Relationship-focused therapy for sexual minority individuals and their parents

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***Under review* – not for circulation**

Finding out that one’s child is gay, lesbian, bisexual, transgender or in some way not heteronormative/cisgender 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 and/or transgender can elicit a plethora of negative emotions, including shock, shame, anger, sadness and fear. Indeed, 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 & Dube, 1998). As Stone Fish and Harvey (2005) point out, “It is impossible to grow up in a heterosexist, homophobic culture like our own and not be influenced by some of the negative messages about queer people” (p. 27). While most parents eventually become more accepting, or at least more tolerant, over time (Beals & Peplau, 2006; Cramer & Roach, 1988; Samarova, Shilo & Diamond, 2014; Savin-Williams & Ream, 2003), a substantial minority of parents remain non-accepting. For example, one Israeli study found that 9% of mothers and 12% of fathers remained fully or almost fully rejecting 18 months post-disclosure (Samarova, Shilo, & Diamond, 2014). Such rejection may be expressed through emotional withdrawal, devaluation, criticism, invalidation, anger, humiliation, coercion and, in extreme cases, physical violence or banishment from the family.

Needless to say, ongoing parental criticism, invalidation, and rejection of one’s sexual identity can take a psychological toll. Such messages from parents not only are internalized and negatively affect one’s sense of self (Carastathis, Cohen, Kaczmarek, & Chang, 2016), but they signal to the individual that it is not safe or helpful to turn to their parents for support when experiencing sexual minority stress (e.g., discrimination, rejection, victimization) outside of the family (e.g., at work, in the community). Indeed, research has shown that parental criticism, invalidation and rejection is associated with internalized homophobia, expectations for future gay-related rejection by others (Pachankis Goldfried, & Ramrattan, 2008), substantially increased risk for depression and suicidal ideation (D’Augelli et al., 2005; 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 individuals 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; Elizur & Ziv, 2001; Evans, Hawton, & Rodham, 2004; Feinstein, Wadsworth, Davila, & Goldfried, 2014; Floyd, Stein, Harter, Allison & Nye, 1999; Hershberger & D’Augelli, 1995: Needham & Austin, 2010; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010; Shilo, Antebi & Mor, 2015; Savin-Williams, 1989). Given the negative impact of ongoing rejection, and the potentially positive, buffering impact of parental acceptance on sexual minority individuals, the development and testing of family based interventions designed to increase acceptance, decrease rejection and criticism, and promote more open, accepting relationships between sexual minority individuals and their parents is warranted (Feinstein et al., 2014; Pachankis & Goldfried, 2004).

Relationship Focused Therapy

This chapter describes relationship-focused therapy for sexual minority individuals and their parents (RFT-SM). RFT-SM is a time limited (26 session), focused treatment designed for families in which the sexual minority individual, and/or their parents, feel that tension, conflict or distance related to the adult child’s sexual identity has negatively impacted their relationship. In some cases, the adult child initiates treatment because they experience their parents as unaccepting or rejecting. In other instances, parents initiate therapy because they themselves recognize that their struggle to accept their child’s sexual orientation or gender identity is negatively affecting their child, and undermining the relationship. The treatment is applicable when both the sexual minority individual and their parents are committed to repairing or improving the relationship.

RFT-SM is a manualized treatment and has its roots in structural family therapy (Minuchin, 1977), multidimensional family therapy (Liddle, 1999) and emotion-focused therapy and theory (Greenberg, 2011; 2012; Johnson & Greenberg, 1995; Greenberg, Warwar & Malcolm, 2010). The treatment is also informed by developmental research on relationships between young adults and their parents (Fingerman et al., 2011; Frank, Avery & Laman, 1988; White, Speisman & Costas, 1983). However, the most immediate and significant influence on RFT-SM is attachment-based family therapy (Diamond, Diamond, & Levy, 2014; Diamond et al., 2012; Diamond, Shahar, Sabo, & Tsvieli, 2016). Indeed, RFT-SM utilizes a similar structure, moves through many of the same intermediary therapeutic steps, and targets many of the same change mechanisms as ABFT. The goal of RFT-SM is to help sexual minority individuals and their parents re-establish or develop loving, supportive, mutually respectful, mutually validating and meaningful relationships, in which the adult child can authentically and openly express all aspects of their identity without fear of rejection or being negatively judged, and with the expectation of being validated and admired. We work from the assumption that people, regardless of age, want to feel like their parents appreciate them and are proud of them.

In RFT-SM, change occurs when the adult child, often for the first time, expresses directly to their parents, in the context of conjoint sessions, their sense of loss, pain and assertive anger associated with their parents’ rejection of, and inability to cope with and affirm, their sexual identity. For example, as one client was able to say to his mother, “When I tell you that David and I are thinking about moving in together and all I see is sadness in your eyes, I feel like you are disappointed in me. That somehow I have failed you and that you would rather not hear about what was going on in my life. I want you to be excited for me”. Such expressions of pain, vulnerability and longing for connection and validation typically elicit parents’ natural desire to embrace, comfort and validate their child. The emotional balance shifts and parents’ become more focused on being present for their child than in protecting themselves from their own sense of loss, shame and fear. From this place of empathy, care, concern and desire for connection, parents invite their child to share more deeply about themselves and their feelings. At first, the adult child typically elaborates regarding their experience of feeling rejected and of being a burden or source of disappointment and pain for their parent. As parents continue to listen empathically, trust increases. The child and their parents are then able to initiate conversations about previously avoided, emotionally-laden topics such as the adult child’s experience of coming out to self and others, past traumas (e.g., being bullied at school as a child), current romantic partners and plans for the future (e.g., marriage, having children, etc.). The more that parents reach-out and listen with empathy, the more the adult child feels understood, cared about, free to be authentic and spontaneous, and less alone. Such sharing not only increases intimacy, strengthens the connection between the adult child and their parents, and positively impacts the adult child’s sense of self, but also helps parents to retrospectively construct a more coherent understanding of their child’s identity which, in turn, increases parents’ validating and affirming behaviors. Once the adult child feels heard and accepted, and most of the “hot topics” have been discussed, parents may share their own fears and other vulnerable emotions regarding their child’s sexual identity and their own coming-out process. As long as such disclosures are not experienced by the child as excuses for not working on being more accepting, they can facilitate adult children’s empathy for their parents and lead to further intimacy and mutual acceptance in the relationship. In the following sections, the structure and intervention strategies of RFT-SM are described, preliminary research supporting the model is summarized, a clinical vignette illustrating the treatment is presented, and some of the constraints and limitations of the model are noted.

Clinical Model

RFT-SM is comprised of a series of five tasks, completed over the course of approximately 26 sessions. The successful completion of one task sets the stage for the next task, and the therapist helps the family to move through the five tasks in sequence. The purpose of Task I, conducted in the first session with both the adult child and parents present, is to establish relationship building (e.g., increased openness and parental acceptance, decreased parental rejection) as the primary goal of therapy. Task II, conducted during individual sessions with the adult child, involves: creating a therapeutic bond, helping the adult child to connect with and articulate primary adaptive emotions and unmet attachment and identity needs associated with the relational rupture, agreeing on the goal of sharing such feelings and needs with parents in subsequent conjoint attachment/identity episodes with parents, and preparing the adult child for such episodes. Task III, conducted during individual sessions with parents, involves: creating a therapeutic bond, exploring and working through parents’ fear, shame, sadness and anger associated with having a sexual minority offspring, highlighting the impact of their rejection and distress on the welfare of their child and their relationships with them, and preparing parents to reach out to their child in subsequent conjoint attachment/identity episodes. Finally, Task IV, conducted in the context of conjoint child-parents sessions, involves facilitating in-session corrective experiences related to the adult child’s attachment and identity needs. Below, each task is described in greater detail.

Task I

Task I begins with the therapist orienting the family to the structure of the therapy setting. For example, the therapist will typically say, “Today, I am going to spend some time getting to know each of you a little bit. Then, we will talk about why you came and what is going on in the relationship. After that, over the course of the next few weeks, I will meet alone with you [adult child], and alone with you two [parents] for a few sessions. Finally, we will all get back together again and try to have a different type of conversation about what is going on. All-in-all, we have 26 sessions to work together”. The therapist responds to any questions or concerns about the setting and then moves on to briefly join with each family member. She asks each family member to share a little about themselves, focusing on their strengths and competencies. Once family members feel comfortable, and an initial bond has been formed, the therapist moves on to the next phase and asks each family member about their relationship and why they have come to therapy.

For some sexual minority individuals, their primary concern is attachment related and involves themes of closeness, intimacy, safety and connection. For example, one young woman we treated reported that she and her father had not spoken at all for the past three years, and that she missed the times that they used to spend together jogging and hiking. Another client was hurt and angry that his parents did not sufficiently protect him. During his visits home, they failed to intervene when his older sister abused him verbally. For other clients, their primary concerns revolve around frustrated identity and autonomy needs. In one case, a transgender client reported that her father’s attempt to control what clothes she wore when visiting home felt invalidating and even humiliating. Another client described the impact of her parents’ repeated claims that she was not lesbian, and that she simply had not made enough of an effort to find a man who was compatible. Some adult children are struggling with trying to balance their concern for their parents’ welfare, their desire to maintain constructive relationships with their parents, and their own identity needs. For example, one client described the great personal sacrifices he had made, and was still making, in terms of not coming out publicly and not bringing his romantic partner home, in order to protect his parents’ feelings. He explained that he had now reached the point at which the cost of protecting his parents was too great, and that it was thwarting his own personal development. These individuals come to treatment with the hope that therapy will help their parents work through their own fears and shame so that the family as a whole can move forward. Finally, in some cases, parents themselves initiate therapy. They come because they feel stuck in their grief or shame, years after their child has come out, and recognize that their inability to accept their child’s sexual identity has negatively impacted upon their child, themselves and the relationship. They are searching for a way out.

As these adult children describes their experience, the therapist works to connect them to and amplify the underlying and previously avoided vulnerable emotions that accompany such experiences. The therapist uses interventions such as accurate empathy, focusing, and empathic conjecture to evoke feelings of loss, sadness, loneliness, fear, humiliation, worthlessness and longing. Typically, this is the first time that parents have witnessed and experienced the extent of their child’s pain. At home, conversations about feelings and unmet needs have usually ended up as arguments, or with family members disengaging from one another. Optimally, when parents witness the full extent of their child’s pain and longing they become more empathic. In such moments, parents suddenly recognize the dramatic and negative effect that their rejection and withdrawal has had on their child. The pain of seeing their child’s pain generates in parents a motivation to change. An urgency arises within them to find a way to support and comfort their child, to help them feel better about themselves, loved, competent, safe and connected to the family. Helping their child work through their pain and helplessness becomes more important than their own disappointment and fear. At this point, the therapist offers therapy as an opportunity for parents to be there for their children in a new manner: more accepting, supportive, loving and affirming. This becomes the relational goal of the therapy.

In some cases, parents initially respond to this goal with ambivalence. On one hand, they want to alleviate their child’s pain and establish a closer, more caring relationship. On the other hand, they are anxious about being asked to do things, think or feel in ways that seem impossible to them. As one father put it: “I know that my daughter wants me to be proud of her, and be happy to see her and her girlfriend together, but I just can’t do that. I am not there yet, and I don’t think I am ever going to be. In my mind, it will always be unnatural. I will always be looking at her sitting at the table and thinking that she should be sitting beside her husband and children, and that will never change”. Such responses are an opportunity for the therapist to acknowledge and empathize with the parent’s sense of disappointment, loss and helplessness, and assure parents that the therapy process will not be coercive. The therapist respects the fact that, for some parents, coming to terms with, let alone embracing, the fact that they have a sexual minority offspring may be a complicated, difficult and ongoing process. At the same time, the therapist refocuses the parent back to the pain and loneliness their adult child is feeling as the result of their rejection or lack of acceptance. The therapist might say: “I know that this is hard for you, and nobody expects you to change things you can’t change. When we meet alone together, I want to hear more about what this has been like for you. Right now, however, I am curious about what it feels like to see your daughter’s tears as she talks about how alone she feels and how much she misses the close relationship you two once had”.

Once the parent is refocused on their child’s pain, the therapist again offers increased acceptance and relational repair as the primary goal of therapy. For example, the therapist might say: “If I could help you find a way to be there for your daughter, hear her pain and longing, help her to feel more connected and valued, without you having to do or say things that you don’t believe or want to do or say, would that be a reasonable goal of therapy?” To the adult child, the therapist might say: “If I could help your parents hear what it has been like for you in a way that they have not heard you before, even if they can’t necessarily do anything differently at first, would that be a worthy goal of therapy?” The answers to these questions are inevitably, “yes”. At this point, we intentionally refrain from talking about specific behavioral changes. The goal of Task I is not to solve problems. Instead, it is to bring to the surface the adult child’s pain, loneliness, frustration and longing associated with their parents’ rejection of their sexual identity, help parents’ to see and connect with their child’s pain, and then harness parents’ innate desire to support, validate and care for their child in order to establish relational repair as the goal of treatment.

Task II

Task II sessions alone with the sexual minority individual begin with getting to know the adult child as a person. The therapist briefly explores the major domains in the individual’s life, including work, friends, romantic relationships, nuclear family system, current stressors (unrelated to their relationships with parents), as well as interests, strengths and support networks. Once the therapist has a sense of the broad strokes of the individual’s life, they explore the adult child’s experience of coming out to themselves and others. In these sessions alone with the therapist, the adult child will typically offer details about experiences that they could not necessarily speak about in front of their parents in the first session. Some describe a long history of feeling ashamed, scared, defective, angry and hopeless; often dating back to even before they came out to their parents. For example, one client who grew up in a family characterized by conservative, traditional values, and whose parents were overtly homophobic, reported praying each day that he would die instead of having to disclose his identity to his father. He reported being jealous of people who had died in car accidents, and described the panic he regularly experienced at the thought of being “discovered”. When he did actually come out to his parents, their response was to withdraw into their own sense of loss, grief, shame and fear. As a result, not only did he lose the companionship and connection he had felt in his relationship with his father, but also felt guilty about causing his parents pain. As the adult child tells their story, the therapist works to connect them fully to their emotions. The therapist asks the adult child to describe specific, representative moments and incidents that were particularly painful – vivid, episodic memories. Typically, feelings such as hurt, sadness, grief, loneliness, helplessness, shame, disappointment, self-hate, terror and assertive anger arise. The therapist then asks if the individual had had anybody to go to with these feelings or, instead, was left to cope with them alone. In particular, the therapist asks if the individual has ever shared these experiences and feelings with their parents, and whether their parents knew the extent to which their rejection and withdrawal had left them feeling bad about themselves, alone, afraid, and disconnected.

In most instances, the client will report that they either have not shared their experiences and feelings with parents, or that they have tried to and such attempts have resulted in conflict or avoidance. In some instances, clients will say that they are afraid to start such conversations because they feel like their parents do not want to hear, or are not strong enough to contain their pain, disappointment and anger. In other instances, clients describe past attempts to speak with their parents that ended up leaving them frustrated, angry, and in even greater despair. For example, one female client reported that each time she attempted to express her anger, sense of loneliness and feeling of being abandoned when not being included in family events, her parents would become defensive, denying that her sexual orientation was an issue for them and accusing her of being overly sensitive. Such conversations only served to increase her distress and isolation, and deepen the rift in the relationship.

At this point in the task, the therapist again offers therapy as an opportunity for the adult child to be heard by their parents in a way that they have never been heard before. For example, the therapist might say: “If I could help your parents really listen and hear how painful and lonely it has been for you throughout the years, and how much it hurts when they behave as if they are ashamed of you, would that be something you want?” The possibility of being finally heard and understood resonates for our clients, and the answer to this question is typically “yes”. In some instances, however, the individual expresses ambivalence. Some are skeptical that their parents have the capacity to listen or fully understand. Some are unsure whether their parents really want to hear. Some are worried about causing their parents further pain. Some wonder if it will make a difference in the relationship. At this point, the therapist takes the position that the adult child deserves to be heard. The therapist states that she will work alone with their parents, in individual sessions, in order to help them learn to listen and respond in a more accepting and less rejecting manner. Finally, and importantly, the therapist assures the individual that she will only convene conjoint session if she is convinced that their parents are willing and able to listen with greater openness. While we don’t promise the moon, in most cases parents are able to listen and understand their child’s experience at least a little bit better. Sometimes even small changes mean the world to the adult child.

Once the individual has agreed to the task of sharing their experiences and feelings with their parents, the therapist prepares them for upcoming attachment/identity episodes. Together, the therapist and client identify the most salient experiences, memories and feelings the client wants to talk about with their parents. Then, the therapist prepares the adult child to articulate their feelings and associated attachment and identity needs from a place of vulnerability and care, and convey them in a non-accusatory, respectful, regulated manner. Finally, the therapist works with the client to set realistic expectations. Parents are not always able to respond optimally during the first try at such conversations. People often fall back into old, habitual, maladaptive patterns of relating (e.g., defensiveness, reactivity). The therapist prepares the child for the fact that it will be a two-step forward, one-step backwards process and, together, they anticipate different types of parental reactions and how the client can respond productively. Once the adult child is prepared for subsequent attachment/identity episodes, the therapist begins working individually with parents.

Task III

Task III involves forming a bond with parents, agreeing on the goal of their reaching out to their child to hear their experience, and preparing parents to respond to their children in a more caring, open, accepting manner during subsequent attachment/identity episodes. The therapist begins by briefly joining with each parent and exploring the major domains of their lives. The therapist asks about work, extended family, friends, support systems, and hobbies, paying special care to note parents’ strengths and competencies. The therapist also briefly explores potential stressors in parents’ lives, such as financial stress, marital stress, health issues, work related stress, caring for older parents, etc. It is important that therapists explicitly recognize the commitment, effort, courage and love for their child that it requires for parents to come and participate in this type of therapy.

Once the therapist has a sense of the broad strokes of parents’ lives, and an initial bond has been formed, she asks parents to share about their experience of having a sexual minority or transgender child. Many begin by describing their sense of shock, disbelief, terror and shame upon learning of their child’s sexual identity. Others report that they suspected their child was different from a young age, and share how painful it was to see their child bullied or excluded at school and in the neighborhood throughout the years. Often, parents describe the loss of their heteronormative dream, and grieve the fact that they will never have what they imagined to be a “normal” family, with a daughter-in-law (or son-in-law) and two grandchildren sitting beside them at the dinner table. Many focus on the shame they feel vis-à-vis friends, extended family and coworkers. They describe their fear that if others find out, they will gossip about them behind their backs, pity them, judge them and distance themselves. They are afraid to lose friends, their community and their life as they know it. Some parents are concerned that if their own parents were to find out, it might place their health at risk or worse. Individual sessions alone are where parents sometimes voice even their most unspeakable thoughts (e.g., “When I look at her, all I see is the son I lost” or “I sometimes wonder whether it would have been better if she wasn’t born”). During this part of the task, the therapist listens with compassion and empathizes with parents’ pain, confusion and fear. It is crucial that parents feel heard, accepted and not judged. Many of them have themselves grown-up in homophobic environments - families and communities in which being gay, lesbian or transgender is perceived of as a defect, sickness or sin.

At this point in the task, therapists may invite parents to more closely examine some of their fears and beliefs that have impeded their becoming more accepting of, or at least more comfortable with, their child’s identity. Some parents report that they haven’t shared their secret with anybody. In such cases, the therapist might wonder aloud if there is a particular family member or friend who might be more accepting than others. In many instances, parents are able to identity at least one person who would be more likely to be accepting. Such questions by the therapist begin to tease apart the global fear that has paralyzed parents and leads to a more differentiated, reality-based perspective. The therapist might then ask: “What would it be like to tell that person? How would they react? Would they embrace your daughter?” Such questions usually reveal possibilities, and underscore the potential for change. Suddenly, parents feel that there may be a light at the end of the tunnel. With parents who have trouble moving forward because they are pre-occupied with causes of their child’s identity (e.g., the influence of environmental and/or biological factors), the therapist might explore how they reached the conclusion, for example, that their parenting style led to their child’s minority sexual orientation. The therapist might also provide some short psychoeducation about what is, and is not, known regarding the causes of sexual orientation and gender identity (see Shpigel, Diamond, & Belsky, 2015, for a more detailed explanation of how we do this). Some parents are skeptical about whether the child is “really” gay or transgender, was always that way, or perhaps made a choice to “adopt” or “give in to” such an identity, etc. This skepticism is often fueled by what appears to parents to be “disconfirming evidence”, derived from their observations over the years. For example, as one father described it: “To be honest, I have trouble accepting that my son is really gay. I was there throughout his high school years. Every six months he had a new girlfriend. He was the most sought-after boy in his school -and these weren’t just “friends”. I saw how he interacted with girls and it was clearly much more than that”. In such cases, we empathize with the parent’s confusion and at the same time offer future conjoint sessions as an opportunity for them to ask their child, from a place of curiosity and openness, how it all goes together, how to make sense of it all.

Once parents have fully connected with their own disappointment, loss, grief, shame and fear, and they have a sense that the therapy will address some of their own struggles and concerns, the therapist invites parents to reflect on how their feelings and responses to their child’s sexual orientation and/or gender identity may have affected their child over the years. At this point, parents often become sad and remorseful. At some level, they know that their reactions have, at times, left their child feeling rejected, ashamed, and alone. In order to help parents fully connect to their child’s pain, therapists will ask for a specific example - an episodic memory. One mother, for example, described the look of humiliation in her transgender daughter’s eyes when they told her that, at home, they refused to call her by her chosen name and would only call her by her birth name. Another mother remembered how her son would come from school after being bullied and ridiculed, and go to his room. She regretted that, at those moments, she would angrily berate him for not fighting back instead of listening to what he had been through and comforting him. It is at this point in the treatment that the therapist offers therapy as an opportunity to be there for their adult child in a manner that the parent was not able to be there for them in the past. The therapist will typically say: “I can see how much you love your son. I can also see how bad you feel about what he must have gone through. I know that, back then, you may have been overwhelmed with your own anger, pain and fear, and it may not have been possible for you to hear what he was going through, but now things are different. You are in a different spot. You have an opportunity to invite your son to open up and share what that time was like for him. Be there with him in those feelings now in a way that you couldn’t back then. Help him to get it off his chest and move forward. Is that something you would want to do?”

Another part of the work with parents is exploring their own attachment history. The goal of this intergenerational work is to help parents connect with their own childhood experiences of needing their parents’ support and protection, and wanting their parents to be proud of them. In some cases, parents describe having grown-up in homes with parents who did not necessarily recognize when they were in distress, or did not know how to reach out to them in a way that allowed them to share, feel comforted and safe. In other cases, parents describe how their own parents made them feel bad about themselves. The therapist works to help the parent to connect to an episodic memory of a time when they themselves experienced such parental rejection or abandonment, in order to help them to access associated feelings of loneliness, worthlessness, etc. and identify what they needed in that moment. For example, one mother we worked with described how, as a child, her mother would verbally abuse her, calling her a “whore”. She described the deep sense of shame and confusion she eventually felt about her body and sexuality and wishing that there was somebody there to protect and comfort her.

Next, the therapist uses parents’ own experiences of parental rejection or disengagement to help them imagine how their own child might feel and what they might need. In the example above, the therapist asked the mother: “You know Gayle, listening to you talk about your experience with your own mother, how confused and shamed you felt about your own sexuality, and how she really wasn’t somebody you could talk to about your feelings, I wonder if Tammy sometimes feels like you are ashamed of her sexual identity and therefore doesn’t really share with you what is going on inside of her. That she is protecting herself. By connecting parents to their own history of relational ruptures and unmet needs, parents become more empathic to their adult child’s pain and longing, and motivated to provide a different type of experience for their child. In other cases, parents describe growing up with parents who were attentive, supportive, and accepting. In such instances, the therapist will help the parent to connect with how meaningful it was for them to have that experience of safety, acceptance and validation in times of need, and asks parents if they think that their own child feels safe, accepted and validated in the same way.

Once parents agree to the goal of reaching out to their child in a more empathic, accepting manner, the therapist begins to prepare them for subsequent conjoint attachment/identity episodes. Again, the purpose of such episodes is to create corrective emotional experiences. During such experiences, parents reach out to their adult child and invite them to share their feelings and emotions about past and present ruptures in the relationship. As a result, the adult child shares previously vulnerable feelings and longings in an emotionally connected manner. Parents then respond in a non-judgmental, accepting, supportive manner. In order to prepare parents for such episodes, the therapist helps them to identify some of the past and current events or interactions they believe are fueling their child’s sense of frustration and distress. Typically, parents already have a good idea about some of the things bothering their child since, over the years, the child has voiced such complaints, often in the heat of arguments. As one father put it: “I know she is furious with me for suggesting that she try to go out with more men before deciding that she was a lesbian”. At the same time, the therapist tells parents that there are some things their son or daughter may want to bring up. The therapist emphasizes that the parents’ task is to listen to their child’s pain, frustration and longing with openness, and without defending themselves. Parents are coached to ask open-ended questions about their child’s feelings, and give their child permission to share potentially painful and hurtful experiences. The therapist reminds parents that, during the upcoming episodes, they may have the impulse to present “their side of the story”, clarify facts, or defend themselves. However, the initial goal is to encourage the adult child to share in a way that they have never shared before, and for them, parents, to listen, empathize, support and comfort. The therapist assures parents that, after their child has shared all that they want to share, and have felt heard and validated, there will be then time for them to share some of what it has been like for them.

Task IV

By the end of the third task, both the adult child and parents are prepared to productively participate in attachment/identity episodes. In sessions alone with the therapist, parents have identified some of the core themes and interactions fueling the adult child’s distress. Moreover, the adult child now has the clarity and language to describe the range and depth of feelings their parents’ rejection and lack of acceptance brings up in them, and what they need from their parents. At the same time, parents have been prepared to listen attentively, non-defensively and with empathy. Consequently, the therapist plays a less central role during these episodes, instead allowing family members to speak directly to one another. When necessary, the therapist will refocus family members onto the core relational and identity themes, block any escalation of conflict or defensiveness, and remind parents to stay focused on their child’s experience and emotions. However, once they do that, they then get out of the way to allow the conversation to progress.

Such episodes typically begin with the adult child bringing up a past incident or interaction that was particularly hurtful. In the following example, a young man begins by talking about the intense pain he had felt 10 years prior:

Adult Child: “I remember when you came to my room that evening to ask me why I looked so sad. I finally got up the courage to tell you that I had been in a relationship with a man for the past six months and that it had just ended. All that you could say was that I deserved it and that if I didn’t find a way to overcome my attraction to men, I was going to ruin my life and the lives of everybody else in the family”

Mother: “What did it feel like when I said those things?”

Adult Child: “I was devastated. I was at my lowest, most vulnerable point and instead of making me feel better, you made me feel worse”.

Therapist (to mom): “See what he needed from you in that moment”.

Mom: “How did you want me to respond at that moment?”

Adult Child (crying): “I just needed you to hug me and say that it was going to be OK.”

Therapist to mother (who had begun crying): “What is going on for you right now, mom?”

Mother: “It hurts. It hurts to realize how much pain he was in and that I wasn’t there for him”.

Once past traumatic events have been processed, the focus typically turns to ongoing dynamics and current interactions that contribute to the child’s sense of rejection. For example, in the following case, a lesbian client described how it felt that her parents had never visited her in her new apartment, the one she had moved into with her partner.

Adult child: “It makes me angry that every week you guys drop by John’s (brother) house just to say hello. Janet and I live only 15 minutes away, yet you have never even seen the inside of our apartment. It feels like you don’t care.”

Mother: “Why does that make you feel like we don’t care?”

Adult child: “I just feel like I’m not important enough for you to make the effort to come see me. It hurts. Janet is such a big part of my life. I just feel like you are willing to give up on me and our relationship because it is hard for you. Come be with us, I know you will love her if you meet her.”

As the child shares their pain and longing, and parents respond with empathy, the child’s experience of their parents, parents’ experience of their child, and the relationship itself are transformed. The adult child feels more important, loved, understood and cared for. They also feel like their identity and autonomy needs are heard and respected. Parents better understand their child and are motivated to do all that they can to help them feel good about themselves and connected. An atmosphere of closeness, intimacy and mutual care evolves. The purpose of this task is to create moments of intimacy and loving connection between family members, not to solve problems or think about what needs to change.

Task V

 Once the adult child feels heard, the tension around previously unresolved conflicts has dissipated, and past hurts and conflicts have been largely resolved, there is a lighter, more relaxed and trusting atmosphere. A new sense of possibility and hopefulness arises. It is within this context that family members are able to keep each other’s needs and feelings in mind as they collaboratively find new solutions to old challenges. For example, during this task the conversation may turn to how parents can better respond in certain circumstances so that the child does not feel judged or rejected. In one case, a son explained to his parents who were worried that he was in an unhealthy relationship: “Instead of telling me that I am making a mistake, and ripping him (romantic partner) apart, I would rather you tell me that you are worried about me and ask how I am protecting myself. That would make me feel like it is coming from a place of care and concern rather than criticism”. In other instances, family members work together to address challenges not directly related to the interactions between them. For example, one family planned together how to come out to various members of the extended family. They each discussed their fears related to telling specific family members, who should be told, when, and how to tell them, etc. In other cases, family members use this task to ask questions that they never asked before because the relationship was too volatile, and every comment or question was interpreted as criticism or invalidation. Now, with a growing sense of understanding and trust, such topics are no longer off limits. For example, in one of the cases mentioned above, the father during task four asked his son about things he had observed during his son’s adolescence.

Father: “Do you mind if I ask you a question about the girls I saw come over all of the time when you were in high school?”

Son: “Go ahead. What do you want to know?”

Father: “It seemed to me like you were definitely attracted to a number of them, especially Kim. I don’t know. It seemed you guys couldn’t keep your hands off of each other”.

Son: “To be honest, I think I was just trying to do whatever I could to not raise suspicions. I was so afraid of how you would react. With regards to Kim, she had a girlfriend at the time and I was seeing somebody as well. There was never anything romantic or sexual between the two of us.”

Such conversations, which were not possible in the past, can be crucial. In this example, the son’s revelations were both painful for his father, as his lingering hope that his son was not really gay was shattered, but at the same time calming, as he no longer was left struggling to put seemingly contradictory pieces of information together. He was now free to move on from being pre-occupied with his doubts about the veracity of his son’s sexual orientation and, instead, get on with the process of accepting his son for who he is.

By the end of the five tasks, many of the adult children we have treated feel that they have finally been heard and understood, and many of the parents we have treated have made meaningful changes in terms of acceptance. Often, family members describe a new sense of togetherness, closeness, trust, collaboration and possibility. Indeed, in some of the follow-up interviews we have conducted in the context of our current clinical trial, family members have told us that the treatment “changed their lives”. Other families, however, have described more modest gains. For example, one male client reported that while his mother still does not accept his being gay, she no longer makes homophobic remarks or encourages him to explore relationships with women. Parents come to the treatment at various points on the acceptance continuum, and what might seem like modest gains for some individuals can feel like a momentous change for others. With that said, not all families have benefited from the treatment. We have worked with parents who, even after hearing their child’s pain and longing for recognition and connection, have not been able to overcome their own sense of loss, embarrassment, fear and anger, and continue to reject their child’s sexual orientation or gender identity. In such cases, we continue working alone with the adult child in order to help them grieve, accept and let go of their expectation that their parents will accept them, at least for the time being.

Empirical Support

 Research from a two small-scale clinical trials suggests that RFT-SM may be efficacious, and provides very preliminary data regarding the purported change mechanisms. In one study, we adapted attachment-based family therapy (ABFT), the predecessor of RFT-SM, for use with suicidal and depressed lesbian, gay and bisexual adolescents, and conducted an open pilot trial (Diamond et al., 2012). Results showed that, by the end of treatment, these adolescents evidenced significant decreases in depressive symptoms and suicidal ideation, as well as attachment anxiety and avoidance. In another study, we adapted and tested ABFT for young adults (as opposed to adolescents) suffering from unresolved anger toward a parent. Results indicated that both ABFT and individual emotion-focused therapy led to significant decreases in unresolved anger, attachment anxiety and psychological systems, while ABFT also led to a reduction in attachment avoidance (Diamond, Shahar, Sabo & Tsvieli, 2016). In 2014, we published our first clinical paper describing relationship-focused therapy for sexual minority adults and their persistently non-accepting parents (Diamond & Shpigel, 2014). Currently, we are in the midst of a nationally funded open clinical trial in which we will be treating 60 LGBTQ individuals reporting moderate to high levels of parental rejection. A preliminary analyses of six pilot cases found that, in cases in which the adult child reported increased parental acceptance and decreased parental rejection, independent observers rated parents as evidencing higher levels of empathy and lower levels of rejection during conjoint attachment/identity sessions (Boruchovitz-Zamir & Diamond, 2017).

Clinical vignette

Ben, a 24-year-old gay man, called us after seeing our project advertised online. At the time, he was studying economics at a local university. He is the youngest of three adult children. His father Ron, an accountant, and his mother, Hannah, a high school teacher, both joined him in the treatment. During the initial session, Ben described his family as generally warm and supportive, but also expressed frustration that his parents had never once talked to him about his being gay in the three years since he had come out. He described being worried about them and the pain they still felt regarding to his sexual orientation. When the therapist invited his parents to share their thoughts, Ron said he was not quite sure why they needed therapy, since he felt that they had gotten past the crisis and had learned to cope. Hannah, on the other hand, began to cry. She described feeling constantly overwhelmed with grief. She also revealed that Ron was very homophobic, and suggested his homophobia made it hard for Ben to feel accepted. Ron responded by saying, “Yes, I am a homophobe. That is not going to change. When I see two men together, I feel disgusted. I am also not the type of person to run around and tell the whole world that my son is gay. But, I told Ben that I love him and accept him for whoever he is”. At this point, the therapist both acknowledged the parents apparent love of their child and their willingness to come with him to treatment, while at the same time focusing the conversation onto how their responses affected Ben and their relationship with him. “Ben, as you look at your parents now and hear what they are saying, how do you feel?” Ben responded by talking directly to parents: “I know it is hard for both of you. I know what types of families you grew up in. But when I see that you are disgusted by me and ashamed of me, it makes me feel bad about myself. That is why I don’t tell you anything about myself or what is going on in my life. That is why I rarely come home to visit”. At this point, Ron looked a bit shaken and Hannah, again, began to cry. The therapist moved closer to both parents, asking: “What is going on for the two of you right now, as you hear Ben talk?” Mother: “I feel horrible. He shouldn’t have to feel this way. I feel like we have made things harder on him”. The therapist then turned directly to father: “What about you Ron?” Father: “I didn’t know he felt those things. We used to have a close relationship. Go to all of the basketball games together, whatever. I don’t want him to feel like he can’t come home whenever he wants to”.

At this point, the therapist offers therapy as an opportunity to help parents work through their own grief, shame and avoidance in order to both help their son feel better about himself as well as improve the relationship. “I know this hard for you two (parents). But if I could somehow help you both feel less overwhelmed, and more comfortable, in relation to your Ben being gay – for your sake, for Ben’s sake and for the sake of the relationship - would that be something you are willing to work on in this therapy?” Turning to Ben, the therapist continued: “If somehow your mother was less overwhelmed with grief, and your dad seemed more open, more comfortable and interested in being involved in your life, is that something that would be important to you?” After all three family members agreed to these therapy goals, the therapist met with Ben and his parents separately for a number of sessions.

 During the second task of therapy, the therapist asked Ben about his current life, unrelated to his parents and his relationship with them. He described enjoying his university studies and having a group of close friends that he had known since his freshman year. He was not currently involved in a romantic relationship. The therapist then asked Ben about his childhood and his coming out process. Ben described a happy childhood, with lots of friends and family around. When he was about 12 years old, he realized he was different from other boys and, at age 15, he realized that he was gay. He described how that realization had left him feeling confused, ashamed, scared and guilty. At around 18, he started feeling more comfortable with his sexual orientation and came out to a close friend who responded supportively. Over the next two years, he came out to all his friends and his siblings, leaving his parents for last. While most of the reactions he received were accepting, his parents’ reactions were more complex. His mother began sobbing. His father, while saying “you are still our son”, was clearly upset and immediately left the house to go outside for a walk. From that moment on, he has felt a tremendous distance from both of his parents. Over the course of the individual sessions with Ben, the therapist helped him to connect to his profound sense of loneliness, terror and abandonment. While he was apprehensive about the idea of sharing such feelings with his parents in upcoming conjoint sessions, he recognized that it was important to him that they know he felt this way. He and the therapist worked on planning what he wanted to say and how to say it.

 During the third task, in sessions alone with the parents, the therapist first inquired about each parent’s personal life, above and beyond their relationship with Ben. They talked about their jobs, friends, extended family and interests. They seemed to have a loving and mutually supportive marriage. The therapist then spoke with them about their experience of Ben’s coming out. Hannah spoke about her deep sense of loss. Ben was her only son and she had felt especially close to him. She looked forward to his getting married and having children, and when he told her, she felt like her whole life had crumbled. Ron spoke about how, after Ben came out, he had withdrawn from his own circle of friends and work colleagues: “I am not as interested in spending time with other people as I was in the past. I don’t feel like answering their questions about Ben and how he is doing, so I just keep my distance”. The therapist empathically helped both parents to connect to their deep sense of pain, loss, shame and loneliness while, at the same time, gently exploring their beliefs about how others might react and the implications of their choice to withdraw. She then asked both parents how they thought that their difficulty accepting Ben has impacted upon him, and his relationships with them. Both looked sad. “I know it hurts him. I would feel the same way. It isn’t his fault”, Hannah said. Ron replied, “I am willing to do anything. I don’t want him to feel like he can’t go on with his life. I am not sure why he feels like he can’t come home to visit”.

 At this point, the therapist asked each parent about their own experiences growing up. Ron described coming from a small family whose parents were holocaust survivors. He described them as loving parents who took good care of him. He also reported, however, that because of all that his parents had been through during the war, he felt like he did not want to cause them any additional pain, and therefore only told them about good things that happened to him, but never about those moments, as a child, that he was upset, scared or lonely. The therapist asked Ron if he thought that, in a way, Ben was similar to him in that he would prefer to protect his (Ron’s) feelings rather than let him know when he was feeling sad, scared or alone? Ron, after a short silence, replied: “I guess so, I never thought of it like that”. Hannah described growing up in a large, well-established family. She spoke with pride about how her mother and father were viewed as the “successful, strong ones”, and were the envy of their brothers and sisters, even until this day. She reported that there was no room for failure, weakness or imperfection as a child, and she remembers the emphasis her parents placed on how they appeared in the eyes of others. At the end of these sessions, the therapists wondered aloud whether Ben, perhaps, was feeling some of the same things they had struggled with during their own childhoods. She wondered if he was concerned about burdening them, kept his feelings of sadness, worthlessness, and helplessness to himself, and worried about how he looked in the eyes of others and how it reflected on the family. Seeing that this resonated with both Ron and Hannah, the therapist offered treatment as an opportunity for them to invite Ben to share with them how he was really feeling, and to support him. Therapy was presented as an opportunity for them to give him the message that he was OK just the way he was, in a manner that their parents couldn’t do for them.

During the task four attachment/identity episodes, Ron and Hannah dared for the first time to ask Ben about his own process of coming out to himself and friends. Ben openly and emotionally described the confusion, shame and fear that dominated his early high school years. He talked about all of the effort he invested in concealing his homosexuality and his fear that if they had found out, they would be disappointed. Both parents were clearly moved. Ron was the first to respond: “I want to make it clear that I don’t care what anybody else thinks or says. You are my son and you have nothing to be ashamed of”. The therapist checked with Ben regarding how he experienced his father’s response. Ben turned directly to his father and said: “You say that, but at the same time you have kept it a secret from everybody. You haven’t even told uncle Joe and uncle Richard! It makes me feel like you are ashamed”. Hannah joined in, saying: “I don’t want you to keep things inside. I want to know what is going on with you”. When the therapist then asked Ben to tell his mother what makes it hard to share with her, he responded: “You break down in tears. I end up feeling worse than before I told you”. Because of the work done in task three, Hannah was able to say: “It is true that it is hard for me. I know that in the past I have sometimes become sad. But it is more important to me than anything in the world for you to come to me, and for me to know what is going on in your life. I am strong enough to cope with my feelings. I might sometimes feel sad, but there is nothing more important for me than to have you as a part of my life. You used to share everything with me, and I miss that”. The therapist then asked Ben, “How does that sound to you, hearing your mom say that? Do you believe your mom when she says that she wants to hear what is going on with you, and is strong enough?” “Yes”, Ben replied. At this point, the therapist suggested that this be the goal for the next few sessions: that both mom and dad use the opportunity to invite Ben to share more about how he has felt in the past, and how he currently feels in the relationship.

Once Hannah, Ron and Ben had worked through many of the past and present ruptures, and had talked about difficult, previously avoided events and feelings, the tension in their relationships decreased and there was a greater sense of closeness. The family used their task five sessions to think and plan together how Ron father and Ben could progressively come out to members of father’s extended family. Hannah helped Ron think about which of his friends might be more accepting, and how to begin to tell them. Ben asked Hannah to accompany him to a PFLAGG meeting, and she agreed.

Constraints and limitations of RFT-SM

Relationship focused therapy is a time-limited, focused treatment specifically designed to improve the quality of the adult child-parent relationship in regards to the adult child’s sexual orientation and gender identity. Sometimes during the course of the therapy, important issues come up that are not immediately related to parental acceptance and the relationship (e.g., rejection anxiety related to romantic partners, depression). In such instances, the therapist will mark these issues as important domains family members might want to work on after RFT-SM has ended. When appropriate, we refer our clients for continued treatment when our work is done. Others are already in individual therapy when they come to us to work on their relationships with parents, and we conduct our work parallel to the work they are doing in individual or couples therapy.

RFT-SM requires that both the adult child and their parents be willing to work, in good faith, on finding ways to help the adult child feel less rejected, more accepted, and to improve the quality of the relationship. That is not to say that all of the family members need to be enthusiastic or optimistic when they present for treatment. Some families come after years of frustration, conflict and disengagement, and may be skeptical about the possibility of change. However, all family members have to be willing to try. In some instances, we have been approached by adult children who want to bring their parents to treatment but are not sure whether their parents will agree. In such cases, we work with them to formulate their request to their parents. We help them to reach out to their parents from a place of vulnerability and longing, not from a place of anger and blame. When adult children say to their parents, “I know that we have had some rough times around my sexual identity but you are my parents and my relationship with you is important to me. I love you and want you in my life. Let’s try to find a way to work through this together rather than drift apart”, parents are usually willing to come in to at least meet us and hear more about the therapy. Some parents, however, intransigently maintain that their child’s orientation or identity is unnatural, a bad choice, or is immoral, and remain focused on trying to change their child rather than accept them or improve the relationship. These parents are not (yet) candidates for this treatment.

It is also important to note that the model is designed for working with families whose adult children have been out of the closet to their parents for at least a year, and is not designed for working with parents who have just found out about their child’s minority sexual orientation or gender identity. For parents who have difficulty accepting their child’s sexual orientation or gender identity, the period immediately subsequent to disclosure can be one of great turbulence. During this period, parents usually require more support, interventions normalizing and containing their emotional reactions, psychoeducation and help getting connected with support groups in the community, such as PFLAG (or its counterpart TEHILA in Israel). Only after they have they regained their ground and some time has passed can they begin to take part in the type of relational work described above.

References

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

Rotem Boruchovitz-Zamir & Diamond (2017, June). *Changes in parental criticism and empathy over the course of attachment-based family therapy with LGBT young adults and their non-accepting parents.* Paper presented at the international conference of the Society for Psychotherapy Research. Jerusalem, Israel.

Carastathis, G. S., Cohen, L., Kaczmarek, E., & Chang, P. (2017). Rejected by Family for Being Gay or Lesbian: Portrayals, Perceptions, and Resilience. *Journal of Homosexuality*, *64*(3), 289-320.

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*(3), 215-242.

D’Augelli, A. R. (2002). Mental health problems among lesbian, gay, and bisexual youths ages 14 to 21. *Clinical Child Psychology and Psychiatry, 7*, 439–462. doi:10.1177/1359104502007003010

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

D’Augelli, A. R., Grossman, A. H., & Starks, M. T. (2005). Parents’ awareness of lesbian, gay, and bisexual youths’ sexual orientation. *Journal of Marriage and Family, 67*, 474–482. doi:10.1111/j.0022-445.2005.00129.x

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. M., Shahar, B., Sabo, D., & Tsvieli, N. (2016). Attachment-based family therapy and emotion-focused therapy for unresolved anger: The role of productive emotional processing. *Psychotherapy*, *53*(1), 34-44.

Diamond, G. M., & Shpigel, M. S. (2014). Attachment-based family therapy for lesbian and gay young adults and their persistently nonaccepting parents. *Professional Psychology: Research and Practice*, *45*(4), 258-268.

Diamond, G. S., Diamond, G. M., & Levy, S. L. (2014). *Attachment-based family therapy for depressed adolescents*. Washington, DC: American Psychological Association.

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

Elizur, Y., & Ziv, M. (2001). Family support and acceptance, gay male identity formation, and psychological adjustment: A path model. *Family Process*, *40*(2), 125-144.

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

Feinstein, B. A., Wadsworth, L. P., Davila, J., & Goldfried, M. R. (2014). Do parental acceptance and family support moderate associations between dimensions of minority stress and depressive symptoms among lesbians and gay men? *Professional Psychology: Research and Practice*, *45*(4), 239-246.

Fingerman, K. L., Pitzer, L. M., Chan, W., Birditt, K., Franks, M. M., & Zarit, S. (2010). Who gets what and why? Help middle-aged adults provide to parents and grown children. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 66B(1), 87–98.

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

Frank, S. J., Avery, C. B., & Laman, M. S. (1988). Young adults’ perceptions of their relationships with their parents: Individual differences in connectedness, competence, and emotional autonomy. *Developmental Psychology*, *24*(5), 729–737. https://doi.org/10.1037/0012-1649.24.5.729

Geoffrey S. Carastathis PhD, Lynne Cohen PhD, Elizabeth Kaczmarek PhD & Paul Chang PhD (2016): Rejected by Family for Being Gay or Lesbian: Portrayals, Perceptions, and Resilience, Journal of Homosexuality, DOI: 10.1080/00918369.2016.1179035

Greenberg, L. S. (2011). *Emotion-focused therapy*. Washington, DC: American Psychological Association.

Greenberg, L. S. (2012). Emotions, the great captains of our lives: Their role in the process of change in psychotherapy. *American Psychologist, 67,* 697–707.

Greenberg, L., Warwar, S., & Malcolm, W. (2010). Emotion-focused couples therapy and the facilitation of forgiveness. *Journal of Marital and Family Therapy, 36,* 28–42.

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

Minuchin, S. (1977). *Families and family therapy*. London, England:Routledge.

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.

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*(3), 265-275.

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

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*(2), 186-200.

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. M., & 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

Samarova, V., Shilo, G., & Diamond, G. M. (2014). Changes in youths' perceived parental acceptance of their sexual minority status over time. *Journal of Research on Adolescence*, *24*(4), 681-688.

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., & Dube, E. M. (1998). Parental reactions to their child’s disclosure of a gay/lesbian identity. *Family Relations, 47*, 7–13. doi:10.2307/584845.

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

Shilo, G., Antebi, N., & Mor, Z. (2015). Individual and community resilience factors among lesbian, gay, bisexual, queer and questioning youth and adults in Israel. *American Journal of Community Psychology*, *55*(1-2), 215-227.

Shpigel, M. S., Belsky, Y., & Diamond, G. M. (2015). Clinical work with non-accepting parents of sexual minority children: Addressing causal and controllability attributions. *Professional Psychology: Research and Practice*, *46*(1), 46-64.

Stone Fish, L., & Harvey, R. G. (2005). *Nurturing queer youth: Family therapy transformed.* New York, NY, US: W W Norton & Co.

White, K. M., Speisman, J. C., & Costos, D. (1983). Young adults and their parents: Individuation to mutuality. In H. D. Grotevant & C. R. Cooper (Eds.), *Adolescent development in the family: New directions for child development* (pp. 61–76). San Francisco: Jossey-Bass‏. https://doi.org/10.1002/cd.23219832206