

Attachment-Based Family Therapy for Lesbian and Gay Young Adults and Their Persistently Nonaccepting Parents

Gary M. Diamond and Maya S. Shpigel
Ben-Gurion University of the Negev

Describes a modification of attachment-based family therapy for working with sexual minority young adults and their persistently nonaccepting parents. The goal of the treatment is to improve the quality of young-adult–parent relationships and promote connection and mutual acceptance. We provide a brief overview of the treatment tasks that comprise the model, describe the rationale behind each task and how it is implemented, offer clinical excerpts, and conclude with thoughts about the limits of the model and future challenges.

Keywords: gay, lesbian, acceptance, family therapy

Finding out that one's child is lesbian or gay is often a life altering event. Even among parents who are generally accepting of sexual minority individuals, the realization that their own children are same-sex oriented can elicit a plethora of challenging emotions, including shock, shame, anger, sadness, and fear. Parents may be concerned that their children are going to be marginalized, stigmatized, and victimized. They may also grieve the loss of the hetero-normative family dream and be anxious about how they will deal with the strangeness of seeing their children with same-sex partners and involved in the gay community. They worry about their children's future and whether they will find loving, committed partners and experience the joys of having their own families, however defined. Most parents also feel at least a twinge of discomfort at the thought of sharing their new status with family, friends, and colleagues. It is not surprising that research suggests over half of parents initially react to their children's disclosure with some degree of negativity (D'Augelli, Grossman, Starks, & Sinclair, 2010; Heatherington & Lavner, 2008; Robinson, Walters, & Skeen, 1989; Savin-Williams, 1998, 2001). As Stone Fish and Harvey (2005) point out, "It is impossible to grow up in a hetero-sexist, homophobic culture like our own and not be influenced by some of the negative messages about queer people" p. 27.

Fortunately, most parents become more accepting, or at least more tolerant, over time (Beals & Peplau, 2006; Cramer & Roach, 1988; Savin-Williams & Ream, 2003). For example, a recent Internet survey of Israeli sexual minority adolescents found that approximately 40% of parents who were initially fully or almost fully rejecting became more accepting by 1.5 years (on average) postdisclosure (Samarova, Shilo & Diamond, 2013). Acceptance seems to be facilitated when parents maintain contact with their children, listen to their stories, and are exposed to sexual minority individuals and culture (Heatherington & Lavner, 2008). Positive responses from extended family members or coworkers, and/or disclosures that they also have a gay or lesbian family member, can also help parents feel more comfortable. Likewise, gay affirmative support groups such as Parents and Friends of Lesbians and Gays (PFLAG) are tremendously helpful for some parents (Ben-Ari, 1995; Holtzen & Agresti, 1990; Robinson, Walters, & Skeen, 1989), as can be the support of gay-affirmative therapists. Many parents report that seeing how relieved and happy their children are helps them to feel more hopeful and accepting (Ben-Ari, 1995).

With that said, a minority of parents remain persistently intolerant or even rejecting. For example, in earlier research on Israeli adolescents and young adults, 9% of mothers and 12% of fathers remained fully or almost fully rejecting a year and a half after disclosure (Samarova, Shilo, & Diamond, 2013). Persistently non-accepting parents typically perceive their children's same-sex orientation as a matter of choice or circumstances (Belsky & Diamond, 2013). They maintain that their children are not really gay, but have identified as such because they were seduced, sexually assaulted, had a traumatic heterosexual experience, are looking for attention, are not able to cope with the stress of heterosexual relations (i.e., "taking the easy way out"), are following current fads, are trying to get back at them (i.e., hurt the parents), and so forth. Acceptance is often more difficult for parents raised or living in families and communities that perceive homosexuality as a deficit, disease, or sin. Such parents may fear losing their extended families and/or social networks. They may be torn between their religious beliefs and their love for their children, or may feel plagued by guilt and shame for not having raised heterosexual children. Often, such parents express their ongoing intolerance or

GARY M. DIAMOND received his PhD in Counseling Psychology from Temple University and completed his post-doctoral training in Clinical Psychology at the University of Pennsylvania School of Medicine. He is an Associate Professor in the Department of Psychology, Ben-Gurion University of the Negev, Beer-Sheva, Israel. His research interests include the process and outcome of family-based treatments, emotional processing and lesbian, gay and bisexual issues in psychotherapy.

MAYA S. SHPIGEL has an MA in Clinical Psychology and is currently completing her PhD dissertation in the Department of Psychology, Ben-Gurion University of the Negev, Beer-Sheva, Israel. She investigates change mechanisms in family therapy, including change processes in family therapy for homosexual offspring and their parents.

CORRESPONDENCE CONCERNING THIS ARTICLE should be addressed to Gary M. Diamond, Department of Psychology, Ben-Gurion University of the Negev, PO. Box 653, Beer-Sheva 84105, Israel. E-mail: gdiamond@bgu.ac.il

rejection through devaluation, criticism, debasement, anger, coercion, or even physical violence. In other cases, they physically withdraw from their children or cut them off from the family (e.g., “You can come back home when you decide to be straight again!”).

Needless to say, ongoing parental criticism, invalidation, and rejection of one’s sexual orientation can take a psychological toll. Criticism, invalidation, rejection, and abuse can lead to internalized homophobia, expectations for future gay-related rejection by others (Pachankis, Goldfried, & Ramrattan, 2008), increased risk for depression and suicidal ideation (D’Augelli et al., 2005; Remafedi, Farrow, & Deisher, 1993; Ryan, Huebner, Diaz, & Sanchez, 2009), and higher levels of drug and alcohol consumption (D’Amico & Julien, 2012; Padilla, Crisp & Rew, 2010; Rothman, Sullivan, Keyes & Boehmer, 2012).

In contrast, parental support of lesbian, gay and bisexual (LGB) youth has been associated with greater self-esteem and greater perceived social support, and has been found to buffer against psychopathology (D’Augelli, 2002; Eisenberg & Resnick, 2006; Evans, Hawton, & Rodham, 2004; Floyd, Stein, Harter, Allison & Nye, 1999; Hershberger & D’Augelli, 1995; Needham & Austin, 2010; Ryan et al., 2010; Savin-Williams, 1989). Adolescents and young adults thrive when their parents are warm, loving, positively involved in their lives and promote autonomy (Steinberg, 2001; Allen, Boykin, & Bell, 2000). Given the potential negative impact of ongoing parental nonacceptance, and the potentially positive impact of parental acceptance on LGB individuals, the development of family-based treatments to increase acceptance among nonaccepting parents is vital.

A number of clinicians have provided insightful guidelines/intervention strategies for working with families of LGB offspring. Lasala (2000), for example, presented an approach rooted in Bowen’s theory (Bowen, M., 1985) designed to help families navigate what he termed the “coming-out crisis.” He described the importance of uncovering and addressing the emotions and needs of both the coming-out individual and his or her parents, helping parents to grieve the loss of their heteronormative dreams, and helping parents to obtain accurate information about sexual orientation, gay identity development, and life choices. He also suggested that treatment focus on helping the individual and his or her parents communicate in a noncombative manner and remain connected in a way that allows them to address their individual needs in a safe environment.

Stone Fish and Harvey (2005), in their book *Nurturing queer youth*, describe a rich clinical model for helping families navigate the coming out process, and for deepening intimacy and expanding queer consciousness in families who are already aware of their children’s nonheterosexual identities. In the first stage of treatment, therapists strive to create safe refuge for all family members by being responsive, e.g., simultaneously empathizing with family members, validating their experiences, expressing a commitment to protect them, and challenging them to think in ways that are new, different, and possible. Once safe refuge has been established, therapists facilitate direct, honest conversations about difficult topics and feelings.

This paper presents a modification of attachment-based family therapy (ABFT: Diamond, Diamond & Levy, 2014) derived from our work with lesbian and gay young adults and their persistently nonaccepting parents. ABFT is an empirically supported,

principle-driven, structured, time-limited (12–16-week) treatment originally designed for depressed and suicidal adolescents. Rooted in the structural tradition (Minuchin, 1977) and influenced by multidimensional family therapy (Liddle, 1999) and emotion-focused therapy (Johnson & Greenberg, 1995), the theoretical foundation for the treatment is based on attachment theory and research on adolescent development and parenting (Allen, Moore, Kuperminc & Bell, 1998; Bowlby, 1988; Kobak & Sceery, 1988; Lynch & Cicchetti, 1991; Rosenstein & Horowitz, 1996; Steinberg, 2001). Secure attachment—the adolescent’s sense that she or he is understood, validated, cared for and protected by her or his parents—has been associated with a range of positive psychosocial indices, including greater self-esteem (Cooper, Shaver & Collins, 1998), better mental health (Kobak & Sceery, 1988; Salzinger, Feldman, Rosario & Ng-Mak, 2011; Sund & Wichstrøm, 2002), and better problem-solving skills (Kobak & Duemmler, 1994). Therefore, ABFT first focuses on improving trust, safety, and parental care and responsiveness in the context of the adolescent–parent attachment relationship. Once the attachment bond has been repaired, the second half of the treatment focuses on promoting adolescent psychological autonomy and competence.

To accomplish these goals, the ABFT therapist works through a sequence of five treatment tasks. Each task may take one or several sessions. The first task, the relational reframe task (Diamond & Siqueland, 1998), involves meeting with the adolescent and parents together to shift the focus of therapy away from extrafamilial challenges (e.g., school failure, peer conflict) or symptoms per se, and onto the quality of the adolescent–parent relationship. By the end of this task, family members have committed to relationship building as the primary goal of treatment. The second task, the alliance building task with the adolescent, occurs in the context of individual sessions with him or her and focuses on engaging the adolescent in treatment, building hope for change, and preparing him or her to productively discuss with parents the circumstances and feelings associated with past attachment ruptures, as well as current unmet attachment needs. The third task, the alliance building task with the parent, is conducted in the context of individual sessions with parents alone. During this task, the therapist supportively explores parents’ strengths and competencies, the stressors affecting them (e.g., psychiatric distress, marital problems), parents’ own attachment history, and their availability to parent their child. In addition, the therapist prepares parents to respond to their children’s distress and unmet attachment needs in an open, empathic, supportive manner in subsequent, conjoint sessions. The fourth task, the attachment task, is the culmination of the work completed in the first three tasks. The attachment task is designed to provide the adolescent with a new, corrective experience of their parents in which they feel heard, cared about, validated, and taken care of. The task, conducted in the context of conjoint sessions, begins with the adolescent identifying past and present negative family processes (e.g., conflict, neglect) that ruptured the attachment bond and damaged trust. As parents respond empathetically, adolescents further disclose vulnerable emotions and unmet attachment needs (Diamond & Liddle, 1999). Such corrective attachment experiences are thought to change adolescents’ very attachment schema (i.e., they begin to see parents as less critical and more available and benevolent), thus increasing the likelihood of their using their parents in the future for support and guidance during times of distress. The fifth task, the competency promoting

task, focuses on helping parents serve as a secure base as they support and guide their children through the normative developmental challenges of adolescence. A more detailed description of the model can be found in the ABFT manual (Diamond, Diamond & Levy, 2014).

Two randomized clinical trials have found ABFT to be more effective than treatment-as-usual (Diamond, Reis, Diamond, Siqueland, & Isaacs, 2002; Diamond, Siqueland & Diamond, 2003; Diamond et al., 2010). ABFT has recently been designated a “proven program” by the RAND Corporation’s Promising Practices Network and appears on the United States Department of Health and Human Services Substance Abuse & Mental Health Services Administration (SAMHSA) National Registry of Evidence-Based Programs and Practices. Secure attachment may be particularly critical for sexual minority adolescents and young adults in light of the potential for (and/or fear of) parental rejection and exposure to minority stress (Mohr & Fassinger, 2003). In prior treatment-development work, the model was adapted for, and tested with, suicidal and depressed LGB adolescents (Diamond et al., 2012). Adaptations included spending more time with parents alone to work through their shame, fear, and anger associated with the same-sex orientation of their adolescent; exploring parents’ meaning of acceptance; recalibrating adolescents’ expectations regarding their parents’ capacity to accept, and pace of acceptance; and raising awareness regarding microaggressions.

ABFT for Lesbian and Gay Young Adults and Their Persistently Nonaccepting Parents

This paper describes further modifications of the treatment as implemented with lesbian and gay young adults and their persistently nonaccepting parents. The modifications are based on our cumulative clinical experience treating such clients over the past 10 years, and on the basis of the first six family-patients completing treatment (two additional cases prematurely terminated therapy) as part of the Ben-Gurion University Family Connection Project located in Beer-Sheva, Israel. The young adults in the Family Connection Project were between 18 and 29 years of age ($M = 24.1$, $SD = 4.5$). Three identified as gay males and three identified as lesbians. All were currently undergraduate or graduate university students, had been “out” to their parents for at least a year, and no longer lived in their parents’ homes. Participants were recruited through LGBT organizations in the university and the surrounding community. The project was presented as an opportunity for sexual minority individuals experiencing parental nonacceptance to work on improving their relationships with their parents. Participants’ reasons for coming to therapy varied. For example, in one case, a young man came to therapy because he was being ridiculed and harassed at home by his sibling for being gay, and had not been able to get his parents to protect him, or even to acknowledge how serious the harassment was. In another case, a young man felt worried and burdened by his parents’ pain and suffering because of his sexual orientation and wanted to somehow find a way to make it easier for them. In two other cases, young women reported feeling frustrated that their parents did not accept them for who they were, and, in fact, denied the authenticity of their same-sex orientation. In both of these cases, the young women were looking for recognition from their parents as well as a path back to having close, honest relationships with them.

Treatment was provided by the first author, an experienced clinical psychologist and family therapist, and one of the developers of ABFT, along with the second author, a clinical psychology doctoral student. The course of treatment lasted between 10 and 50 sessions ($M = 33.5$, $SD = 17$). On average, we conducted 17.7 ($SD = 5.5$) sessions with each young adult alone, 9.5 ($SD = 6.1$) sessions with parents alone, and 5.7 ($SD = 3.8$) conjoint sessions per case. Treatment was provided free of charge.

Below, we provide a brief overview of the treatment tasks that comprise the model as adapted for lesbian and gay young adults and their nonaccepting parents. In contrast to our work with suicidal and depressed adolescents, in which the *parents* typically initiate treatment out of concern for their adolescents’ welfare, in this sample it was the *young adults* who initiated therapy. Their presenting complaints or problem definitions were inherently relational (i.e., “My parents do not accept me”) and questions regarding “if, when, or how” to engage their parents in the treatment were salient. Therefore, the first task of treatment involved alliance building in sessions alone with the young adult, rather than conjoint relational reframe sessions. Also, since recruiting their non-accepting parents to participate in therapy posed a challenge for these young adults (due to anxiety about being rejected again), the second task in this adapted model involved helping the young adult plan and prepare to recruit their parents. In the following paragraphs, we describe the rationale behind each task and how it was implemented, as well as provide clinical excerpts. Identifying information, including the names of the clients, was altered to protect confidentiality.

Overview of Model

In an effort to promote healthy young-adult–parent attachment, the therapist conducts a sequence of five treatment tasks. The first task is to build a therapeutic alliance with the young adult. The therapist meets alone with the young man or woman to form a bond, identify strengths and stressors, better understand the presenting problem, and establish relationship building with parents as the primary treatment goal. The second task is to prepare the young adult to effectively reach out to her or his parents for the purpose of recruiting them to participate in the treatment process. Once parents have agreed, the third task involves building a therapeutic alliance with them. During individual sessions with parents, therapists form a bond; identify strengths and stressors; hear the parents’ experiences of having a lesbian or gay child; work through some of the parents’ anger, fear, and shame; explore the parents’ relationships with their extended families; explore the impact the child’s same-sex orientation has had on their relationship with their child; and establish relationship building with their young-adult child as the goal of therapy. The fourth task involves preparing the young-adult children and their parents separately for subsequent in-session conversations about difficult and previously heretofore avoided topics, including those related to the child’s lesbian or gay identity. Preparation includes identifying core, relational (e.g., trust) content; articulating thoughts and feelings; and coaching family members to speak and listen to one another in a nondefensive, nonreactive, compassionate manner. During the fifth task, the therapist facilitates the unfolding of these conversations, which we refer to as attachment episodes. When parents and their children are able speak about their pain, loss, and longing in

an empathic, honest, open manner, such conversations can diffuse tension, make new information available to both parents and their young-adult child, and create the possibility of increased intimacy and acceptance. When such conversations go well, they can change the way family members experience one another and transform the nature and strength of the attachment bond.

Task I: Alliance Building With the Young Adult

The alliance building with the young-adult task includes a number of stages and typically requires multiple sessions alone with the young adult to complete. The first stage involves forming a bond with the adult child. We begin by getting to know him or her as a person, above and beyond the challenges he or she is having with his or her parents. We actually say, "I know you have come to us because there are some issues with your parents, and we will get into that shortly. Beforehand, however, I would like to take some time to get to know other aspects of your life, what is going well. Can you tell me a little about yourself, your life, what you like, what you are good at?" During this part of the conversation, we try to get an understanding of what is going on in the central domains of the young man or woman's life: school, work, friendships, romantic relationships, interests and talents, life challenges unrelated to relationships with parents (e.g., health issues), and the existence of available support systems. During this stage, we try to focus on strengths and accomplishments. The purpose of this stage is to connect with these young adults, increase comfort, to communicate that we know they are much more than their problems/struggles, and to get a better understanding of the psychological/emotional resources available to them as we prepare for the work ahead. At this point in the session, we do not delve too deeply into any given domain or topic, but rather try to get a sense of the contours of their lives before moving to the next stage.

In the second stage of the alliance task, we focus on the adult child's experiences/definitions of the problems(s) at hand. We ask them to describe their relationships with their parents, including the frustrations and concerns that have brought them to therapy. For example, one young woman complained about her mother's disinterest in getting to know her partner. She continued by saying that, since coming out to her parents, her relationship with her mother had become more distanced, and that she, the young woman, now had to initiate all contact. She described a recent period during which she was busy with work and couldn't come home to visit for weeks on end, and neither her mother nor father called to find out how she was doing.

During this stage, we not only empathize with the young woman or man, but look to frame their complaints in terms of frustrated attachment needs. In the example above, after spending a good part of the session exploring how the parents had withdrawn, the therapist responded by saying, ". . . it sounds like you feel your parents have disengaged from you ever since you came out to them." The client nods yes. The therapist goes on, "That since you came out, you feel like you and the relationship have become less and less important to them." At this point, the client began to cry. The therapist continued by trying to deepen the affect and help the client access and process previously avoided primary, adaptive emotions associated with the attachment rupture: "I see how painful this is for you."

In other cases, the presenting complaint is more explicitly related to autonomy, boundaries, respect, and safety, rather than a longing for care or connection. For example, one young man reported that what bothered him most was the relentless criticism from his parents and their attempts to control his behavior. He described the following scenario: "Every time I am on the phone, planning to go out with my friends, my mother anxiously tries to listen in to what I am saying. After I hang up, she begins to interrogate me. She wants to know whether I am going out with my old childhood friends or what she calls "those other people." If she realizes that I am going out with my gay friends, she begins crying, yelling at me, trying to hide the keys to the family car." In this case, the therapist responded: "That sounds horrible!" After affirming the young man's feelings, the therapist continued, "I can understand that your mother may be terrified and not know how to handle all of this. At the same time, it is unreasonable for you to have to face these kinds of attacks. You deserve to be treated with respect. You are 20 years old and have the right to choose your own company." The purpose of this stage is to frame the problem in terms of frustrated or unmet attachment needs (e.g., "I want my father to accept and care more about me and our relationship;" "I want my mother to respect my autonomy") and to elicit, amplify, validate, and process the associated pain and/or primary, adaptive, assertive anger.

In the next stage, the objective is to establish relationship building as the goal of therapy. After helping the young adult define her or his frustration and longing in attachment terms, and after documenting her or his pain and anger, the therapist moves to generating hope that the relationship can change, that a healthier connection with the parents can be formed. For example, the therapist might say: "I can see how much you miss what you and your mother once had, how painful this is. Do you wish that, somehow, it could be different? That somehow she could get past her disappointment, anger and fear about your being a lesbian and be there for you again the way she once was?" In another example, the relational goals were less lofty and more instrumental: "It sounds like you aren't asking for much. Just that during those Saturday afternoon meals when the family gets together for three hours, your mother stops making homophobic comments—at least from the time you come over to her house until the time you leave. It sounds like that would be important to you, allow you to feel like you can come to family gatherings once a week and stay connected." Typically the answer is "yes." The objective here is to create relationship building, including mutual acceptance or respect, as the primary goal of therapy.

Once a relational goal for the therapy has been formulated, the next stage involves getting the young adult to "sign on" to the idea of speaking directly to his/her parents about what is bothering him/her and what he/she needs in the context of conjoint sessions. This is not always easy. The young women and men we see often come to therapy after months or even years of frustrating attempts to convey their needs to their parents. They have pleaded, cried, yelled, threatened to distance themselves—to no avail. Consequently, they come to us with a fair degree of ambivalence or even trepidation, fearful that things may not ever work out, regardless of what they do. So, although they turn to us hoping for change, they are also tentative.

We acknowledge their fears and, simultaneously, engender hope. We present ourselves as experts who can help. We often say:

"I hear how ambivalent you are—I know that you have tried many times to talk with your mother about this, and nothing has worked. This is my job. My job is to find a way to help parents listen to their children so that their children feel heard." We also make it clear to the young adult that we are not going to put him or her in a position to be hurt further as the result of the therapy: "I have a lot of experience doing this. In most cases, I am able to help parents listen better and respond better. However, I will meet with your parents alone before we have any meetings together. If I think that they are not capable of listening, then we won't have the conversation. I am not going have you two in the same room together if I am not sure that things can be better." We are also careful not to create unrealistic expectations. We know that in some cases, the best parents may be able to do is to refrain from being hurtful. For these parents, acceptance of their children's same-sex orientation may be currently beyond their capabilities and, instead, the goal of treatment is to establish a civil, respectful relationship with clear boundaries. After generating hope and insuring safety, we verify that the client is onboard: "So, you have tried this alone for a long time with no avail. Are you willing to give it a try with me?" Assuming the answer is yes, we move forward with the treatment.

Task II: Preparing Young Adults to Reach Out to Their Parents

As mentioned above, in most cases with nonaccepting parents, it is the young adult who initiates treatment, not the parent. Most nonaccepting parents are too angry, scared, or ashamed to consider therapy. Many are waiting, hoping for their children to "change back" to being heterosexual. They tend to see sexual orientation as a choice and take their children's supposed choice personally, as an expression of selfishness or disrespect. Even those who acknowledge that their children's sexual orientation is not necessarily a choice may be consumed by their shame, loss, and anger. Such parents try to avoid thinking or talking about their children's sexuality and are reluctant to ask for help for themselves. Consequently, we spend time in sessions alone with the young adults, strategizing about how to best invite their parents to therapy.

Our general approach is to help the young man or woman appeal to his or her parents' innate love or urge to care for them. We assume that behind parents' disappointment, resentment, and anger at their children's same-sex orientation, they harbor a natural instinct to love, care for, and protect their son or daughter. We help gay adult children articulate their desire to have different, closer, more respectful and caring relationships with their parents, which is sometimes difficult. The young adults who come to us have often been hurt badly, having been teased, criticized, rejected, or sometimes abused because of their sexuality. However, if we have been successful during the alliance-building task, the young adults will have accessed their underlying wishes for their parents' protection, acceptance, and care. We work with young adults to prepare them to express those wishes to their parents from a place of need and vulnerability by helping them find the right words. Sometimes the first formulation is too accusatory. In other instances, it reflects the hurt but doesn't express a wish for things to be different—for the relationship to be better. We typically spend a whole session helping the young man or woman articulate what he or she wants to say.

In some cases, our young-adult clients choose to have the conversation with their parents at home. In other cases, they prefer to write their parents letters. When our clients choose to speak to their parents at home, we first practice the conversation with them during individual sessions. When a client chooses to write a letter, we have them write the letter during the session, or have her or him write a draft at home and we then go over it during the next session. It is important that the words touch the parent's heart-strings—the goal is to circumvent shame, fear, resentment, and anger. If parents feel threatened or blamed, they are not likely to come.

We also prepare our young-adult clients for the possibility that their parents will refuse to attend therapy. If the preparation is done well, this rarely happens, but is always a possibility. A particular parent may be so hurt, angry, or scared that she or he refuses to engage in the process. In such circumstances, we help the young adults grieve the loss of their relationships with their parents. Even in such circumstances, the young woman or man can be comforted in knowing that she or he has done all that was in her or his power to reach out. When parents are unresponsive, we help the young adults to identify and solicit other family members or individuals who might be able to provide the care, support, and protection they need and deserve.

Task III: Alliance Building With Parents

In our clinical experience, most parents respond positively to their gay young-adult children's heartfelt pleas to at least come and meet with us once. This is perhaps the most critical and delicate part of the therapy (Shpigel & Diamond, 2013). We immediately schedule a session alone with the parents so that we can devote our full attention to their distress and concerns. We begin by thanking them for coming. Then we ask a few questions about the details of their lives, focusing on their strengths and accomplishments. We then invite them to share what it has been like for *them* since finding out that their child is lesbian or gay. Since we have already met with their children, we know that the road has been difficult for these parents. We are empathetic and try to connect to their pain as directly and deeply as possible. The therapist will say something like, "Mr. Simon. I am so honored that you agreed to come here today. I know that all of this has not been easy, learning that your son is gay." Typically, just acknowledging and validating parents' sense of loss and pain elicits a wave of emotion. Some parents have never spoken to anybody about their feelings, and they begin sobbing. We hear responses such as, "You have no idea. Life has not been the same. I go to sleep living a nightmare and, when I wake up, the nightmare hasn't gone away—this is our life. I can't focus at work and my wife's blood pressure has gone up. Our life as we know it has been destroyed". Some parents are organized by anger and blame: "By deciding to be with girls, she is ruining her life and ours!" The therapist remains supportive and empathetic. Even if we disagree with parents' perspectives, this is not yet the time to challenge them. The therapist asks for more details and validates and accepts the parents' pain. For example, the therapist might say, "Think back and tell me what happened the night you found out" or "What has been the worst moment or part of this all?" At this juncture of the alliance-building task, we want to bear witness to and validate parents' pain, anger, sadness, and confusion. We want to create an atmosphere where even the most

unthinkable, unspeakable thoughts and feelings can be said (e.g., “I feel horrible saying this, and I would not ever say to anybody else, but if I had known he would be gay, I would have stopped after two children”). Sexuality can be an emotionally laden, reactive topic, and sessions alone with parents allow them to express and process things it would be better not to say in front of their children (Lasala, 2000).

With parents who blame their children for their same-sex orientation, we eventually begin to *gently* challenge their causal attributions. A substantial amount of research has shown a consistent link between causal attributions and acceptance (Haider-Markel & Joslyn, 2008; Shpigel, Belsky & Diamond, 2013). The more parents believe that sexual orientation is innate, the more accepting they are. The more they believe it is a choice, the less accepting they are (Belsky & Diamond, 2013). With a great deal of empathy, we ask questions of the type below:

Therapist: “Mr. Gur, I can see how hard this has been for you—I can feel your pain. I wanted to ask you about something you said a few minutes ago. You mentioned that you were angry at your daughter for choosing to have a relationship with a woman. I was curious, do you think your daughter has chosen to be attracted to women and not men or that this is simply the way she was born?”

Father: “I definitely think this is a choice. It is her pattern. Whenever she can take the easy road, she does. This woman approached her, was nice, and it was just easier than dating and dealing with men.”

Mother: “. . . and it isn’t like she hasn’t been with men. Remember, she was with her first boyfriend almost two years! If she wasn’t attracted to men, then what was she doing with him! I saw them together, I saw the affection, I saw them kiss . . .”

Challenging parents’ blaming causal attributions is important for a number of reasons. First, it allows the therapist to gradually introduce the possibility that their child has not “chosen” to have a same-sex orientation. When parents come to the realization that, perhaps, their children did not choose to be gay, they often soften. Such a realization can be a critical turning point in the acceptance process. Second, once the therapist has introduced the possibility that the young adult’s sexual orientation may be innate, parents typically become confused, anxious and motivated to make sense of the apparent contradictions between their children’s self-stated identity and his or her past behavior. The therapist is then in the position to suggest direct, in-session conversations between parents and their children as an opportunity for parents to ask questions and gain clarity.

Therapist: “You know Mrs. Gur, that is a great question. I am sure as a parent, watching from the side, it must be very confusing witnessing what seemed like contradicting behaviors. I have known women, for example, who have stayed in relationships with men because they thought that that was what they were supposed to do or because they were afraid of others finding out that they were lesbian. That may or may not be the case with your daughter. In any event, I think that would be a great conversation for you to have with your daughter. If you would be willing to ask the questions and really hear and respect the answers, I would be willing to work with her and help her to be as honest as possible with you.”

In the next stage of the alliance-building-with-parent task, the therapist shifts to exploring parents’ relationships with other fam-

ily members. We do this for a number of reasons. We want to know who else in the family knows of the child’s same-sex orientation and how they responded. We want to know which family members may be possible sources of support, and which represent added stressors. For parents struggling with accepting their same-sex-oriented children, support (or lack thereof) from extended family members can be crucial. Typically, not all extended family members respond in the same way. Even in generally nonaccepting families, the therapist is usually able to help parents identify one or more flexible, understanding, and accepting relatives. We encourage parents to turn to these family members, increase their contact with them. For example, in one case we treated, the mother had one sister who was particularly critical and dismissive. Each interaction with this sister made the mother feel worse—more ashamed and angry about her daughter’s lesbianism. In contrast, she had another sister with whom she had less contact, but who was much more accepting and supportive in her attitude. One thrust of the therapy was to help this mother increase contact with her supportive sister and to set better boundaries with her more critical sister. As therapists, we look for potential islands of support and acceptance wherever we can find it.

In the next stage of the alliance-building-with-parent task, therapists initiate the relational reframe. Such reframes are designed to change the focus of conversation away from the purported intrapersonal deficits of the child (i.e., “my son is gay”), and onto the quality of the parent–child relationship. Typical reframe interventions include the following: “Mrs. Elbaz, I hear how disappointed and hurt you were when Keren came out to you. How has that impacted the relationship, the closeness between you?” At this point, there is usually a pause—the conversation slows and parents take a step back and see the bigger picture. Often, such moments of reflection elicit sadness—a sadness associated with the loss of what once was or what could have been.

Mother: “We used to be very, very close. In fact, I was the closest with Rose among all of my children. We would shop together, cook together, and laugh together. When she told me she was lesbian, I felt like I had lost my best friend.”

Therapist: “How did it happen that you two grew apart?”

Mother: “I am angry at her—I just can’t get used to it, to the idea that she is living with a woman.”

Therapist (trying to amplify and document the pain and loss): “It sounds like a big loss, like you have lost one of the dearest and most important relationships in your life.”

Mother (beginning to cry): “Yes, we had so many special moments together.”

When a parent is able to connect to the loss and pain felt in association with the rupture in the relationship with his or her gay child, the therapist amplifies and uses that pain and longing to introduce the possibility of, and generate motivation for, reconciliation. For example, the therapist might say, “Mrs. Elbaz, I see how hard this is for you. I see how sad you are about this. I was wondering if, somehow, you and Keren could find your back to each other, gradually create some of the closeness that was once there—would that be something that you would want?”

In some cases, parents respond with an emotional, unequivocal, and enthusiastic “yes.” They readily adopt relationship building as the goal and agree to make that the focus of the therapy. In most cases with nonaccepting parents, however, it is not so simple. Parents are still scared, avoidant or even resentful. Their focus easily slips back to how hard it is for them, what a difficult position their children’s sexual orientation has put them and their families in, and how much they would like their children to simply “change back” or “decide” to be straight. In such instances, the therapist returns to empathizing with the parent and how difficult this process must be for them. We are compassionate and accepting. At the same time, we continue to gently challenge parents’ attributions regarding the origins and “meaning” of their children’s sexuality and return the focus to the quality of the relationship and the possibility of increased closeness.

Therapist: “Mrs. Gur, I hear how hard this has been for you. I also hear that you are angry at Keren and, perhaps, somewhere inside, you expect her to become the heterosexual girl you always dreamed of having and thought you had. I have to say that my experience is that people generally don’t “choose” whom they are attracted to. I think you might be angry at her or disappointed about something over which she may have no control. We can talk more about this if you want. In the meantime, what strikes me most is the scale of the tragedy I see unfolding between the two of you. You love and miss your daughter so much—that is clear to me. When I talk with Keren, I see the same love and longing to have her mother back, to once again be close. Not every child is willing to come to a program like ours and fight for her relationship with her mother! You are like two ships in the night, passing each other by. Can we use our time together to help the two of you talk? To help the two of you, even in the midst of the confusion, disappointment, fear and anger, reconnect? Is that something you would want?” In most cases, the answer is “yes.”

Task IV: Preparing Family Members for Attachment Episodes

Once our adult-child client and parents have signed on to the goal of relationship building, we move to the next task which is to prepare them, separately, to productively participate in conjoint, in-session conversations we call “attachment episodes.” During attachment episodes, family members speak openly and honestly, often for the first time, about their feelings and needs from one another. It is during such episodes that family members allow themselves to be vulnerable, scared, and sad in the presence of one another. When appropriate, we also help family members to express assertive anger in a compassionate, regulated, nonblaming manner, all in the service of deepening the relationship. Family members experience aspects of each other they may not have seen before (e.g., a father’s underlying care and concern for his son or daughter or the young adult’s longing for parental acceptance). Such conversations become the vehicle for promoting intimacy, reconnection, mutual respect, and acceptance.

For attachment episodes to be productive, however, both the young adult and his or her parents must be motivated and prepared. During alliance-building sessions alone with our young-adult clients, therapists help them to organize their thoughts and feelings and decide what they want to share with their parents first. The goal is to help our clients to access and put words to their heretofore avoided or interrupted primary adaptive emotions, as well to their hopes and needs from their parents. In one case, for

example, a young man decided that what was most important for him to say to his parents was that he felt like they had sacrificed him—cut him out of their lives to placate other family members. He wanted to tell them that he was angry and hurt that they hadn’t stood up for him, and that he expected them to do so in the future. Again, we work with each young-adult to articulate what he or she wants to say as honestly and compassionately as possible. We encourage them to refrain from attacking and, instead, to speak of their anger, pain, and needs in a direct but regulated manner. We also prepare them for potentially less-than-optimal parental responses. We remind them that such conversations will also be hard for their parents, and that it might take time and a number of attempts to get parents to respond in a way that feels satisfactory. We also remind them that we will prepare parents ahead of time and not put them in the room together if we think that their parents aren’t ready. We assure them that we will be in the room with them to support, guide, and protect them when necessary.

Not only do we prepare young adults to speak their feelings, we also ready them to answer their parents’ questions honestly. Part of the reason some parents are confused and frustrated is because their children have (understandably) misled them. So, for example, we prepare young adults to answer their parents’ questions about when they first thought they might be lesbian or gay, whether at some time in the past they had been romantically attracted to somebody of the opposite gender, and so forth. Obviously, we support our young-adult clients’ privacy and are careful to make sure they do not compromise their safety or autonomy. At the same time, however, answering these questions, even if it is somewhat uncomfortable for the young man or woman, can be essential to parents’ coming to terms with the young adult’s sexual orientation.

In sessions alone with parents, we prepare them to use the upcoming attachment episodes to learn more about their children’s experiences and be present in ways they have not been able to do since she or he came out. We teach them about the importance of listening and attunement. We coach them to be curious, remain nondefensive, to be open to their children’s experiences without feeling like they have to agree or justify themselves. In short, we help prepare them to be there for their children while temporarily putting their own fears, shame, and disappointment aside. We know this is difficult and we acknowledge that explicitly. However, we remind them that close, meaningful relationships are based on empathy and sharing. We help them anticipate how they might feel during the conversation, what might come up for them emotionally, and what content or interactions are most likely to trigger or upset them. We help them strategize how to respond in such situations, how to regulate themselves and how to return their focus to their children’s anger, pain, and needs. We also prepare them to ask their children about things that have been confusing for them as parents. For example, in many cases, parents have never really heard the details about their children’s sexual identity development, as such conversations have been too scary to have. During our preparations with parents, we offer the upcoming attachment sessions as opportunities to ask those questions they have never dared to ask before—questions such as, “When did you first realize that you preferred women?” “Was that boy you spent all that time with in 10th grade a boyfriend or just a friend, as you said then?” and “How do you know that you are not attracted to or won’t enjoy sex with women?” Parents often want to know why their children did not tell them about their same-sex attractions

earlier. That type of question opens up the opportunity to engage in conversations about themes such as trust and acceptance and the relationship itself. Like we do when preparing young adults, we assure parents that we will be there to support, guide, and protect them if needed, and ask for their permission beforehand to intervene when necessary.

Task IV: Conducting Attachment Episodes

During attachment episodes, the role of the therapist is to facilitate conversations between the young adult and his or her parents, and to stay on the periphery, outside of the interaction as much as possible. Attachment episodes are safe spaces in which family members can take the risk of speaking about those difficult topics and feelings that have been so hard to talk about in the past. Some of the content has already been prepared in the individual sessions alone with the young-adult and his or her parents. Other content arises spontaneously from such interactions. To the degree possible, the therapist keeps family members focused on core attachment themes such as trust, care, acceptance, and protection. Primary adaptive emotions are marked, amplified, and processed.

In the example below, a mother expresses her confusion and frustration toward her gay son for breaking up with his girlfriend of 3 years:

Mother: "To be honest, I am angry at you. What was wrong with Sheila? I saw how happy you two were together, why couldn't you just stay together and make it work? Things would have been so much easier for you and for everybody else."

Son: "Yes, we got along well but I wasn't in love with her, wasn't attracted to her."

Mother: "Never? All those times I saw you walking hand in hand, you weren't in love?"

Son: "Not in that way. I was never physically attracted to her."

As the mother incorporated the new information her son was providing her, and realized its meaning, she looked down sadly, deflated.

As the conversations continued, the father complained to his son that he is too secretive, that he doesn't tell them (his wife and him) anything about what is going on in his life. The son responded:

Son: "I don't tell you because when I do tell you, you become agitated and critical, both of you."

Mother: "Look, I know you have a boyfriend. I hear the conversations on the phone."

Son: "Yes, I do have a boyfriend."

Father: "How long has it been going on?"

Son: "I would say a year, a little more than a year." (There is a long, tense moment of silence.)

Mother (breaking the silence): "I am actually relieved that you have a boyfriend, happy in fact. My biggest fear was that you would be alone and miserable. The fact that you have somebody comforts me, despite the fact that I don't want you to tell me about him and I don't want to see or meet him—that would be too difficult."

Therapist (to the son): "How does it feel to hear your mother say that?"

Son: "It actually feels good. It feels good to finally be honest and not have to keep that secret anymore. I am also glad that my mother can say clearly that she doesn't want to hear more about him or meet him because it is hard for her. I wish it was different but I can respect that."

Therapist: "Anything else?"

Son: "I need to know that when I come to visit, I am not going to be interrogated. It is uncomfortable and makes the whole visit unpleasant. I want to be able to come over and just enjoy being home with the family."

This short excerpt is an example of family members talking about difficult, threatening themes and emotions in a courageous, open, honest manner. Family members express their fear, pain, disappointment and limitations, disclose new information, and express care for one another. Such conversations, as hard as they may be, are the crucible for forging closer, more intimate parent-child relationships. They promote connection and mutual acceptance.

Discussion

The above clinical model describes the systematic steps ABFT therapists use when working with families with parents having ongoing difficulty accepting their lesbian and gay young adult children. When the process goes well, it can be beautiful and life altering. We have watched resentful, angry, entrenched parents gradually open their hearts and minds and embrace their children in ways we could only dream of. We have watched some parents reach out to develop a close relationship with their children's partners, including them in family events. Some parents have gone through their own process of coming out to family, friends, and coworkers. In other cases, the gains are more modest. As one mother put it, "I feel less angry and anxious about it, but it is still hard for me to think about, imagine. I am a bit disgusted and it is hard for me to talk about, but I don't blame him, don't think he is at fault. I want him to be happy, to have friends and be a part of a community." When successful, this therapy improves the emotional welfare of all involved, as well as the quality of the young-adult-parent attachment relationship.

Even as the ABFT model provides a template for working with these families, the process of the therapy varies from case to case. In some instances, the therapist may have to meet with parents alone for months before they are ready to speak directly with their young adult child. In other instances, parents prefer not to participate in attachment episodes at all, but they and their children report moving, relationship-transforming conversations or acts that occur outside of sessions, at home, at family members' own initiative and timing. For example, in one case, we were working with a lesbian client who came to a session reporting that she was stunned, relieved, happy, and hopeful. She went on to describe an incident with her mother, who had refused for over a year to come see the new apartment she and her partner had been living in. She described how her mother had suddenly showed up that past Sunday morning, unannounced, with a cake in honor of her partner's college graduation. The mother stayed and talked openly with both her daughter and her daughter's partner all day.

The model above presents a sequence of in-therapy tasks for repairing or strengthening the young-adult–parent relationship and increasing acceptance. ABFT therapists also refer parents to extratherapeutic resources. For example, therapists explore with parents the possibility of their participating in gay-affirmative parent groups such as Parents and Friends of Lesbians and Gays (PFLAG). Such groups exist in many communities around the world and have been associated with increased parental acceptance. We also refer parents to relevant literature, including material describing other parents' experiences, as well as the experiences of other gay youth and young adults. We also help parents navigate their own coming-out processes. Sometimes we help them identify potentially accepting or supporting people in their extended families, workplaces, or friendship networks, and think together with parents whether and how they would like to share this personal information with others, how to prepare for potential responses, and so forth.

While we have been successful in some cases; in other cases we have hit the proverbial stone wall. This is a hard population to reach and engage. We have encountered parents who were so scared, so rigid, and so angry that we were unable to get any movement whatsoever. In one case, a father told us during the first session with his wife and him that homosexuality was wrong and that as long as his son was gay, he wanted nothing to do with him. He informed us that there was nothing we or anybody else could say or do to change his mind. Despite our best attempts, he was right—he had shut the door tight and we had no way in. At the end of the session, we shook hands and wished him the best. In another case, the process was far less congenial. From the beginning, the parents explained to us that their child was not really gay and that they believed that, at some time in his life, he had been seduced by an older gay man. They explained that what they wanted from us was to work together with them to change their child's sexual orientation back to heterosexual. We told them that we did not engage or believe in sexual orientation change efforts but that we were willing to help support them in what was obviously a very big crisis for them, as well as help them to figure out how to maintain some type of relationship with their son as this crisis unfolded. We listened empathically to their fear, confusion, and pain. The parents, however, found it difficult to remain with these feelings for any length of time and repeatedly, reflexively returned to the goal of changing their son. After two sessions, they informed us that they were stopping the therapy and berated us for not doing more to help them.

A number of limitations regarding the generalizability of this model should be noted. First, to date, participants in the Family Connection Project have all identified as gay or lesbian, and not as bisexual or transsexual. Working with bisexual and transsexual clients and their families can present unique challenges. Indeed, there are research findings indicating that parents may have particular difficulty accepting their bisexual daughters (Samarova, Shilo, & Diamond, 2013), and that bisexual individuals experience less social support than lesbians and gay men (Balsam & Mohr, 2007). Accepting a transgendered child can be even more complicated and trying. With that said, our clinical experience suggests that child–parent relationship building, and the themes of trust, love, support, validation, and protection, are relevant for, and resonate with, a wide range of sexual minority clients.

Second, all of the young-adult clients in the Family Connection Project to date have been university students with relatively high intellectual and overall functioning. Such resources and strengths likely served them well in the context of this highly demanding therapy. Therapy with less reflective, more impulsive, less regulated individuals might require more behavioral interventions and skills training.

Finally, caution should be used before engaging in this type of work with persistently nonaccepting parents of sexual minority adolescents (as opposed to young adults), particularly if those adolescents are still living at home. Youth living at home are more vulnerable to negative parental reactions. With parents who are verbally abusive, volatile, and have the potential to become physically aggressive, openly discussing the topic of sexual orientation may lead to negative consequences. In such cases, the adolescent may do better to remain in the closet at home, or at least under the radar, and look for support and validation in other places (e.g., LGBTQ support groups, individual therapy, individuals accepting of them within the family or community, etc.). Even among young men and women who are living outside the home, there are cases in which parents are so angry or rigid, and the family is so toxic, that relational work is not possible or indicated, and instead, we work with the gay or lesbian individual only.

This paper presents a working model for improving relationships and promoting connection between lesbian women and gay men and their nonaccepting parents. Although such work is often challenging and not always successful, we believe that in most cases, it is worth a sustained attempt. Developmental research, anecdotal reports, and common sense all suggest that parents continue to be important to their children throughout the life span. At any age, knowing that your parents love you, accept who you are, admire you and will come to your aid, if possible, are comforting thoughts. Such knowledge contributes to self-worth and provides a sense of security, an internalized safe base. Such a safe base can help sexual minority individuals deal with the common and unique challenges inherent in growing up and living in a heterosexist culture. Even when parents have a hard time becoming more accepting, but are at least able to be less critical and more respectful and protective, their children feel safer, can more easily remain connected to the extended family, and are more resilient. The treatment model presented in this article provides a template for helping persistently nonaccepting parents and their lesbian and gay adult children to work through pain, resentment, disappointment, fear, and anger, and toward understanding, compassion, mutual respect, connection, and acceptance. Future research should formally test the efficacy of this adaptation of ABFT, as well as further articulate the model as applied to bisexual and transgendered populations.

References

- Allen, J., Boykin, K., & Bell, K. (2000, March–April). *Autonomy in discussions vs. autonomy in decision making as predictors of developing close friendship competence*. Paper presented at the biennial meeting for the Society of Research on Adolescents, Chicago, IL.
- Allen, J. P., Moore, C., Kuperminc, G., & Bell, K. (1998). Attachment and adolescent psychosocial functioning. *Child Development, 69*, 1406–1419. doi:10.2307/1132274

- Balsam, K. F., & Mohr, J. J. (2007). Adaptation to sexual orientation stigma: A comparison of bisexual and lesbian/gay adults. *Journal of Counseling Psychology, 54*, 306–319. doi:10.1037/0022-0167.54.3.306
- Beals, K. P., & Peplau, L. A. (2006). Disclosure patterns within social networks of gay men and lesbians. *Journal of Homosexuality, 51*, 101–120. doi:10.1300/J082v51n02_06
- Belsky, Y., & Diamond, G. M. (2013). *Causal attributions and parental acceptance of homosexual adult children*. Manuscript submitted for publication.
- Ben-Ari, A. (Ed.) (1995). The discovery that an offspring is gay: Parents', gay men's, and lesbians' perspectives. *Journal of Homosexuality, 30*, 89–112. doi:10.1300/J082v30n01_05
- Bowen, M. (1985). *Family therapy in clinical practice*. New York, NY: Jason Aronson.
- Bowlby, J. A. (1988). *A secure base: Parent-child attachment and healthy human development*. New York, NY: Basic Books.
- Cooper, M. L., Shaver, P. R., & Collins, N. L. (1998). Attachment styles, emotion regulation, and adjustment in adolescence. *Journal of Personality and Social Psychology, 74*, 1380–1397. doi:10.1037/0022-3514.74.5.1380
- Cramer, D. W., & Roach, A. J. (1988). Coming out to mom and dad: A study of gay males and their relationships with their parents. *Journal of Homosexuality, 15*, 79–92. doi:10.1300/J082v15n03_04
- D'Amico, E., & Julien, D. (2012). Disclosure of sexual orientation and gay, lesbian, and bisexual youths' adjustment: Associations with past and current parental acceptance and rejection. *Journal of GLBT Family Studies, 8*, 215–242. doi:10.1080/1550428X.2012.677232
- D'Augelli, A. R. (2002). Mental health problems among lesbian, gay, and bisexual youths ages 14 to 21. *Clinical Child Psychology and Psychiatry, 7*, 433–456.
- D'Augelli, A. R., Grossman, A. H., Salter, N. P., Vasey, J. J., Starks, M. T., & Sinclair, K. O. (2005). Predicting the suicide attempts of lesbian, gay, and bisexual youth. *Suicide and Life-Threatening Behavior, 35*, 646–660. doi:10.1521/suli.2005.35.6.646
- D'Augelli, A. R., Grossman, A. H., Starks, M. T., & Sinclair, K. O. (2010). Factors associated with parents' knowledge of gay, lesbian, and bisexual youths' sexual orientation. *Journal of GLBT Family Studies, 6*, 178–198. doi:10.1080/15504281003705410
- Diamond, G. S., Diamond, G. M., & Levy, S. L. (2014). *Attachment-based family therapy for depressed adolescents*. Washington, DC: American Psychological Association.
- Diamond, G. M., Diamond, G. S., Levy, S., Closs, C., Ladipo, T., & Siqueland, L. (2012). Attachment-based family therapy for suicidal lesbian, gay, and bisexual adolescents: A treatment development study and open trial with preliminary findings. *Psychotherapy, 49*, 62–71. doi:10.1037/a0026247
- Diamond, G. S., & Liddle, H. A. (1999). Transforming negative parent-adolescent interactions: From impasse to dialogue. *Family Process, 38*, 1999, 5–26. doi:10.1111/j.1545-5300.1999.00005.x
- Diamond, G. S., Reis, B. F., Diamond, G. M., Siqueland, L., & Isaacs, L. (2002). Attachment-based family therapy for depressed adolescents: A treatment development study. *Journal of the American Academy of Child & Adolescent Psychiatry, 41*, 1190–1196. doi:10.1097/00004583-200210000-00008
- Diamond, G. S., & Siqueland, L. (1998). Emotions, attachment and the relational reframe: The first session. *Journal of Systemic Therapies, 17*, 36–50.
- Diamond, G. S., Siqueland, L., & Diamond, G. M. (2003). Attachment-Based Family Therapy for Depressed Adolescents: Programmatic Treatment Development. *Clinical Child and Family Psychology Review, 6*, 107–127. doi:10.1023/A:1023782510786
- Diamond, G. S., Wintersteen, M. B., Brown, G. K., Diamond, G. M., Gallop, R., Shelef, K., & Levy, S. (2010). Attachment-based family therapy for adolescents with suicidal ideation: A randomized controlled trial. *Journal of the American Academy of Child & Adolescent Psychiatry, 49*, 122–131. doi:10.1097/00004583-201002000-00006
- Eisenberg, M. E., & Resnick, M. D. (2006). Suicidality among gay, lesbian and bisexual youth: the role of protective factors. *Journal of Adolescent Health, 39*, 662–668. doi:10.1016/j.jadohealth.2006.04.024
- Evans, E., Hawton, K., & Rodham, K. (2004). Factors associated with suicidal phenomena in adolescents: A systematic review of population-based studies. *Clinical Psychology Review, 24*, 957–979. doi:10.1016/j.cpr.2004.04.005
- Floyd, F. J., Stein, T. S., Harter, K. S. M., Allison, A., & Nye, C. L. (1999). Gay, lesbian, and bisexual youths: Separation-individuation, parental attitudes, identity consolidation, and well-being. *Journal of Youth and Adolescence, 28*, 719–739. doi:10.1023/A:1021691601737
- Haider-Markel, D. P., & Joslyn, M. R. (2008). Beliefs about the origins of homosexuality and support for gay rights: An empirical test of attribution theory. *Public Opinion Quarterly, 72*, 291–310. doi:10.1093/poq/nfn015
- Heatherington, L., & Lavner, J. A. (2008). Coming to terms with coming out: Review and recommendations for family systems-focused research. *Journal of Family Psychology, 22*, 329–343. doi:10.1037/0893-3200.22.3.329
- Hershberger, S. L., & D'Augelli, A. R. (1995). The impact of victimization on the mental health and suicidality of lesbian, gay, and bisexual youths. *Developmental Psychology, 31*, 65–74. doi:10.1037/0012-1649.31.1.65
- Holtzen, D. W., & Agresti, A. A. (1990). Parental responses to gay and lesbian children: Differences in homophobia, self-esteem, and sex-role stereotyping. *Journal of Social and Clinical Psychology, 9*, 390–399. doi:10.1521/jscp.1990.9.3.390
- Johnson, S. M., & Greenberg, L. S. (1995). The emotionally focused approach to problems in adult attachment. In N. S. Jacobson & A. S. Gurman, (Eds.), *Clinical handbook of couple therapy* (pp. 121–141). New York, NY: Guilford Press.
- Kobak, R., & Dummmler, S. (1994). Attachment and conversation: Toward a discourse analysis of adolescent and adult security. In K. Bartholomew & D. Perlman (Eds.), *Attachment processes in adulthood. Advances in personal relationships*, (Vol. 5, pp. 121–149). London, England: Jessica Kingsley.
- Kobak, R. R., & Sceery, A. (1988). Attachment in late adolescence: Working models, affect regulation, and representations of self and others. *Child Development, 59*, 135–146. doi:10.2307/1130395
- LaSala, M. C. (2000). Lesbians, gay men, and their parents: Family therapy for the coming-out crisis. *Family Process, 39*, 67–81. doi:10.1111/j.1545-5300.2000.39108.x
- Liddle, H. A. (1999). Theory development in a family-based therapy for adolescent drug abuse. *Journal of Clinical Child Psychology, 28*, 521–532. doi:10.1207/S15374424JCCP2804_12
- Lynch, M., & Cicchetti, D. (1991). Patterns of relatedness in maltreated and nonmaltreated children: Connections among multiple representational models. *Development and Psychopathology, 3*, 207–226. doi:10.1017/S0954579400000080
- Minuchin, S. (1977). *Families and family therapy*. London, England: Routledge.
- Mohr, J. J., & Fassinger, R. E. (2003). Self-acceptance and self-disclosure of sexual orientation in lesbian, gay, and bisexual adults: An attachment perspective. *Journal of Counseling Psychology, 50*, 482–495. doi:10.1037/0022-0167.50.4.482
- Needham, B. L., & Austin, E. L. (2010). Sexual orientation, parental support, and health during the transition to young adulthood. *Journal of Youth and Adolescence, 39*, 1189–1198. doi:10.1007/s10964-010-9533-6
- Pachankis, J. E., Goldfried, M. R., & Ramrattan, M. E. (2008). Extension of the rejection sensitivity construct to the interpersonal functioning of gay men. *Journal of Consulting and Clinical Psychology, 76*, 306–317. doi:10.1037/0022-006X.76.2.306

- Padilla, Y. C., Crisp, C., & Rew, D. L. (2010). Parental acceptance and illegal drug use among gay, lesbian, and bisexual adolescents: Results from a national survey. *Social Work, 55*, 265–275. doi:10.1093/sw/55.3.265
- Remafedi, G., Farrow, J. A., & Deisher, R. W. (1993). Risk factors for attempted suicide in gay and bisexual youth. In L. D. Garnets & D. C. Kimmel (Eds.), *Psychological perspectives on lesbian and gay male experiences* (pp. 486–499). New York, NY: Columbia University Press.
- Robinson, B. E., Walters, L. H., & Skeen, P. (1989). Response of parents to learning that their children is homosexual and concern over AIDS: A national study. *Journal of Homosexuality, 18*, 59–80. doi:10.1300/J082v18n01_03
- Rosenstein, D. S., & Horowitz, H. A. (1996). Adolescent attachment and psychopathology. *Journal of Consulting and Clinical Psychology, 64*, 244–253. doi:10.1037/0022-006X.64.2.244
- Rothman, E. F., Sullivan, M., Keyes, S., & Boehmer, U. (2012). Parents' supportive reactions to sexual orientation disclosure associated with better health: Results from a population-based survey of LGB adults in Massachusetts. *Journal of Homosexuality, 59*, 186–200. doi:10.1080/00918369.2012.648878
- Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in White and Latino lesbian, gay, and bisexual young adults. *Pediatrics, 123*, 346–352. doi:10.1542/peds.2007-3524
- Ryan, C., Russell, S. T., Huebner, D., Diaz, R., & Sanchez, J. (2010). Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing, 23*, 205–213. doi:10.1111/j.1744-6171.2010.00246.x
- Salzinger, S., Feldman, R. S., Rosario, M., & Ng-Mak, D. S. (2011). Role of parent and peer relationships and individual characteristics in middle school children's behavioral outcomes in the face of community violence. *Journal of Research on Adolescence, 21*, 395–407. doi:10.1111/j.1532-7795.2010.00677.x
- Samarova, V., Shilo, G., & Diamond, G. M. (2013). Changes over time in youths' perceived parental acceptance of their sexual minority status. *Journal of Research on Adolescence. doi:10.1111/jora.12071*
- Savin-Williams, R. C. (1989). Coming out to parents and self-esteem among gay and lesbian youths. *Journal of Homosexuality, 18*, 1–35. doi:10.1300/J082v18n01_01
- Savin-Williams, R. C. (1998). The disclosure to families of same-sex attractions by lesbian, gay, and bisexual youths. *Journal of Research on Adolescence, 8*, 49–68. doi:10.1207/s15327795jra0801_3
- Savin-Williams, R. C. (2001). *Mom, Dad, I'm gay: How families negotiate coming out*. Washington, DC: American Psychological Association. doi:10.1037/10437-000
- Savin-Williams, R. C., & Ream, G. L. (2003). Sex variations in the disclosure to parents of same-sex attractions. *Journal of Family Psychology, 17*, 429–438. doi:10.1037/0893-3200.17.3.429
- Shpigel, M. S., Belsky, Y., & Diamond, G. M. (2013). Clinical work with non-accepting parents of sexual minority children: Addressing causal and controllability attributions. *Professional Psychology: Research and Practice*. Advanced online publication: doi:10.1037/a0031824
- Shpigel, M. S., & Diamond, G. M. (2013). Good versus poor therapeutic alliances with non-accepting parents of same-sex oriented adolescents and young adults: A qualitative study. *Psychotherapy Research, 23*, 464–73. doi:10.1080/10503307.2013.856043
- Steinberg, L. (2001). Adolescent development. *Annual Review of Psychology, 52*, 83–110. doi:10.1146/annurev.psych.52.1.83
- Stone Fish, L., & Harvey, R. G. (2005). *Nurturing queer youth: Family therapy transformed*. (2005). New York, NY, US: W W Norton & Co.
- Sund, A. M., & Wichstrøm, L. (2002). Insecure attachment as a risk factor for future depressive symptoms in early adolescence. *Journal of the American Academy of Child & Adolescent Psychiatry, 41*, 1478–1485. doi:10.1097/00004583-200212000-00020

Received April 19, 2013

Revision received September 30, 2013

Accepted October 21, 2013 ■