishing committed relationships (Carl, 1986). Some couples may commit prematurely or stay in dissatisfying relationships because of the fear of AIDS (Forstein, 1986). When a partner is diagnosed with HIV or AIDS, the couple relationship is transformed, and it may either be terminated or strengthened. Some family members may learn of a son being gay at the same time they learn that he is HIV-positive or has AIDS and may die. Many gays and lesbians are dealing with a different type of grief—a grief related to multiple deaths of significant others in their extended family network.

Family therapists need to be aware of the massive impact of AIDS in the gay community, as well as the fears and shame in the family of origin in discovering a gay family member. The therapist must effectively work with both the extended gay family and the biological family members of a person with AIDS in order to help both systems deal with the extensive emotional and physical caretaking demands of the situation (Lovejoy, 1990; Tunnell, 1993). In working with a couple in which one partner is diagnosed as HIV+, the family therapist must help each partner to understand the meaning of this in their lives and assist the couple in renegotiating sexual, emotional, financial, and other aspects of the relationship. Guidance for working with AIDS in various ethnic communities has been provided by the National Commission on AIDS (1992).

RECOMMENDATIONS FOR THERAPY

Lesbian and gay individuals and couples enter therapy for the same reasons others do, that is, for depression, anxiety, alcoholism (Shernoff & Finnegan, 1991), conflicts in intimate relationships, and dysfunctional families of origin (Isenee, 1991). Their concerns are frequently intertwined with issues specific to gays and lesbians such as concerns about disclosure, lack of role models or guiding rituals, discrimination, and anti-gay violence (Herek, 1995). The therapist needs to assess the extent to which the presenting problems are related to a gay or lesbian identity. In working with individuals, it is useful to assess the stages of lesbian/gay identity development and how this intersects with other aspects of identity development (e.g., ethnic/cultural, religious, or professional), the degree of connection or support the client can draw from the lesbian and gay community, and the degree of real or feared discrimination in job, housing, or neighborhood safety. Additional considerations in working with couples include assessing the impact of the lack of social validation of the relationship, the need for positive role models, exploring effects of gender role socialization and current relationship expectations of each partner, and assessing differences between the two partners in acceptance of a gay or lesbian identity and degree of disclosure to others. All of this must be done within an environment of recognition and validation for the hurdles clients currently face and those that have been overcome. A few specific recommendations follow.

1. Be aware of heterosexism. An essential aspect of understanding stereotyping and prejudice is examining one's own biases. Cultural heterosexism, like institutional racism and sexism, is pervasive in societal customs and institutions. Psychological heterosexism is the manifestation of cultural heterosexism in the individual, as "reflected in feelings of personal disgust, hostility or condemnation of homosexuality and of lesbians and gay men" (Herek, 1995, p. 322). We are less challenged in our biases about things when we have little information about or exposure to them.

Therapists may be uncomfortable discussing lesbian and gay sexuality. In addition, therapists who have introjected negative ecosystemic values about multiple sex partners may need to reexamine those beliefs. Therapists trained to believe that extramarital sex is always a reflection of problems in a primary relationship need to be sensitive to research (Kurdek, 1995) indicating that such perspectives are not necessarily valid for lesbian and gay couples. Reexamining one's beliefs about sexuality often takes courage and support.

2. Use gender-free language. A useful technique for consciousness-raising about our own heterosexist bias is developing the habit of using gender-free language when exploring relationships with any client. (For example: "You indicated you were involved with someone in college, tell me about this person;" "In understanding your current marital relationship, it will be helpful for each of you to describe your experience with former romantic relationships.") Rather than assume that someone is heterosexual, or that you will know if someone is struggling with sexual identity, leave open the possibility that any client or family member may have some feelings or experiences related to same-sex relationships. There is ample evidence that therapists' premature assumptions of heterosexuality have prevented many clients from disclosing same-sex attractions or relationships (Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991). Using gender-neutral language when asking about relationships provides a message to all family members that the therapist is aware that intimacies can exist between members of the same sex and, furthermore, that the therapist is open to receive information about these relationships or feelings.

3. Educate yourself and your clients about lesbian and gay experience. This would include becoming familiar with models of lesbian and gay identity formation and couple development such as those presented in this chapter. These models, an essential foundation for affirmative work with lesbians and gays, address the following: (a) the process by which an individual comes to develop a positive, integrated lesbian or gay identity, (b) stages in the development of lesbian and gay couple relationships, and (c) the unique characteristics of these relationships. Therapists need to appreciate differences between lesbians, gays, and bisexual men or women, and to have some understanding of the vast diversity within each community. The specific cultural context of each client regarding attitudes toward sexuality and sexual identity development can then be considered against this knowledge base. A psychoeducational approach is often indicated as part of working with lesbian and gay clients as well as their families of origin.

4. Identify and use a consultant. A colleague with more experience with gay or lesbian clients can provide clinical consultation. Discussions with a friend who is familiar with the gay or lesbian communities might provide useful consciousness raising. Many professional associations now have formal or informal groups of members interested in the concerns of lesbians and gays. Our clients are our best consultants concerning their own experiences, but it is often counterproductive to rely solely on our clients to provide us with broad perspectives about their experiences.

5. Learn about local support networks. Networks for lesbians may be totally different from those for gays, and networks for bisexual men and women different still. Are lesbians welcome at certain gay events? Where is child care for gay families available? Therapists who are knowledgeable about differences between various resources can encourage clients to become involved in appropriate support networks. Finding positive lesbian or gay role models can be a powerful tool for enhancing self-esteem and allaying fears and stereotypes that are based on misinformation or lack of information.

6. Become aware of relevant ethical issues. Therapists practicing lesbian and gay family psychology need to be aware of ethical issues common to

family psychology—for example, confidentiality, impact of the therapist's values, determining who the client is in family therapy, and so on (Patten, Barnett, & Houlihan, 1991). Dworkin (1992) discussed issues of beneficence, autonomy, diagnosis, confidentiality, privilege, transference and countertransference, dual relationships, and boundary violations in providing therapy to lesbians and gay men. Common bias in therapy with gays and lesbians have been reported by the Committee on Lesbian and Gay Concerns (1990).

7. Use genograms. Genograms (McGoldrick & Gerson, 1985) are useful tools in family therapy and help the therapist and client to understand the family context intergenerationally. In sketching a genogram with a lesbian or gay individual or couple, it is critical to ask who belongs on the genogram and how close the connection should be. Spouses and children from any former heterosexual marriages may be important parts of the genogram (Buxton, 1994). If gay and lesbian clients do not identify extended nonbiological family members, it is recommended that the therapist raise the possibility of defining *family* beyond biological and marital kinship.

8. Use bibliotherapy. You do not need to be the sole source of information for clients, even if they are very closeted about their sexual orientation. Guiding clients to the excellent literature now available, in both fiction and nonfiction forms, can help them discover the variety of experiences for lesbians, gays, and bisexual men and women (see, e.g., Berzon, 1993; Clark, 1990; Fairchild & Hayward, 1989). Their choice of readings and responses to the content can be useful material for therapy.

9. Consider referral when appropriate. We believe that all therapists who sensitize themselves to the concerns of gay and lesbian people can do effective work with these clients. Yet, there are times when referring clients to others is an appropriate choice. Perhaps a client is at a stage in the development of his or her identity where working with a gay or lesbian therapist would be optimal. Perhaps you have worked so well with other gay clients that your caseload is becoming too homogeneous. Working within a small town or with members of the therapist's own culture (e.g., gay, religious, ethnic) may also necessitate referrals to avoid dual relationships (Eldridge, Mencher, & Slater, 1993). If you work with a lot of clients with AIDS or those who have lost lovers and friends to HIV-related illness, you may feel too drained to accept new clients with these concerns for awhile. In such cases, referral to other professionals seems ethical and wise.

Therapists need to be aware of local attorneys, physicians, dentists, and other health care professionals who are competent in addressing lesbian and gay issues in their respective fields. Some clients will not be familiar with these resources.

CONCLUSION

There are negative ecosystemic factors that contribute to the high divorce rate among heterosexuals, and some of these factors are a source of stress for lesbian and gay couples as well. Negotiating these sources of stress without the benefit of legal boundaries and protection is evidence for the strength of lesbian and gay couple relationships. Although the longevity of a relationship is not necessarily an indicator of relationship quality, it is notable that some lesbian and gay couples remain together for more than 50 years, and relationships of 20 years or more are common in the studies that include older gay and lesbian cohorts (Peplau, 1991).

In this chapter, we have addressed important aspects of lesbian and gay family psychology in an effort to make the hidden more visible and to assist clinicians in affirmative work with a range of families that include lesbian and gay members. The discussion of gender role socialization contributes to an understanding of the impact of gender on all family forms, as well as the significant differences that are found between gay and lesbian relationships. We hope that the greater knowledge about lesbian and gay families will bring an appreciation for the similarity of issues and struggles across all family systems and for the diversity of creative responses that are available to all of us in the human family.

References

Balka, C., & Rose, A. (1989). *Twice blessed: On being lesbian, gay and Jewish*. Boston: Beacon Press.

Bergman, S. J. (1991). Men's psychological development: A relational perspective. *Work in Progress, No. 48*.

(Stone Center Working Paper Series). Wellesley, MA: Stone Center.

Bernstein, F. (Ed.). (1993, Spring). *The PFLAGpole: Newsletter of Parents, Families and Friends of Lesbians and Gays.* Washington, DC: Parents, Families and Friends of Lesbians and Gays.

Berry, D. V., & Marks, P. A. (1969). Antihomosexual prejudice as a function of attitude toward own sexuality. *Proceedings, 77th annual convention, American Psychological Association,* 573–574.

Berzon, B. (Ed.). (1993). *Positively gay.* Berkeley, CA: Celestial Arts.

Burch, B. (1993). *On intimate terms: The psychology of difference in lesbian relationships.* Chicago: University of Illinois Press.

Buxton, A. (1994). *The other side of the closet: The coming-out crisis for straight spouses and families.* New York: Wiley.

Campbell, S. M. (1980). *The couple's journey: Intimacy as a path to wholeness.* San Luis Obispo, CA: Impact.

Carl, D. (1986). Acquired immune deficiency syndrome: A preliminary examination of the effects of gay couples and coupling. *Journal of Marital and Family Therapy, 12*(3), 241–247.

Carroll, L., & Gilroy, P. (1993, August). *Study of merger in lesbian couples.* Paper presented at the meeting of the American Psychological Association, Toronto, Canada.

Cass, V. C. (1979). Homosexual identity formation: A theoretical model. *Journal of Homosexuality, 4,* 219–253.

Chodorow, N. J. (1994). *Femininities, masculinities, sexualities.* Lexington, KY: The University Press of Kentucky.

Clark, D. (1990). *Loving someone gay.* Berkeley, CA: Celestial Arts.

Clunis, D. M., & Green, G. D. (1988). *Lesbian couples.* Seattle, WA: Seal Press.

Coleman, E. (1982). Developmental stages of the coming out process. *Journal of Homosexuality, 7*(2/3), 31–44.

Coleman, E. (1987). Assessment of sexual orientation. *Journal of Homosexuality, 14*(1/2), 1–8.

Committee on Lesbian and Gay Concerns, American Psychological Association. (1990). *Final report of the Task Force on Bias in Psychotherapy with Lesbians and Gay Men.* Washington, DC: Author.

Curry, H., & Clifford, D. (1991). *A legal guide for lesbian and gay couples.* Berkeley, CA: Nolo Press.

D'Augelli, A. R., & Garnets, L. D. (1995). Lesbian, gay and bisexual communities. In A. R. D'Augelli & C. J. Patterson (Eds.), *Lesbian and gay identities over the lifespan: Psychological perspectives on personal, relational, and community processes* (pp. 293–320). New York: Oxford University Press.

Devine, J. (1984). A systemic inspection of affectional preference orientation and the family of origin. In R. Schoenberg & R. S. Goldberg (Eds.), *Homosexuality and social work* (pp. 9–17). New York: Haworth.

Dworkin, S. H. (1992). Some ethical considerations when counseling gay, lesbian, and bisexual clients. In S. H. Dworkin & F. J. Gutierrez (Eds.), *Counseling gay men and lesbians: Journey to the end of the rainbow* (pp. 325–334). Alexandria, VA: American Association for Counseling and Development.

Eldridge, N. S. (1987). Gender issues in counseling same-sex couples. *Professional Psychology, 18,* 567–572.

Eldridge, N. S., & Gilbert, L. A. (1990). Relationship satisfaction in lesbian couples. *Psychology of Women Quarterly, 14,* 43–62.

Eldridge, N. S., Mencher, J., & Slater, S. (1993). The conundrum of mutuality in psychotherapy: A lesbian perspective. *Work in Progress, No. 48.* (Stone Center Working Paper Series). Wellesley, MA: Stone Center.

Elise, D. (1986). Lesbian couples: The implications of sex differences in separation-individuation. *Psychotherapy, 23*(2), 305–310.

Fairchild, B., & Hayward, N. (1989). *Now that you know: What every parent should know about homosexuality.* New York: Harvest/HBJ.

Forstein, M. (1986). Psychodynamic therapy with gay male couples. In R. S. Stein & C. J. Cohen (Eds.), *Contemporary perspectives on psychotherapy with lesbians and gay men* (pp. 103–137). New York: Plenum.

Fox, R. C. (1995). Bisexual identities. In A. R. D'Augelli & C. J. Patterson (Eds.), *Lesbian and gay identities over the lifespan: Psychological perspectives on personal, relational, and community processes* (pp. 48–86). New York: Oxford University Press.

Garcia, N., Kennedy, C., Pearlman, S., & Perez, J. (1987). The impact of race and culture differences: Challenges to intimacy in lesbian relationships. In the Boston Lesbian Psychologies Collective (Ed.), *Lesbian psychologies* (pp. 142–160). Chicago: University of Illinois Press.

Garnets, L., Hancock, K. A., Cochran, S. D., Goodchilds, J., & Peplau, L. A. (1991). Issues in psychotherapy with lesbian and gay men: A survey of psychologists. *American Psychologist, 46,* 964–972.

Goodrich, T. J., Rampage, C., Ellman, B., & Halstead, K. (1988). *Feminist family therapy: A casebook.* New York: Norton.

Greene, B. (1994). Ethnic-minority lesbians and gay men: mental health and treatment issues. *Journal of Consulting and Clinical Psychology, 62*(2), 243–251.

Green, G. D., & Bozett, F. W. (1991). Lesbian mothers and gay fathers. In J. C. Gonsiorek & J. D. Weinrich (Eds.), *Homosexuality: Research implications for public policy* (pp. 197–229). Newbury Park, CA: Sage.

Hammersmith, S. (1987). A sociological approach to counseling homosexual clients and their families. *Journal of Homosexuality, 14*(1/2), 173–190.

Helminiak, D. (1994). *What the Bible really says about homosexuality.* San Francisco: Alamo Square Press.

Herek, G. M. (1995). Psychological heterosexism in the United States. In A. R. D'Augelli & C. J. Patterson (Eds.), *Lesbian and gay identities over the lifespan: Psychological perspectives on personal, relational, and community processes* (pp. 321–346). New York: Oxford University Press.

Herz, F. M., & Rosen, E. J. (1982). Jewish families. In M. McGoldrick, J. K. Pearce, & J. Giordano (Eds.), *Ethnicity and family therapy* (pp. 364–392). New York: Guilford Press.

Isensee, R. (1991). *Growing up gay in a dysfunctional family: A guide for gay men reclaiming their lives.* New York: Simon & Schuster.

Jackson, L. (1993). *Colorlife: The lesbian, gay, twospirit & bisexual people of color magazine* (pp. 21–23). 2840 Broadway, Suite 287, New York, New York 10025.

Klinkenberg, D., & Rose, S. (1994). Dating scripts of gay men and lesbians. *Journal of Homosexuality, 26*(4), 23–35.

Kurdek, L. A. (1995). Lesbian and gay male close relationships. In A. R. D'Augelli & C. J. Patterson (Eds.), *Lesbian and gay identities over the lifespan: Psychological perspectives on personal, relational, and community processes* (pp. 243–261). New York: Oxford University Press.

Lockman, P. (1984). Ebony and ivory: The interracial gay male couple. *Lifestyles, 7*(1), 44–55.

Lovejoy, N. C. (1990). AIDS: Impact on the gay man's homosexual and heterosexual families. In F. W. Bozett & M. B. Sussman (Eds.), *Homosexuality and family relations* (pp. 285–316). New York: Harrington Park.

Martin, A. (1993). *The lesbian and gay parenting handbook: Creating and raising our families.* New York: Harper Collins.

Mattison, A. M., & McWhirter, D. P. (1990). Emotional impact of AIDS; Male couples and their families. In B. Voeller, J. M. Reinisch, & M. Gottlieb (Eds.), *AIDS and sex* (pp. 401–419). New York: Oxford University Press.

McGoldrick, M., & Gerson, R. (1985). *Genograms in family assessment.* New York: Norton.

McPherson, D. (1994, August). *Gay parenting couples: Same gender parents raising children.* Paper presented at the meeting of the American Psychological Association, Los Angeles, CA.

McWhirter, D. P., & Mattison, A. M. (1984). *The male couple: How relationships develop.* Englewood Cliffs, NJ: Prentice-Hall.

Mencher, J. (1990). Intimacy in lesbian relationships: A critical re-examination of fusion. *Work in Progress, No. 42.* (Stone Center Working Papers Series). Wellesley, MA: Stone Center.

Morales, E. (1989). Ethnic minority families and minority gays and lesbians. *Marriage and Family Review, 14,* 217–239.

Morin, S. F., & Charles, K. A. (1983). Heterosexual bias in psychotherapy. In J. Murray & P. R. Abramson (Eds.), *Bias in psychotherapy* (pp. 309–338). New York: Praeger.

National Commission on AIDS. (1992). *The challenge of HIV/AIDS in communities of color.* Washington, DC: Author.

Patten, C., Barnett, T., & Houlihan, O. (1991). Ethics in marital and family therapy: A review of the literature. *Professional Psychology, 22,* 174–176.

Patterson, C. J. (1995). Lesbian mothers, gay fathers, and their children. In A. R. D'Augelli & C. J. Patterson (Eds.), *Lesbian and gay identities across the lifespan: Psychological perspectives on personal, relational, and community processes* (pp. 262–290). New York: Oxford University Press.

Paul, J. P., Hays, R. B., & Coates, T. J. (1995). The impact of the HIV epidemic on U.S. gay male communities. In A. R. D'Augelli & C. J. Patterson (Eds.), *Lesbian and gay identities over the lifespan: Psychological perspectives on personal, relational, and community processes* (pp. 347–397). New York: Oxford University Press.

Peplau, L. A. (1991). Lesbian and gay relationships. In J. C. Gonsiorek & J. D. Weinrich (Eds.), *Homosexuality: Research implications for public policy* (pp. 177–196). Newbury Park, CA: Sage.

Peterson, J. L. (1992). Black men and their same-sex desires and behaviors. In G. Herdt (Ed.), *Gay culture in America* (pp. 147–164). Boston: Beacon Press.

Plummer, K. (1975). *Sexual stigma: An interactionist account.* London: Routledge and Kegan Paul.

Pollack, W. S. (1990). Men's development and psychotherapy. *Psychotherapy, 27*(3), 316–321.

Robinson, B. E., Walters, L. S., & Sheen, P. (1989). Response of parents to learning that their child is homosexual and concerns over AIDS. *Journal of Homosexuality, 18*(1/2), 59–80.

Rohrbaugh, J. B. (1992). Lesbian families: Clinical issues and theoretical implications. *Professional Psychology, 23,* 467–473.

Savin-Williams, R. C. (1995). Lesbian, gay, and bisexual adolescents. In A. R. D'Augelli & C. J. Patterson (Eds.), *Lesbian, gay, and bisexual identities across the lifespan: Psychological perspectives on personal, relational, and community processes* (pp. 165–189). New York: Oxford University Press.

Scrivner, R. W. (1984, August). *A model for the development of lesbian and gay identities.* Paper presented at the meeting of the American Association for Marriage and Family Therapy, San Francisco, CA.

Shernoff, M., & Finnegan, D. (1991). Family treatment with chemically dependent gay men and lesbians. *Journal of Chemical Dependency Treatment, 4*(1), 125–135.

Shernoff, M., & Scott, W. A. (1988). *The sourcebook on lesbian/gay health care.* Washington, DC: The National Lesbian and Gay Health Foundation.

Slater, S. (in press). *The lesbian family life cycle.* New York: Free Press.

Slater, S., & Mencher, J. (1991). The lesbian family life cycle: A contextual approach. *American Journal of Orthopsychiatry, 61*(3),. 372–382.

Smith, M. J. (Ed.). (1983). *Black men/white men.* San Francisco: Gay Sunshine Press.

Smith, R. W. (1975). Why are many societies sex negative? A social-functionist theory. *Counseling Psychologist,* 5(1), 84–89.

Strommen, E. (1989). Hidden branches and growing pains: Homosexuality and the family tree. *Marriage and Family Review, 14*(3/4), 9–34.

Tafoya, T., & Rowell, R. (1988). Counseling gay and lesbian Native Americans. In M. Shernoff & W. A. Scott (Eds.), *The sourcebook on lesbian/gay health care* (pp. 63–67). Washington, DC: The National Lesbian/Gay Health Foundation.

Troiden, R. R. (1979). Becoming homosexual: A model of gay identity acquisition. *Psychiatry, 42,* 362–392.

Tunnell, G. (1993, August). *Couples therapy with gay males: The challenges of HIV and AIDS.* Paper presented at the meeting of the American Psychological Association, Toronto, Canada.

Weinberg, M. S., Williams, C. J., & Pryor, D. W. (1994). *Dual attraction.* New York: Oxford University Press.

Weston, K. (1991). *Families we choose.* Boston: Alyson.

Whitman, F. L., & Mathy, R. M. (1985). *Homosexuality in four societies: Brazil, Guatemala, the Philippines, and the United States.* New York: Praeger.

Zacks, E., Green, R., & Marrow, J. (1988). Comparing lesbian and heterosexual couples on the circumplex model: An initial investigation. *Family Process,* 27, 472–484.

APPENDIX

Resources for Lesbian and Gay Families

Publications

Barrett, R. L., & Robinson, B. E. (1990). *Gay fathers.* Lexington, MA: Lexington Books.

Bor, R., Miller, R., & Goldman, E. (1993). *Theory and practice of HIV counseling: A systemic approach.* New York: Norton.

Carl, D. (1990). *Counseling same-sex couples.* New York: Norton.

Gay and Lesbian Parents Coalition International (1993). *Books for children of lesbian and gay parents.* Washington, DC: Gay and Lesbian Parents Coalition International.

Graham, D. L., Rawlings, E. I., Halpern, H. S., & Hermes, J. (1984). Therapists' needs for training in counseling lesbians and gay men. *Professional Psychology: Research and Practice, 15,* 482–496.

In the Family, 7302 Hilton Av., Takoma Park, MD 20912 (professional magazine).

Kimmel, D. C., & Sang, B. E. (1995). Lesbians and gay men in midlife. In A. R. D'Augelli & C. J. Patterson (Eds.), *Lesbian and gay identities across the lifespan: Psychological perspectives on personal, relational, and community processes* (pp. 190–214). New York: Oxford University Press.

Quan, J. D. (Ed.). (1994). *Outward.* (Quarterly newsletter of the Lesbian and Gay Aging Issues Network of the American Society on Aging, 833 Market St., Suite 511, San Francisco, CA 94103-1824).

Reid, J. D. (1995). Development in late life: Older lesbian and gay lives. In A. R. D'Augelli & C. J. Patterson (Eds.), *Lesbian and gay identities across the lifespan: Psychological perspectives on personal, relational, and community processes* (pp. 215–240). New York: Oxford University Press.

Roth, S. (1985). Psychotherapy with lesbian couples: Individual issues, female socialization, and the social context. *Journal of Marital and Family Therapy, 11,* 273–286.

Walker, G. (1991). *In the midst of winter: Systemic therapy with families, couples, and individuals with AIDS infection.* New York: Norton.

Youth Magazine, P.O. Box 34215, Washington, DC 20043. Tel: (202) 234-3562 (for lesbian and gay youth).

Organizations

Children of Lesbians and Gays Everywhere (COLAGE), 3023 North Clark, Box 121, Chicago, IL 60657. Tel: (202) 583-8029.

Gay and Lesbian Parents Coalition International (GLPCI), P.O. Box 50360, Washington, DC 20091. Tel: (202) 583-8029.

Parents, Families, and Friends of Lesbians and Gays (PFLAG), P.O. Box 96519, Washington, DC, 20090-6519. Tel: (202) 638-4200.