Clinical work with non-accepting parents of sexual minority children: Addressing causal and controllability attributions

Article *in* Professional Psychology Research and Practice · February 2015

DOI: 10.1037/a0031824

CITATIONS
9

READS
170

3 authors, including:

Yael Belsky
Ben-Gurion University of the Negev
2 PUBLICATIONS **13** CITATIONS

SEE PROFILE

Professional Psychology: Research and Practice

Clinical Work With Non-Accepting Parents of Sexual Minority Children: Addressing Causal and Controllability Attributions

Maya S. Shpigel, Yael Belsky, and Gary M. Diamond

Online First Publication, March 11, 2013. doi: 10.1037/a0031824

Professional Psychology: Research and Practice

0735-7028/13/$12.00 DOI: 10.1037/a0031824

Clinical Work With Non-Accepting Parents of Sexual Minority Children: Addressing Causal and Controllability Attributions

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

Nonaccepting parents of sexual minority children typically attribute their child's same-sex orientation to external causes (e.g., early childhood experiences, peer pressure) and perceive sexual orientation as mutable and under their child's control. Using scientific findings to introduce the possibility that sexual orientation may be, at least to some degree, biologically influenced, not a matter of choice and not under the child's control, can reduce blame and anger and elicit empathy among these parents. This paper provides therapists with an abbreviated summary of the extant research findings on the association between biology and sexual orientation, and on the results of sexual orientation change efforts, written in easily accessible language of the type we use when working with nonaccepting parents. In addition, we discuss the clinical issues therapists must consider when deciding how and when to introduce such information. Finally, we present a case study to illustrate this therapeutic process.

Keywords: gay, lesbian, causal attributions, parents

Parents react to their children's disclosure of a lesbian, gay, or bisexual (LGB) orientation (i.e., "coming out") in various ways. Whereas some respond with understanding, acceptance, love, and support, others initially react with shock, disbelief, anger, guilt, shame, hurt, and grief. Indeed, research findings suggest that upward of 50% of parents initially react with some degree of negativity, with a small minority exhibiting severe forms of rejection, threatening behavior, and, in extreme cases, physical violence and/or ejection from the home (D'Augelli et al., 2010; Heatherington & Lavner, 2008; Robinson, Walters & Skeen, 1989; Savin-Williams, 1998, 2001). Very religious parents are more likely to react with rejection (Heatherington & Lavner, 2008).

Fortunately, many parents who initially react negatively become more accepting, or at least more tolerant, over time. For example, studies of parents participating in gay affirmative support groups (e.g., Parents and Friends of Lesbians and Gays) show that the great majority feel more comfortable with, and supportive of, their child's minority sexual orientation with the passing of time (Ben-Ari, 1995; Holtzen & Agresti, 1990; Robinson, Walter, & Skeen, 1989). Likewise, a number of surveys of sexual minority adolescents have found that, on average, parents' level of acceptance, and the quality of adolescent-parent relationships, improved over time (Beals & Peplau, 2006; Cramer & Roach, 1988; Savin-Williams & Ream, 2003), though one study found no change (D'Augelli et al., 2010). 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 one and one half years (on average) postdisclosure (Samarova, Shilo & Diamond, under review).

Facilitating increased tolerance or acceptance among initially rejecting parents is of tremendous import. When parents remain rejecting, angry, blaming, and invalidating over time, it can undermine the very fabric of the attachment relationship, the adolescent's or young adult's self-esteem, and his or her emotional/psychological well-being. Indeed, research shows that parental criticism, invalidation, rejection, and abuse increase sexual minority adolescents' and young adults' risk for depression and suicidal ideation (D'Augelli et al., 2005; Remafedi, Farrow, & Deisher, 1991; Ryan, Huebner, Diaz, & Sanchez, 2009). In contrast, parental support buffers against psychopathology (D'Augelli, 2003; Eisenberg & Resnick, 2006; Evans, Hawton, & Rodham, 2004; Needham & Austin, 2010; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). Not surprisingly, when asked directly, sexual minority adolescents explicitly express a desire for improved relationships with their parents (Diamond et al., 2011; Samorova et al., under review).

For many parents stuck in nonaccepting stances, their blame, anger, and criticism rest, in part, on the belief that their child's sexual orientation is: caused by situational/environment factors (as opposed to biological factors); subject to change (i.e., mutable); and under the control of their child (controllability; Bernstein,

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, Israel. She investigates change mechanisms in family therapy, including change processes in family therapy for homosexual offspring and their parents.

YAEL BELSKY received her MA in Clinical Psychology from the Department of Psychology, Ben-Gurion University of the Negev, Israel. Her research interests are family dynamics and family therapy.

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, Israel. His research interests include the process and outcome of family-based treatments, emotional processing and lesbian, gay and bisexual issues in psychotherapy.

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

1990). These three dimensions are related but not identical. Typically, nonaccepting parents attribute the onset of their child's same-sex orientation to environmental forces such as peer influence, fear of the opposite sex, an absent father, a smothering mother, the lure of the gay community, and so forth. They use "evidence" from the past (e.g., a close relationship with a member of the opposite sex) to "prove" that their child's sexual orientation was once heterosexual, and cling to stories they have heard or read of people who supposedly changed their orientation via pastoral counseling, conversion therapy, or simple strong will. By believing that their child was once heterosexual, and that his or her same-sex orientation was caused by external events, these parents maintain the hope that with sufficient motivation, effort, and/or the correct intervention, their child will "revert" to being heterosexual and, thus, alleviate their (the parents') fears, conflicts, embarrassment, shame, loss, and so forth. When their child does not change, these parents' frustrations turn to anger.

A number of studies have explored the association between causal and controllability attributions and attitudes to LGB orientation. In one analogue study asking 356 colleges students to imagine that they were the parents of a 16-year-old homosexual boy, findings showed that the more the child's homosexuality was perceived as being under his control, the more fury, anger, hate, and shame emerged. Conversely, the less homosexuality was perceived as under the adolescent's control, the more affection was demonstrated (Armesto & Weisman, 2001). In two studies conducted by Haslam and Levy (2006), employing a sample of 487 college students and a sample of 216 adults from the community, the authors found that tolerance of minority sexual orientation was associated with the belief that same-sex orientation is immutable, biologically based, and historically and cross-culturally universal. In a study of two nationally representative samples of adults, Haider-Markel and Joslyn (2008) found that perceiving homosexuality as controllable was associated with negative affect toward homosexuals and perceiving homosexuality as uncontrollable (e.g., biological, genetic in origin) was associated with positive affect toward homosexuals.

In our clinical work with nonaccepting parents, we have found that introducing the possibility that their child's same-sex orientation may not simply be a choice but is, rather, influenced by biology and immutable, can lead to a decrease in anger and an increase in empathy toward their child. In some cases, when parents realize that they may have been demanding something from their child that their child cannot provide (i.e., change their sexual orientation), the enormity of the tragedy sinks in and sadness and compassion emerge. For some, though not for all, this realization is momentous and signals the transition from denial and rejection to the beginning of the acceptance process.

One strategy for introducing the possibility that their children cannot control their sexual orientation, and therefore are not culpable, is to provide parents with up-to-date, scientifically accurate, user friendly information regarding what is known about the link between biology and sexual orientation and about the immutability of same-sex orientation. A number of good, detailed reviews of research findings on these topics already exist (cf. Hill, Dawood & Puts, 2012; Jenkins, 2010). However, such reviews are not necessarily aimed for the consumption of the average parent. The primary purpose of this paper to is to provide clinicians with an abbreviated, select summary of the most compelling and easily understood findings on the link between biology and sexual orientation and on efforts to change sexual orientation. The summary is written in accessible language, of the type we typically use when working with nonaccepting parents. For those clinicians and parents wanting more detailed information about biology and sexual orientation, we have included a list of relevant references (see Appendix). In addition, we discuss the clinical issues therapists must consider when deciding how and when to introduce such information. Finally, we present a case study to illustrate this therapeutic process.

Clinically Oriented Summary of Research on Biology and Sexual Orientation and on Sexual Orientation Change Efforts

Biology refers to a wide range of factors and processes, including genetic makeup, organ structure, enzyme production, dendritic growth, and exposure to prenatal hormones, to name a few. Below, we review findings from the areas of behavioral genetics, prenatal development, and brain morphology.

Behavioral Genetics

Many parents wonder whether their child's sexual orientation is determined by genes. Indeed, genetics have been found to influence many of our physical traits, as well as our psychological functioning. Researchers typically describe the contribution of genes in terms of heritability rate—the degree to which individual differences in the population are explained by our genes. One way to estimate heritability rates is through family and twin studies. Fifty years of such research have generated compelling and consistent evidence that lesbians and gay men are more likely than heterosexual men and women to have gay siblings. For example, in one study researchers found that approximately one-quarter of gay men's brothers also reported being gay—roughly four times the rate found among brothers of heterosexual men (Pillard & Weinrich, 1986). Moreover, twin studies consistently show that identical twins, who by definition share the same genetic make-ups, are 2 to 4 times more likely to both be gay than nonidentical twins, who share only half of their genetic makeup. In one recent large-scale twin study conducted in Sweden, genetics accounted for up to 39% of the variation in sexual orientation identity among males and up to 19% among women (Långström, Rahman, Carlstrom, & Lichtenstein, 2010). In another recent large-scale study conducted in Finland, the heritability rate was 45% and 50% for women and men, respectively (Alanko et al., 2010). In summary, genetics appear to play an important role in the development of sexual orientation. While their influence is less than that found in traits such as height and eye color (with heritability rates of approximately 80%) (Bräuer & Chopra, 1978; Magarey, Boulton, Chatterton, Schultz, & Nordin, 1999), it is substantially higher than that found in phenomena such as major depression (with a heritability rate of approximately 34%; Nes et al., 2012). Moreover, the closer the genetic relation, the greater the likelihood that two *related* individuals will be concordant for sexual orientation However, despite the overwhelming evidence suggesting that genes are to some degree implicated in the development of sexual orientation, there is still no reliable evidence indicating exactly which genes are implicated (Hill, Dawood & Puts, 2012; Jenkins, 2010).

Prenatal Development

There is some research suggesting that levels of certain hormones (e.g., testosterone, estrogen), released during pregnancy, may influence the development of sexual orientation. One approach to investigating the link between such hormones and sexual orientation is by examining finger length, because these same hormones are thought to influence finger growth in utero. Perhaps the most researched phenomenon relates to the relative lengths of the second and fourth fingers. A number of studies have found that the ratio of the second finger to fourth finger (2D:4D) is lower in gay males than it is in heterosexual males. A recent systematic review of the research on this topic, however, concluded that although there seems to be evidence that 2D:4D differs between lesbian and heterosexual women, there does not seem to be a difference between gay and heterosexual men (Grimbos, Dawood, Burriss, Zucker, & Puts, 2010; Rahman, & Wilson, 2003).

Another biological marker studied has been "handedness." Handedness is thought to be the result of prenatal development of the brain. A meta-analysis (Lalumière, Blanchard, & Zucker, 2000) of all studies up until the year 2000 found that gay men were a third more likely than heterosexual men, and lesbians were almost twice as likely as heterosexual women, to be left-handed or ambidextrous. Findings from these two lines of research provide some support for the hypothesis that prenatal hormone levels may partially determine or influence sexual orientation development (Hill, Dawood & Puts, 2012).

Brain Morphology

Although the brains of homosexual and heterosexual men, and lesbian and heterosexual females, are for the most part similar, a number of studies have found differences between individuals with same-sex versus other-sex orientations regarding specific brain structures. One such structure is the hypothalamus, which is implicated in the generation of male typical sexual behavior (LeVay, 1991). Studies have found that the size and density of neurons in the hypothalamus differ among homosexual men versus heterosexual men (Byne et al., 2001; LeVay, 1991; Swaab & Hoffman, 1990). Another such structure is the anterior commissure (AC)—a bundle of nerve fibers connecting the two cerebral hemispheres. One study found that homosexual males evidenced the largest anterior commissure, followed by heterosexual women and, in turn, heterosexual men (Allen & Gorski, 1993), though a later study found no between-gender or between-orientation differences in the size of the AC (Lasco, Jordan, Edgar, Petito, & Byne, 2002). Researchers have also found that the corpus callosum, the primary band of neural fibers connecting the left and right cerebral hemispheres, is larger in homosexual men than in heterosexual men (Witelson et al., 2008). In terms of the relative size of the two cerebral hemispheres, there is evidence that whereas heterosexual males and homosexual women have slightly larger right hemispheres than left hemispheres, the two hemispheres of homosexual males and heterosexual women are symmetrical (Savic & Lindstrom, 2008). In addition, the amygdala—that brain structure implicated in the processing of emotional memories—appears to function differently according to gender and sexual orientation. More specifically, whereas the left amygdala showed greater connectivity to other brain structures among heterosexual women and homosexual men, the right amygdala showed greater connectivity among heterosexual men and homosexual women (Savic & Lindstrom, 2008). Finally, there are findings suggesting that certain basic cognitive processes, such as spatial memory, mental rotation, verbal fluency, and recognition of facial expressions of emotion, are different among homosexual men in comparison with heterosexual men. In summary, a substantial body of research suggests that there are brain differences between lesbian or gay individuals in comparison with heterosexual individuals, though much more research is required to understand the nature of the association between brain structure and sexual orientation (Hill, Dawood & Puts, 2012; Jenkins, 2010).

Environment/Life Experiences

In the past, some have suggested that environmental factors, such as early parent–child interactions and sexual experiences, could cause an individual to become homosexual or lesbian (Friedman & Downey, 2008). To date, however, there is no methodologically sound research supporting such theories (Frankowski, 2004). In fact, there is quite a lot of research showing that parental gender, gender behavior, and attitudes toward homosexuality most likely do *not* influence children's sexual orientation. For example, studies show that children raised by homosexual or lesbian couples are not more likely to be homosexuals or lesbians themselves (Allen & Burrell, 1996; Bailey, Bobrow, Wolfe, & Mikach, 1995; Gartrell, Bos, & Goldberg, 2011; Golombok & Tasker, 1996; Stacey & Biblarz, 2001), though in one recent study adolescent females raised by lesbian mothers were more likely to have had same-sex contact and define themselves as bisexual (Gartrell, Bos, & Goldberg, 2011). With regard to sexual experiences, research shows that lesbian adolescents were as likely as heterosexual female adolescents to have experienced intercourse, suggesting that they were not lesbian because they had not experienced heterosexual sex (Saewyc, Bearinger, Blum & Resnick, 1999).

Sexual Orientation Change Efforts (SOCE), Including Conversion Therapy

What we tell parents about SOCE is derived, primarily, from the report by the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation (APA, 2009). We explain that there is a very small amount of rigorous research on sexual orientation change efforts. A summary of the findings that are available suggests that enduring change to an individual's sexual orientation is uncommon and that a very small minority of people in these studies showed *any* evidence of reduced same-sex sexual attraction. Likewise, evidence that SOCE increased sexual behavior with the opposite sex is rare. Counseling and psychotherapy approaches designed to change sexual orientation have not been rigorously evaluated, and there is no basis for concluding that they are effective.

Not only is there no evidence that SOCE are effective, there is evidence to indicate that individuals experience harm from such efforts. For example, in a study of 202 individuals who had undergone sexual orientation change efforts, including aversion conditioning, psychotherapy, and religious counseling, two thirds described the interventions they received as "harmful only" (38%) or "both harmful and helpful" (28%) (Shidlo & Schroeder, 2002). Participants of sexual orientation change efforts describe negative

social, emotional, and spiritual consequences as a result of their experience, including anger, anxiety, confusion, depression, grief, guilt, hopelessness, deterioration of relationships with family, loss of social support, loss of faith, poor self-image, social isolation, intimacy difficulties, intrusive imagery, suicidal ideation, self-hatred, and sexual dysfunction. A minority of participants did report experiencing benefits, such as relief, happiness, improved relationship with God, and perceived improvement in mental health status, though some described experiencing these benefits initially, only to later experience or acknowledge the negative effects (Morrow & Beckstead, 2004; Shidlo & Schroeder, 2002). It is important to note, however, that we have no way of knowing to what degree these samples are representative of the entire population of individuals undergoing SOCE. Nevertheless, because of the lack of support for SOCE, and because of their potential to cause harm, the American Psychological Association suggests that mental health professionals avoid telling clients that they can change their sexual orientation through therapy or other treatment. The APA also suggests that therapists advise clients to avoid sexual orientation change efforts that portray homosexuality as pathological and, instead, to seek treatment, social support, and educational services that provide accurate information about sexual orientation, increase family and school support, and reduce rejection of sexual minority youth (APA, 2009). The American Psychiatric Association adopted a similar resolution in 2000, stating that the organization opposes therapeutic techniques intended to change an individual's sexual orientation from homosexual to heterosexual. The Board of Trustees went on to state that there is no evidence that so-called reparative therapies have any efficacy (APA, 2000). Recently, the California State Assembly passed a bill making it illegal for mental health practitioners to administer treatments intended to change the sexual orientation, romantic attractions, or gender expression of children and adolescents under the age of 18.

Clinical Issues

Introducing the possibility that sexual orientation may be innate and/or immutable is a powerful intervention that must be skillfully and sensitively employed. If the possibility is introduced prematurely, parents may experience the therapist as allied with their child and as lacking understanding and empathy for their own suffering and anger. Along the same lines, if the possibility is introduced too forcefully, as an unequivocal fact, parents may feel coerced or railroaded into adopting a position they are not yet ready or able to fully consider. Both of these negative processes can undermine the therapeutic alliance. For that reason, introducing the possibility that sexual orientation may not be a choice, and may not be controllable, needs to be done gradually, nonpassionately, and in a manner that accurately reflects the current state of the science. Only after parents feel that the therapist understands and empathizes with their own distress, and that they (they parents) have the freedom and time to weigh all of the evidence, will they be open to considering alternative causal and controllability attributions.

When speaking with parents, we always begin by pointing out that, at this point in time, nobody knows for sure exactly why an individual expresses a same-sex orientation, though we make it clear that there is no credible evidence that sexual orientation is attributable, even in part, to social factors. To date, researchers have yet to identify specific genes, hormones, or other physiological factors that can be said, with certainty, to determine or influence the development of sexual orientation. Nevertheless, there are findings from a substantial amount of studies across a wide range of domains that strongly suggest that biology plays a role in the development of sexual orientation.

Depending on the needs and capacities of the parents, the findings listed above can be presented in less or more detail. For some parents, it is enough to hear that there is some research suggesting a link between genes and sexual orientation. Others may want to know how much variance genes account for, how many studies have been conducted, and whether the findings are the same for men and women. Also, the breadth of information provided at a given moment varies. In some cases, parents make a general request for information on the association between biology and sexual orientation and we respond with a five- to 10-minute psycho-educational summary of the data appearing above. In other instances, we introduce brief bits of data as part of our responses to parents' specific questions or concerns, as they arise. For example, some parents may have questions about the potential benefits of conversion therapy at the start of therapy, and only later, after recognizing that their child is not likely to change their sexual orientation, then have other questions about the role of genetics in the development of same-sex orientation.

In all cases we are careful to monitor parents' reactions as we present them with the data. When parents respond with openness, curiosity, and in an engaged manner, we proceed to offer additional information and explore the impact the information is having on the parent and on his or her attitudes/feelings toward their child. On the other hand, when parents respond defensively or become overwhelmed, we take a step back, empathize with their distress about how hard the process is for them, and offer support.

Composite Case Example

Yaacov (age 64) and Rivka (age 60) immigrated to Israel from Yemen as children in the 1950s. Rivka works as clerk in a government office and Yaacov as a foreman in a factory. Although they do not identify themselves as being religious, both come from traditional families. They are parents of 6 children ranging in age from 20 to 52. Yonni (age 25), their second to youngest son, came out to them as gay approximately one year ago. They agreed to participate in our family therapy program after Yonni, with our encouragement, wrote them a letter explaining how much he cared about them, how important his relationship with them was, and how much he wanted them to join him in family treatment.

During the first session, both Rivka and Yaacov described the shock they experienced when Yonni disclosed his sexual orientation to them.

> Rivka: "I thought I didn't hear him correctly. I had to ask him to repeat what he said—it was like . . . I couldn't think or comprehend for . . . I don't know how many minutes passed. My heart dropped. He is the last person in the world I would have thought would be like that—he was always so manly, liked sports—the girls were all over him."

> Yaacov: "Yes. That's true. It was like thunder on a clear day. I still don't understand. I have asked myself a million times—where did I go wrong—was I not involved enough with him? Was I too soft with him?"

Therapist: "I don't think many parents are fully prepared to hear their son say, 'Mom, Dad . . . I am gay.' Especially when it comes completely unexpectedly."

After hearing more about their shock, anger, shame, and fears, the therapist returned to Yaacov's questions about his possible role in the development of Yonni's sexual orientation.

Therapist: "You know, Yaacov, I heard you saying that you wonder whether something you did or didn't do, something about your parenting, the way you treated Yonni, is responsible for his being gay. What exactly do you think you should have done differently?"

Yaacov: "I don't know . . . maybe I should have provided more of a masculine role model . . . played more sports with him."

Therapist: "I hear what you are saying. For a lot of parents, that is a natural instinct—to question or blame themselves. We can talk more about it later if you would like, but I just want you to know right now that there is no compelling evidence of any kind suggesting a connection between parenting and children's sexual orientation. There have been lots of theories about absent fathers, overinvolved mothers, and so forth but really no data supporting these contentions. Even among families with two lesbian parents, boys are not more likely to grow up gay."

Later in the session, Rivka returns to the question of how her son came to be gay and the implications.

Rivka: "I don't understand. What would make him choose that path? Doesn't he realize that his life is going to be hell? That our life is going to be hell?"

Therapist: "I hear how hard this is for you. It also sounds like you are worried about how hard it is going to be for Yonni—that you are pained thinking about what he will be up against . . . ."

After spending some time exploring and acknowledging Rivka's and Yaacov's fears about the future, the challenges both they and Yonni will face, and introducing the possibility of an alternative narrative—an alternative future that is not dominated by isolation, shame and loss but rather connection and meaning—the therapist turns to the question of causality.

Therapist: "Rivka, a few minutes ago you mentioned the word 'choice'—that you couldn't understand why Yonni 'chose' to be homosexual. I was wondering whether you had considered that maybe Yonni didn't 'choose' to be gay, but was perhaps born that way?"

Rivka: "We have heard others say that. What can I say . . . "

Yaacov: "You know, we have relatives—Rivka's cousin. They have two daughters who are both lesbian."

Rivka: "I feel terrible for them. It was one catastrophe after the other for them."

Therapist: "You know, there is quite a bit of research suggesting that sexual orientation, at least in part, may be related to genetics or other biological processes and may not be much of a choice, if at all. For example, there are some findings suggesting that the amount of certain hormones released during pregnancy may impact upon sexual orientation."

Yaacov: "Yes, on one hand it makes sense—I can't think of anything we did or that was out of the ordinary while he was growing up."

Finally, near the end of the session, Rivka lamented about wishing Yonni would change, wishing that he would at least try to live a "normative" lifestyle, find a woman, start a family.

Rivka: "I just wish he would try . . . to see if he could change himself back to normal."

Yaacov: "We wanted him to come and speak with our Rabbi—the Rabbi said he was willing to talk to Yonni. I thought that maybe if I could get him more involved in the synagogue, in the morning prayer group, perhaps that might make a difference."

Rivka: "We heard from others that in some cases, it is possible to get the person back on the 'right' track. I even heard one man speak about how he had overcome his homosexuality and was now living a life just like everybody else—married, with children."

Therapist: "I can certainly understand why you would wish that, somehow, all of this could be different and that Yonni would somehow transform into being heterosexual, the way you always expected. The idea of having a gay son, particularly in the beginning, is hard and scary, and magically 'changing' him into a heterosexual would somehow eliminate all of those problems. You know, many have explored whether it is possible to change one's sexual orientation. The fact is that reports of people changing their sexual orientation, particularly when they identify as exclusively homosexual, are very rare and generally unvalidated. There have been numerous surveys on people's experience participating in all sorts of sexual orientation change efforts, including psychotherapy, pastoral counseling. Overall, there is no credible evidence that such efforts change sexual orientation, though there has been very little rigorous research examining this question. For people who report a more fluid or bisexual orientation, fluctuations in self-defined sexual orientation are more common. However, in large surveys, a very small percentage of respondents reporting that they were gay and went to therapy to change (either because of family or societal pressure or because of internalized discomfort) reported that they had indeed changed. Just as importantly, the great majority of people surveyed who underwent sexual orientation change efforts reported feeling harmed by the effort, including experiencing increased guilt, self-contempt, hopelessness, and suicidal ideation, among other things."

Discussion

The primary purpose of this paper is to provide therapists working with nonaccepting parents of LGB individuals with a user-friendly summary of research findings that they can use to introduce, or better establish, the possibility that sexual orientation is, at least partially, attributable to biology and not a choice, and that efforts to change sexual orientation, particularly coercive efforts, are likely to be unsuccessful and detrimental. Introducing the possibility that sexual orientation may be biologically determined and immutable is a potentially critical change intervention for nonaccepting parents and, in turn, their relationship with their child. As mentioned above, there is a strong link between causal and controllability attributions and attitudes toward homosexuality. Nonaccepting parents who tenaciously hold onto the belief that their child has "chosen" to be gay, and can therefore choose to become heterosexual, are less likely to be willing to work toward acceptance or even tolerance. On the other hand, when such parents recognize that there is even a small possibility that their child is not responsible for their same-sex orientation and, in fact, has suffered in his or her struggle to come to peace with his or her sexual orientation, parents are likely to become more empathic and supportive and the process of shared acceptance can begin.

Although the potential usefulness of introducing the idea that biological factors influence sexual orientation is clear, a number of caveats are warranted. First, for some religious families, the contention that homosexuality may be even partly attributable to biological factors runs counter to their interpretation of the Bible and, therefore, holds little traction. They argue that the Bible is unequivocal about homosexuality being a sin and that God would not have created individuals who were innately gay. Indeed, holding orthodox or fundamental religious beliefs is one of the more robust predictors of parental nonacceptance (Heatherington & Lavner, 2008; Newman & Muzzonigro, 1993; Schope, 2002). To resolve or circumvent this conflict, some gay friendly clergy have reinterpreted the relevant biblical verses, emphasized the distinction between sexual orientation (urges) and actual sexual behavior, highlighted fundamental Judeo-Christian values such as acceptance and the importance of not judging others, focused on the greater good of preserving the parent–child relationship, and reminded parents that no one can fully understand God's intentions and plans (Rodriguez & Ouellette, 2000). With that said, orthodox religious parents are likely to have a difficult time integrating biological causal attributions for homosexuality with their religious beliefs, and introducing them to such research findings may be ineffective, inappropriate, or even counterproductive in some cases. With this population, therapists need to be particularly cautious and carefully monitor parents' reactions to the information presented on a moment-to-moment basis.

Second, invoking biological, essentialist causal attributions may be more challenging with parents of nonheterosexual females, and in particular bisexual females, than with parents of homosexual males. Research suggests that sexual orientation is generally more clearly defined among men, with most men identifying as either homosexual or heterosexual, and only a few identifying as bisexual (Hammack, 2005). Moreover, men less often report change in their sexual orientation over time (Kinnish, Strassberg & Turner, 2005). These two related findings are consistent with an essentialist approach: that one's physiology is central in determining sexual orientation. In contrast, female sexual orientation appears to be more varied, with women reporting a wider range of self-identifications including many who self-identify as bisexual (Hammack, 2005). Moreover, research suggests that female sexual orientation is more fluid than that of men (Diamond, 2000, 2003; Kinnish et al., 2005; Savin-Williams & Diamond, 2000; Savin-Williams & Ream, 2007). Such fluidity presents a challenge to biological, essentialist explanations and, in turn, may complicate the acceptance process. Indeed, there are research findings that indicate that fathers have particular difficulty accepting their lesbian daughters (Heatherington & Lavner, 2008). Also, a recent study of Israeli sexual minority adolescents suggests that parents had the most difficulty accepting their bisexual daughters (Samarova, Shilo, & Diamond, under review).

Third, although a biological causal model is likely to reduce parents' blame and anger toward their child, it has the potential to increase parents' own guilt, and in some cases, even lead one parent to blame the other. However, it is worth noting (and perhaps reminding parents) that individuals (including themselves) are not responsible for their own genetic makeup or biological functioning. Moreover, biological causal models alleviate what is generally a *greater* concern among parents: that they may have somehow actively, albeit unwittingly, influenced their child's sexual orientation through their parenting style/choices.

A fourth consideration when invoking biological causal models is that they can potentially be used to pathologize sexual minority individuals. He is gay because he has a disease, a genetic deformity, and so forth. Above and beyond the insult inherent to pathologizing what is in fact a normal variation of human sexuality, such pathologizing can quickly lead to stigmatization and, subsequently, to discrimination. Moreover, many fear that pathologizing homosexuality can lead to, or promote, eugenic ideas: provide a rational or justification for biological interventions to eliminate or alter same-sex orientation.

Yet another concern is that the very use of terms such as homosexual, lesbian, bisexual, and heterosexual is offensive to certain individuals. For many sexual minority individuals aligned with a "queer" stance, such labels are experienced as artificial, restrictive, and essentialist in nature—vehicles for defining what is normal, permissible, and not. Such individuals are more likely to view gender, gender behavior, sexual orientation and behavior, and self-identification as varied, fluid, and as socially, historically, culturally, and politically constructed (Spargo, 1999). They are likely to spurn both the use of labels and biological causal theories. In such circumstances, the adolescent or adult child him/herself might be averse to the idea of the therapist invoking biological models when explaining their sexual orientation to their parents.

An additional concern is that, for some individuals, any discussion of cause is perceived as "missing the point." Such individuals take the position that it doesn't matter "why" somebody is gay. Instead, parents should be concerned with accepting and being proud of their children, regardless of their sexual identity and inclinations. To this we can only respond with an emphatic, resounding, "Yes. We agree!" However, for many parents, being affirming, or even just least tolerant, is the end result of a process, not the beginning. Nonaccepting parents are typically organized by their shame, fears, frustrations, and anger. Introducing a frame in which no one is to blame can serve to neutralize or temper such feelings long enough for parents to become more reflective and allow other feelings and thoughts to arise, such as their love for their child, concern for his or her emotional welfare, and the importance of their relationships with him/her. For such parents, introducing the possibility of biological causes is an instrumental, strategic intervention useful early in the therapy process. In a study of parents participating in a gay empowerment parent support group, Fields (2001) found that most newcomers to the group experienced the biological argument as comforting. However, with time, most members eventually rejected the debate on the causes of homosexuality and, instead, focused more on acceptance, affirmation, and advocacy. Indeed, one of the participants reported that while she initially found the biological argument comforting, after becoming more comfortable with her son's gay identity she now resented discussions of biological causal models. Most interestingly, long-term members of the group reported that they themselves were strategic in their use of biological causal models when speaking with new members. They invoked research supporting such models when addressing new members who were still consumed by their search for reasons why their child was gay and who were concerned about the possibility that they had contributed to their child's same-sex orientation through their parenting. For many parents new to the group, "assigning responsibility for homosexuality to natural forces over which they had no control allowed them to avoid embracing lesbian and gay sexuality while still accepting their daughters and sons" (Fields, 2001, p. 174).

Finally, some might take the position that working with nonaccepting parents is a useless endeavor or, worse, unethical—that it inval-

idates children's (young or adult) legitimate expectations that their parents fully accept and prize them for who they are, in their entirety, including their sexuality. They take an all-or-nothing position: Until parents are able to come to full acceptance, any contact with that parent is toxic. Unquestionably, ongoing contact with nonaccepting parents is potentially harmful for their sexual minority offspring. For parents who are particularly critical and rejecting, even intermittent contact can be destructive. For that reason, as therapists, we place a premium on helping adolescents and young adults protect themselves from excessive criticism, humiliation, or abuse. With that said, relationships with parents continue to be important to most individuals throughout their lives. Consequently, we work individually with nonaccepting parents, sometimes for months, in an effort to help them articulate, differentiate between, and overcome their fears, anger, shame, and loss. We help them to focus more on their love for their child, the welfare of their child, and their deep-seated, instinctual desire to maintain a relationship with their child. When parents' fear, anger, and shame sufficiently subside, and their desire to work on their relationship comes to the fore, we initiate conjoint sessions focused on increasing safety and acceptance in the relationship and deepening the attachment bond. In those cases in which, despite our best efforts, parents rigidly hold onto their anger and demands that their child "change," we are left to grieve, together with the child. However, in light of the research demonstrating the protective role of parental acceptance and support, and in light of the deep seated need we all carry to feel that our parents our proud of us, accept us, and love us, articulating and testing interventions that can potentially facilitate the acceptance process among nonaccepting parents is warranted.

Whereas the focus of this paper is on conducting psychotherapy with families with nonaccepting parents, the potential utility of introducing parents to research on biology and sexual orientation extends beyond the clinic to other settings. For example, many schools and community centers offer parenting classes for parents of young children and adolescents. In the context of such classes, introducing same-sex orientation as a common phenomenon influenced, to some degree, by biology may help moderate the reactions of parents whose children subsequently "come out" (i.e., primary prevention). Likewise, professionals can present such information to parents concerned about what they perceive as their child's atypical gender behavior (i.e., secondary prevention). Finally, the more such findings are profiled in the mass media, the more likely it is that the general public will adopt more tolerant, accepting attitudes to sexual minority individuals (Altemeyer, 2002; Haslam & Levy, 2012).

References

Alanko, K., Santtila, P., Harlaar, N., Witting, K., Varjonen, M., Jern, P., Johansson, A., von der Pahlen, B., & Sandnabba, N. K. (2010). Common genetic effects of gender atypical behavior in childhood and sexual orientation in adulthood: A study of Finnish twins. *Archives of Sexual Behavior, 39,* 81–92.

Allen, L. S., & Gorski, R. A. (1992). Sexual orientation and the size of the anterior commissure in the human brain. *Proceedings of the National Academy of Science, 89,* 7199–7202.

Allen, M., & Burrell, N. (1996). Comparing the impact of homosexual and heterosexual parents on children: Meta-analysis of existing research. *Journal of Homosexuality, 32,* 19–35.

Altemeyer, B. (2002). Changes in attitudes toward homosexuals. *Journal of Homosexuality, 42,* 63–75.

APA Position Statement on Therapies Focused on Attempts to Change Sexual Orientation (Reparative or Conversion Therapies). Washington, DC: American Psychiatric Association.

APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation. (2009). *Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation*. Washington, DC: American Psychological Association.

Armesto, J. C., & Weisman, A. G. (2001). Attribution and emotional reactions to the identity disclosure ("coming-out") of a homosexual child. *Family Process, 40,* 145–161.

Bailey, J. M., Bobrow, D., Wolfe, M., & Mikach, S. (1995). Sexual orientation of adult sons of gay fathers. *Developmental Psychology, 31,* 124–129.

Beals, K. P., & Peplau, L. A. (2006). Disclosure patterns within social networks of gay men and lesbians. *Journal of Homosexuality, 51,* 101–120.

Ben-Ari, A. (1995). The discovery that an offspring is gay: Parents', gay men's, and lesbians' perspectives. *Journal of Homosexuality, 30,* 89–112.

Bernstein, B. E. (1990). Attitudes and issues of parents of gay men and lesbians and implications for therapy. *Journal of Gay & Lesbian Psychotherapy, 1,* 37–52.

Bräuer, G., & Chopra, V. P. (1978). Estimation of the heritability of hair and eye color. *Anthropologischer Anzeiger, 36,* 109–120.

Byne, W., Tobet, S., Matiace, L. A., Lasco, M. A., Kemether, E., Edgar, M. A., Morgello, S., . . . Jones, L. B. (2001). The interstitial nuclei of the human anterior hypothalamus: An investigation of variation with sex, sexual orientation and HIV status. *Hormones and Behavior, 40,* 86–92.

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,* 79–91.

D'Augelli, A. R. (2003). Lesbian and bisexual female youths aged 14 to 21: Developmental challenges and victimization experiences. *Journal of Lesbian Studies, 7,* 9–29.

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.

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.

Diamond, G. M., Shilo, G., Jurgensen, E., D'Augelli, A., Samarova, V., White, K. (2011). How depressed and suicidal sexual minority adolescents understand the causes of their distress. *Journal of Gay & Lesbian Mental Health, 15,* 130–151.

Diamond, L. M. (2000). Sexual identity, attractions, and behavior among young sexual minority women over a 2-year period. *Developmental Psychology, 36,* 241–250.

Diamond, L. M. (2003). Was it a phase? Young women's relinquishment of lesbian/bisexual identities over a 5-year period. *Journal of Personality and Social Psychology, 84,* 352–364.

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.

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.

Fields, J. (2001). Normal queers: Straight parents respond to their children's "coming out". *Symbolic Interaction, 24,* 165–187.

Frankowski, B. L. (2004). Sexual orientation and adolescents. *Pediatrics, 113,* 1827–1832.

Friedman, R. C., & Downey, J. I. (2008). *Sexual orientation and psychodynamic psychotherapy: Sexual science and clinical practice* (Vol. 978, No. 0-12052). New York, NY: Columbia University Press.

Gartrell, N. K., Bos, H. M. W., & Goldberg, N. G. (2011). Adolescents of the U.S. national longitudinal lesbian family study: Sexual orientation, sexual behavior, and sexual risk exposure. *Archives of Sexual Behavior, 40,* 1199–1209.

Golombok, S., & Tasker, F. (1996). Do parents influence the sexual orientation of their children? Findings from a longitudinal study of lesbian families. *Developmental psychology, 32,* 3–11.

Grimbos, T., Dawood, K., Burriss, R. P., Zucker, K. J., & Puts, D. A. (2010). Sexual orientation and the second to fourth finger length ratio: A meta-analysis in men and women. *Behavioral Neuroscience, 124,* 278–287.

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.

Hammack, P. L. (2005). The life course development of human sexual orientation: An integrative paradigm. *Human Development, 48,* 267–290.

Haslam, N., & Levy, S. R. (2006). Essentialist beliefs about homosexuality: Structure and implications for prejudice. *Personality and Social Psychology Bulletin, 32,* 471–485.

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.

Hill, A. K., Dawood, K., & Puts, D. A. (2012). Biological foundations of sexual orientation. C. J. Patterson & A. R. D'Augelli, (Eds.), *Handbook of psychology and sexual orientation*. New York, NY: Oxford University Press.

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.

Jenkins, W. J. (2010). Can anyone tell me why I'm gay? What research suggests regarding the origins of sexual orientation. *North American Journal of Psychology, 12,* 279–296.

Kinnish, K. K., Strassberg, D. S., & Turner, C. W. (2005). Sex differences in the flexibility of sexual orientation: A multidimensional retrospective assessment. *Archives of Sexual Behavior, 34,* 173–183.

Lalumière, M. L., Blanchard, R., & Zucker, K. J. (2000). Sexual orientation and handedness in men and women: A meta-analysis. *Psychological Bulletin, 126,* 575–592.

Långström, N., Rahman, Q., Carlström, E., & Lichtenstein, P. (2010). Genetic and environmental effects on same-sex sexual behavior: A population study of twins in Sweden. *Archives of Sexual Behavior, 39,* 75–80.

Lasco, M. S., Jordan, T. J., Edgar, M. A., Petito, C. K., & Byne, W. (2002). A lack of dimorphism of sex or sexual orientation in the human anterior commissure. *Brain Research, 936,* 95–98.

LeVay, S. (1991). A difference in hypothalamic structure between heterosexual and homosexual men. *Science, 253,* 1034–1037.

Magarey, A. M., Boulton, T. J., Chatterton, B. E., Schultz, C., & Nordin, B. E. (1999). Familial and environmental influences on bone growth from 11–17 years. *Acta Paediatrica, 88,* 1204–1210.

Morrow, S. L., & Beckstead, A. L. (2004). Conversion therapies for same-sex attracted clients in religious conflict: Context predisposing factors, experiences, and implications for therapy. *The Counseling Psychologist, 32,* 641–650.

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.

Nes, R. B., Czajkowski, N. O., Røysamb, E., Orstavik, R. E., Tambs, K., Reichborn-Kjennerud, T. (2012). Major depression and life satisfaction: A population-based twin study. *Journal of Affective Disorders, 28,* DOI 10.1016.

Newman, B. S., & Muzzonigro, P. G. (1993). The effects of traditional family values on the coming out process of gay male adolescents. *Adolescence, 28,* 213–227.

Pillard, R. C., & Weinrich, J. D. (1986). Evidence of familial nature of male homosexuality. *Archives of General Psychiatry, 43,* 808–812.

Rahman, Q., & Wilson, G. D. (2003). Sexual orientation and the 2nd to 4th finger length ratio: Evidence for organising effects of sex hormones or developmental instability? *Psychoneuroendocrinology, 28,* 288–303.

Remafedi, G., Farrow, J. A., & Deisher, R. W. (1991). Risk factors for attempted suicide in gay and bisexual youth. Garnets L. D. & Kimmel D. C. (Eds.), *Psychological perspectives on lesbian and gay male experiences. Between men—Between women: Lesbian and gay studies* (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 child is homosexual and concern over AIDS: A national study. *Journal of Homosexuality, 18,* 59–80.

Rodriguez, E. M., & Ouellette, S. (2000). Gay and lesbian Christians: Homosexual and religious identity integration in the members and participants of a gay-positive church. *Journal for the Scientific Study of Religion, 39,* 333–347.

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.

Ryan, C., Russell, S. T., Huebner, D., Diaz, R. M., & Sanchez, J. (2010). Family acceptance in adolescence and the health of LGB young adults. *Journal of Child and Adolescent Psychiatric Nursing, 23,* 205–213.

Saewyc, E. M., Bearinger, L. H., Blum, R. W., & Resnick, M. D. (1999). Sexual intercourse, abuse and pregnancy among adolescent women: Does sexual orientation make a difference? *Family Planning Perspectives, 31,* 127–131.

Samarova, V., Shilo, G. & Diamond, G. M. (under review). Changes over time in parents' acceptance of their Israeli sexual minority adolescents.

Savic, I., & Lindstrom, P. (2008). PET and MRI show differences in cerebral asymmetry and functional connectivity between homo- and heterosexual subjects. *PNAS, 105,* 9403–9408.

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.

Savin-Williams, R. C. (2001). A critique of research on sexual-minority youths. *Journal of Adolescence, 24,* 5–13.

Savin-Williams, R. C., & Diamond, L. M. (2000). Sexual identity trajectories among sexual-minority youths: Gender comparisons. *Archives of Sexual Behavior, 29,* 607–627.

Savin-Williams, R. C., & Ream, G. L. (2007). Prevalence and stability of sexual orientation components during adolescence and young adulthood. *Archives of Sexual Behavior, 36,* 385–394.

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.

Schope, R. D. (2002). The decision to tell: Factors influencing the disclosure of sexual orientation by gay men. *Journal of Gay and Lesbian Social Services, 14,* 1–22.

Shidlo, A., & Schroeder, M. (2002). Changing sexual orientation: A consumers' report. *Professional Psychology: Research and Practice, 33,* 249–259.

Spargo, T. (1999). *Foucault and queer theory*. New York, NY: Totem Books.

Stacey, J., & Biblarz, T. J. (2001). (How) does the sexual orientation of parents matter? *American Sociological Review, 66,* 159–183.

Swaab, D. F., & Hofman, M. A. (1990). An enlarged suprachiasmatic nucleus in homosexual men. *Brain Research, 537,* 141–148.

Witelson, S. F., Kigar, D. L., Scamvougeras, A., Kideckel, D. M., Buck, B., Stanchev, P. L., Bronskill, M., & Black, S. (2008). Corpus callosum anatomy in right-handed homosexual and heterosexual men. *Archives of Sexual Behavior, 37,* 857–863.

(*Appendix follows*)

Appendix

Select Resources for Information on Biology and Sexual Orientation

LeVay, S. (2009). The biology of sexual orientation. http://www.simonlevay.com/the-biology-of-sexual-orientation

LeVay, S., & Hamer D. H (1994). Evidence for a biological influence in male homosexuality. Scientific American, *270*, 44–49.

Hill, A.K., Dawood, K., & Puts, D.A. (2012). Biological foundations of sexual orientation. C. J. Patterson & A. R. D'Augelli, (Eds.), *Handbook of psychology and sexual orientation*. New York, NY: Oxford University Press.

Jenkins, W.J. (2010). Can anyone tell me why I'm gay? What research suggests regarding the origins of sexual orientation. *North American Journal of Psychology*, *12*, 279–296.

Savic, I., Garcia-Falgueras A., & Swaab, D.F. (2010). Sexual differentiation of the human brain in relation to gender identity and sexual orientation. *Progress in Brain Research*, *186*, 41–62.

Swaab, D. F., Gooren, L. J., & Hofman, M. A. (1995). Brain research, gender and sexual orientation. *Journal of Homosexuality*, *28*, 283–301.

Swaab, D. F. (2008). Sexual orientation and its basis in brain structure and function. *Proceedings of the National Academy of Sciences of the United States of America*, *105*, 10273–10274.

Received August 6, 2012
Revision received December 27, 2012
Accepted January 7, 2013 ■