

Diamond and Boruchovitz-Zamir have developed the only evidence-based psychotherapy to help LGBTQ people and their parents resolve the often-unacknowledged, painful tensions that can linger between them. Every page of this book shines with clinical wisdom, concrete guidance, and compassion derived from the authors' many years of firsthand experience working with these families. Therapists will do a tremendous service to LGBTQ people and their families by reading this book and applying its intuitive, accessible lessons to their own practice.

—**John Pachankis, PhD**, Susan Dwight Bliss Professor of Public Health, Yale University, New Haven, CT, United States

This is the definitive work on this new and effective treatment for families struggling to stay connected. Attachment-based family therapy is a theoretically grounded, highly teachable treatment, and this rich description of it is rendered with clarity and empathy. Highly recommended!

—**Laurie Heatherington, PhD**, Edward Dorr Griffin Professor of Psychology Emerita, Williams College, Williamstown, MA, United States

The authors describe a step-by-step process for conducting attachment-based family therapy for sexual and gender minority young adults and their nonaccepting parents. The ideas presented are very clear, and the book is well-structured, integrated, and organized. This excellent book will make a fantastic addition to the literature for family therapists and especially those who work with families of LGBTQ+ adolescents and young adults.

—**Yochay Nadan, PhD**, Associate Professor, The Hebrew University of Jerusalem, Jerusalem, Israel; Social Worker; and Licensed Couple and Family Therapist and Supervisor

Diamond and Boruchovitz-Zamir's book is a hands-on clinical guide that walks therapists through the theory, structure, and mechanics of attachment-based family therapy for sexual and gender minority young adults and their nonaccepting parents. For the purposes of growth and transformation, the authors provide a clear strategy for helping families attune to the pain of feeling disconnected from one another as well as the incredible strength that comes from relationship repair. Through illustrative case examples and narratives, the authors take us into the room with their client families, help us to experience therapeutic emotional shifts, and allow us to witness the rebuilding of "sacred trust" through their work. Most important, we are reminded that parents are willing to come into contact with difficult emotions, such as pain and fear, for the sake of their young adult and can, therefore, use their caregiving instinct to respond in ways that have been previously unavailable to them. A powerful prompt for therapists to harness the attachment capabilities of parents in therapeutic practice with LGBTQ+ young adults.

—**Jody Russon, PhD, LMFT**, Department of Human Development and Family Science, Virginia Tech, Blacksburg, VA, United States

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1 INTRODUCTION TO ATTACHMENT-BASED FAMILY THERAPY FOR SEXUAL AND GENDER MINORITY YOUNG ADULTS AND THEIR NONACCEPTING PARENTS

Although homosexuality is still denounced or even criminalized in many parts of the world, Western society as a whole has become increasingly accepting of lesbian, gay, bisexual, transgender, and queer (LGBTQ+)¹ people. LGBTQ+ people are more visible in almost all spheres of public life. In many countries, important antidiscrimination laws have been passed, and same-sex marriages are now recognized. That said, individual attitudes remain deeply divided. More than a quarter of Americans still view same-sex orientation as unacceptable. Moreover, increased societal acceptance and legal protections for LGBTQ+ people have sparked a dramatic backlash. For example, the United States is currently seeing a surge in anti-LGBTQ+ rhetoric and policies, including an extraordinary legal assault on transgender rights and the rights of parents to provide their trans children with gender-affirming medical care. Florida recently passed a law banning any discussions about sexual orientation and gender in kindergarten through third grade. Shortly thereafter, a member of

¹We use the terms *LGBTQ+* and *sexual and gender minority* interchangeably throughout this book to refer to the full range of people who are stigmatized because of whom they are attracted to, their sexual behavior or gender expression, or their self-identification. We discuss our choice of terminology later in this chapter.

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Attachment-Based Family Therapy for Sexual and Gender Minority Young Adults and Their Nonaccepting Parents, by G. M. Diamond and R. Boruchovitz-Zamir
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the U.S. Supreme Court suggested that federal laws protecting LGBTQ+ rights, including the right to marry, should be reconsidered. Such nonaccepting, reactionary views are more prevalent in conservative communities and are often grounded in religious fundamentalism, identity politics, and a fear of change and otherness (Drumheller & McQuay, 2010; Rosenkrantz et al., 2020; van der Toorn et al., 2017).

Perhaps nowhere are attitudes more evenly divided than in Israel, where we (GMD and RBZ) live and work. The most recent Pew Research Center survey found that whereas half of Israelis accept homosexuality, the other half does not. Moreover, these figures have not changed over the past decade (Poushter & Kent, 2020). Although the predominantly liberal and secular metropolis of Tel Aviv has consistently been voted one of the world's most gay-friendly cities, same-sex couples still cannot marry in Israel. On the one hand, 5% of Israeli parliament members are openly gay—the fourth highest percentage in the world—yet, on the other hand, leading rabbis, educators, and politicians continue to openly and unabashedly spread hateful, homophobic, and transphobic messages. During the 2015 Gay Pride parade in Jerusalem, an ultraorthodox Jew stabbed to death a 16-year-old marching in support of LGBTQ+ rights (PBS News Weekend, 2015). In 2022, the Pride parade scheduled for June in the southern Israeli town of Netivot was canceled after a bullet was left at the office door of the mother of a parade organizer (*The Times of Israel* Staff, 2022). Indeed, the most recent (2020) findings from The Aguda, The Association for LGBTQ Equality in Israel, showed that hate speech and violent acts against LGBTQ+ individuals in Israel rose by 27% in just 1 year alone, with transgender people being particularly targeted (Dvir, 2021).

As Stone Fish and Harvey (2005) pointed out, it is impossible to grow up in a culture in which heterosexist, homophobic, and transphobic messages are prevalent and not be affected by such messages. It is no wonder that most parents experience some degree of fear, shame, and loss on learning that their own child is same-sex oriented or gender nonconforming. Some parents perceive being LGBTQ+ as unnatural, a flaw, a liability. They worry about how others, including their friends and extended family members, will react. They are afraid that they will be pitied, ridiculed, or judged and that people will distance themselves from them. They grieve the loss of their hetero- and gender-normative dream of sitting around the dinner table with their child, his or her opposite-sex spouse, and biological grandchildren. They are forced to let go of the future they once imagined. Some parents panic about their child's welfare, afraid that they will be taken advantage of, discriminated against, and victimized. They imagine a dark future in which

their child is living alone, marginalized, miserable, and unfulfilled, with no support system or joy in their life. Those parents who are religious may face the additional challenge of reconciling their love for their child with their beliefs that homosexuality is immoral. They may be afraid that those in their religious community will judge or shun them and their child.

Parents' fear, shame, sense of loss, and anger can lead them to reject their young adult's² sexual or gender identity. Such parental rejection can manifest in many different ways. In extreme cases, parents may humiliate their young adult (e.g., "Stop acting like a woman") or invalidate their lived experience (e.g., "I know what and who you are better than you know yourself, and you are not a lesbian"). Some may attempt to coerce their young adult into trying to "change" their orientation, gender identity, or behavior (e.g., "I'm not willing to help support you if you choose to live with a woman"). Less direct, but still painful, forms of parental rejection include withdrawing from their young adult. Parents may spend less time with their young adult, be less emotionally involved in their lives, and be less physically affectionate with them. They may also ask their young adult to conceal their identity from certain family members or acquaintances (e.g., "I don't want Mum-mum to know").

Sometimes parents convey their lack of acceptance via more subtle messages. For example, one genderqueer young adult we (GMD, RBZ, and colleagues) worked with described how hurt and invalidated she feels each time her mother raises her eyebrows in a sign of disapproval when noticing that she is wearing nail polish. Such subtle, negative, invalidating messages directed toward stigmatized or marginalized people, including LGBTQ+ individuals, have been termed *microaggressions* (Balsam et al., 2011; Sue, 2010). Although most parents become more accepting, or at least more tolerant, over time, others remain partially or fully rejecting, even years after learning of their child's identity (Beals & Peplau, 2006; Cramer & Roach, 1988; Grossman et al., 2021; Samarova et al., 2014).

Ongoing parental criticism, invalidation, and rejection of one's sexual or gender identity can take a profound psychological toll. Such criticism, invalidation, and rejection are associated with young adults' internalized

²We have chosen the term *young adult* as opposed to "youth," "emerging adults," or "adults" because most of the young adults we work with are between 25 and 40 years old. This age range is thought to represent a unique development stage, distinguishable from emerging adulthood on the one hand and adulthood on the other (Arnett, 2000). That said, we have found this work appropriate for emerging adults, ages 20 to 25 who are no longer living in their home, and for adult children older than 40.

homophobia, expectations for future gay-related rejection by others (Pachankis et al., 2008), depression, suicidal ideation, anxiety symptoms (D'Augelli et al., 2005; Kibrik et al., 2019; Remafedi et al., 1991; Ryan et al., 2009), and drug and alcohol consumption (D'Amico & Julien, 2012; Padilla et al., 2010; Rothman et al., 2012).

Parental rejection can also destroy the fabric of family relationships. Young adults may distance themselves from their parents to protect themselves from being hurt and frustrated. They may avoid family events, particularly when parents are unwilling to include their partner or refuse to address them using their preferred names or pronouns. Even when spending time together, conversations may be constricted and shallow or emotionally loaded and quick to escalate. Both parents and their young adult may feel like they are walking on eggshells. Over the course of time, such dynamics erode relationships. Relationships become superficial, strained, conflicted, detached or cut off. Family members feel increasingly hopeless, resentful, and alone. What may have once felt like loving, secure, meaningful, and nurturing family bonds—a secure base and safe haven that could always be counted on—now feels fragile, tenuous, toxic or nonexistent.

In contrast, when parents are accepting of their young adult's sexual or gender minority identity, it has a positive effect on the self of the young adult and on the young adult–parent relationship (Ryan et al., 2009, 2010). Importantly, such acceptance is not simply the absence of rejection but rather overt supportive and affirming behaviors that convey to the young adult that they are prized and admired for who they are (D'Amico & Julien, 2012; Kibrik et al., 2019; Ryan et al., 2010). Parental acceptance means actively encouraging one's young adult to be themselves. Accepting parents are proud of their children and affirm their identity. They show interest in their young adult's personal life. They make an effort to both get to know their young adult's friends and partners and to include them in family events. Accepting parents come out to family and friends, stand up for their child, and advocate for their child's rights.

Not surprisingly, parental acceptance is associated with young adults' lower rates of suicidal thoughts and suicide attempts, higher levels of perceived social support, lower levels of psychological symptoms, and better general health (Kibrik et al., 2019; Ryan et al., 2010). When young adults feel accepted by their parents, they feel better about themselves (Ryan et al., 2010). They internalize their parents' interest, care, and pride in them. This positive view of the self helps the young adult to feel confident, explore, take chances, allow themselves to be vulnerable, and remain resilient in the face of negative life events. Indeed, self-esteem has been linked to well-being, goal attainment, and better interpersonal relationships (Harris & Orth, 2020).

Parental acceptance also allows sexual and gender minority young adults to remain positively connected to their parents. Research findings show that emerging and young adults in general, unrelated to sexual orientation or gender identity, report that their parents are one of their most important relationships and a primary source of support (Arnett, 2014; Fingerman et al., 2012). When parents accept their young adult's identity and autonomy, while at the same time provide support and closeness, young adults feel worthwhile, secure, and connected (Aquilino, 2006). Their bond with their parents is integral to young adults' well-being and functioning in the world and is on par with their relationships with romantic partners and peers (van Wel et al., 2000, 2002).

For sexual and gender minority young adults, such parental support and connection may be even more critical because they are subjected to minority stress. *Minority stress* refers to the stress LGBTQ+ people experience as a consequence of being marginalized, discriminated against, and victimized because of their stigmatized identity. It also refers to the stress associated with understandable yet maladaptive responses to such prejudice and victimization, including internalized homophobia, identity concealment, and rejection sensitivity (Hatzenbuehler et al., 2009; Meyer, 2003). When LGBTQ+ young adults can turn to and use their parents for support when facing such stressors, and parents are available to help their young adult process their emotions, problem solve, and feel less alone, it serves to buffer against the negative effects of minority stress. Indeed, research has shown that parental support moderates the negative effects of gay-related victimization (Evans et al., 2004; Shilo et al., 2015) and the association between minority sexual orientation and suicidal thoughts (Eisenberg & Resnick, 2006; Needham & Austin, 2010). Even when there is no immediate stressor, feeling connected to parents engenders a sense of safety and well-being. The young adult knows that whatever might happen, they are not alone (L. M. Diamond & Alley, 2022).

Whereas the idea of helping parents and their sexual and gender minority young adults form more accepting, open, closer relationships may have seemed almost inconceivable 50 years ago, times and attitudes are changing. Greater societal acceptance has created new possibilities and expectations. Positive role models of accepting families fill our television and movie screens. Most parents have a family member, friend, or colleague who is openly LGBTQ+. Many places of worship now advertise that they are LGBTQ+ friendly. All of this makes it possible for an increasing number of parents and their LGBTQ+ adult children to imagine being connected in an open, loving, and meaningful manner.

Therapists' expectations and goals for such families have also changed. In the past, treatment typically focused on helping LGBTQ+ young adults manage their parents' rejecting behaviors and move on with their lives. Parents were usually not involved in the therapy. Instead, the emphasis was on protecting the young adult from toxic family interactions; mourning the loss of their relationships with their biological parents; and identifying new, alternative sources of social support, such as "chosen" families. Today, however, therapists know that parents can change and that relationships between LGBTQ+ young adults and their parents can be transformed (G. M. Diamond et al., 2022). Therapists are more likely to work with families in an effort to facilitate greater acceptance; repair relational ruptures; and promote safe, mutually respectful and open relationships that allow family members to remain meaningfully connected. A number of excellent professional books have been written about how to help families navigate the coming out process, facilitate parental acceptance, and transform parent-child relationships (e.g., LaSala, 2010; Stone Fish & Harvey, 2005; Harvey & Stone Fish, 2015). Our (GMD and RBZ's) experience is that deep down, most sexual and gender minority young adults long to feel loved by, and remain positively connected to, their parents. Likewise, most parents long to feel good about their child, share in their joys, and be there to support them in tough times.

PURPOSE OF THIS BOOK

This book describes the step-by-step process of conducting attachment-based family therapy for sexual and gender minority young adults and their non-accepting parents (ABFT-SGM). ABFT-SGM for this population is specifically designed to help reduce parental rejection; facilitate parental acceptance; and, ultimately, promote safe, mutually respectful, closer, validating, loving, authentic, and meaningful relationships between LGBTQ+ young adults and their parents. The treatment is meant for families that continue to experience ongoing frustration, disappointment, conflict, grief, or distance in their relationships months or even years after their young adult has come out.

TERMINOLOGY

An abundance of terms has been used to describe people who are not exclusively heterosexual or cisgender (Eliason, 2014). Perhaps the most common and recognizable are the labels "lesbian," "gay," "bisexual," and "transgender."

Such labels, however, are limited. They do not always capture the person's lived experience or account for the full range and variety in sexual attraction, sexual behavior, gender identity, and gender performance. For example, the term "transgender," typically used to refer to a person whose gender identity differs from the sex that they were assigned at birth, may not align with the experience of a person who feels that their gender goes beyond simply identifying as either a man or a woman. Such people may feel that terms such as "nonbinary" or "genderqueer" better capture their identity. For others, labels in general may feel restrictive, irrelevant, or even offensive, and they may prefer not to label themselves. Such might be the case with two women in a committed romantic relationship who do not conceive of themselves as lesbian or bisexual. Most labels also do not capture the dynamic nature of sexuality and gender, which can fluctuate and evolve over time (L. M. Diamond, 2006).

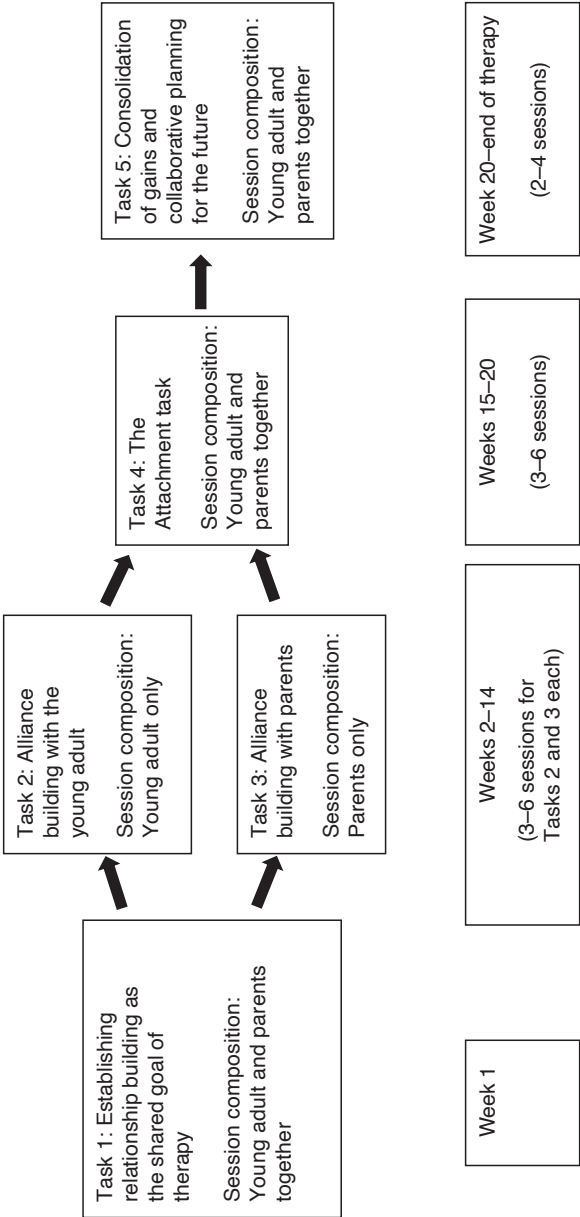
In our clinical work, we (GMD and RBZ) ask the young adult what language or terms best suit them and then use that language in our work together. For the purposes of this book, however, we have chosen to use a single set of terms for the sake of clarity. We did so, recognizing that no single term or set of terms fully reflects the varied experiences of our clients. In the end, we chose to use the terms *sexual and gender minority* and *LGBTQ+* to refer to people whose same-sex orientation, attraction, or behaviors, or whose non-conforming gender identity or performance, has led to their being rejected or not accepted by their parents (Eliason, 2014).

OVERVIEW OF ABFT-SGM

ABFT-SGM is a systematic, empirically informed, LGBTQ+-affirmative, experiential, emotion-focused, and family-based treatment. The model is rooted in attachment theory (Bowlby, 1988), research on young adult–parent relationships (Arnett, 2014; Fingerman et al., 2012), research on parental rejection and acceptance of LGBTQ+ young adults (Kibrik et al., 2019; Ryan et al., 2009, 2010), emotion theory (Safran & Greenberg, 1991), and multidimensional family therapy (Liddle, 2009). ABFT-SGM is an adaptation of attachment-based family therapy (ABFT) for depressed adolescents (G.S. Diamond et al., 2014).

The treatment comprises five treatment tasks (see Figure 1.1), typically completed in sequence over the course of between 16 and 26 weeks. The first task is to establish relationship building as the shared goal of therapy. This task begins by connecting family members to their loss, grief, regret, and longing associated with the rupture or loss of their relationships and the

FIGURE 1.1. Overall Structure of ABFT-SGM



ABFT-SGM = attachment-based family therapy for sexual and gender minority young adults and their nonaccepting parents.

fear that things may never change. Once they are connected with their loss, pain, fear, and longing, the therapist offers treatment as an opportunity for things to be different. For parents, the therapy is presented as an opportunity to work through their fear, anger, shame, and grief and to find a way, at their own pace, to become positively involved in their child's life again. For the young adult, treatment is presented as an opportunity to be heard, understood, validated, supported, and prized for who they are. For both the young adult and their parents, the opportunity to repair their bond and stay connected in a meaningful, loving, mutually respectful manner touches a deep emotional chord and existential need, and it becomes the shared goal for treatment.

Once all family members are on board, the second task of treatment is to form a strong therapeutic alliance with the young adult. To this end, the therapist meets alone with the young adult for a number of sessions. During these individual sessions, the therapist helps the young adult to connect with, and put into words, their emotions (e.g., anger, fear, sadness) associated with past and current ruptures in the relationship. These ruptures may be the result of past traumatic events (e.g., being told to not come home until they "turn straight again") or ongoing, frustrating, invalidating interactions (e.g., fights about parents' homophobic comments, parents' unwillingness to include their young adult's partner in family events). Once the young adult is fully connected with their emotions, the therapist then helps them to access and articulate their associated unmet attachment and identity needs (e.g., the need to be heard, taken seriously, respected, loved and prized for who they are). At the end of these individual sessions, the therapist prepares the young adult to share these emotions and needs directly with their parents in subsequent conjoint attachment sessions. The goal is to help the young adult share these feelings and needs with parents in a manner that will make it most likely that they will be heard. In other words, to help them share their feelings and needs in a regulated, nonattacking manner and from a place of vulnerability, while simultaneously asserting healthy boundaries.

Concurrently, the therapist meets with parents alone for several sessions. The goal of these sessions, the third task of the treatment, is to build a strong therapeutic alliance with each parent. During these sessions, the therapist helps parents access and work through their shame, grief, anger, and fear associated with their young adult's sexual orientation or gender identity. The therapist also invites parents to reflect on how their feelings and responses to their young adult's sexual orientation or gender identity have negatively affected their child and their relationship with them. As parents begin to connect to, and empathize with, their young adult's hurt, fear, anger, and

loss associated with feeling rejected, parents' natural instinct to protect and care for their young adult is activated. They become motivated to better understand and support their young adult. Once parents have softened, are better able to reflect on how their nonacceptance affects their young adult and the relationship, and are motivated to do better, the therapist reintroduces relational repair as the goal of treatment. The therapist presents the therapy as an opportunity for parents to listen to, and emotionally be there for, their young adult in a manner that they have not been previously. The therapist systematically prepares the parents to respond to their young adult's feelings and needs in a more attuned manner during subsequent conjoint attachment episodes. More specifically, parents are coached to remain nondefensive, open, curious, empathic, and validating as their young adult shares their pain and adaptive needs for acceptance and connection directly with them.

The fourth task of treatment is the attachment task. During these conjoint sessions, the young adult is helped to express—directly to their parents—their hurt, fear, frustration, and anger associated with their parents' rejection/nonacceptance as well as their longing to be recognized, validated, prized, loved, and respected. The young adult is helped to communicate these feelings from a place of vulnerability and in a regulated, respectful manner. At the same time, parents are helped to respond in a nondefensive, empathic manner. As a result, the young adult feels heard, understood, and validated—often for the first time. This sense of feeling heard, understood, cared for, and safe leads the young adult to further disclose vulnerable feelings and needs. This iterative cycle of disclosure and vulnerability on the part of the young adult, and empathy, validation, concern, and support on the part of parents, leads to a reduction in tension, productive processing of grief and anger about past injuries, and a sense of trust and relief. In some cases, parents show remorse and offer an apology for having hurt their young adult. They may also take ownership of their own fears and internal conflicts associated with their young adult's identity. At the end of such episodes, family members tend to feel closer, more tender and compassionate toward one another, more mutually accepting, and more connected. Such corrective attachment episodes are considered the primary change mechanism of the therapy.

In the fifth and final task, after much of the tension in the relationship has been resolved and trust and intimacy have increased, parents and their young adult revel in the gains they have made in their relationship. They are also freed to work collaboratively to navigate the often scary next steps of living fuller, more open, and authentic lives. This may include planning together how parents will finally come out to their own parents (i.e., the grandparents), extended family members, friends, or community members.

They might also discuss when and how to invite their son's romantic partner to dinner for the first time. Conversations during this fifth task may also focus on strategies for how family members can avoid conflicts or misunderstandings in the future. For example, family members may use this task to plan how to have difficult or emotionally laden conversations when new issues come up after the treatment has ended.

In ABFT-SGM, each task builds on the previous tasks. For example, the therapist must be sure that each family member is sufficiently signed on to the goal of having difficult conversations in the therapy room before bringing them together for conjoint attachment sessions. Sometimes a task will take one or two sessions to complete; other times, it might take five or six sessions. In some cases, the therapist will want to meet with the young adult alone for an extended number of sessions because the young adult is highly anxious about directly expressing their feelings and needs to their parents. In other cases, the therapist might decide to meet with parents alone for an extended number of sessions because the parents are highly distressed and not yet in a position to hear their young adult's feelings and unmet needs. In yet other cases, the therapist may begin the attachment task only to realize that the parents or the young adult are not sufficiently on board with the treatment goal or perhaps are having a hard time regulating themselves and remaining open. In such instances, the therapist may decide to go back to meeting with family members alone to shore up the therapeutic alliance and better prepare them before resuming the conjoint attachment task. In that sense, the treatment is flexible and responsive to each family's unique needs and therapeutic process.

Although ABFT-SGM does not follow a strict protocol, the treatment does have a clear framework. The successful completion of one task sets the stage for the following task. Also, each task has its own structure with a well-articulated, detailed sequence of microsteps or subtasks. This provides the therapist with a road map and compass, directing them to where they need to go next. It also provides therapists with signposts to evaluate where they are in the treatment process. In that sense, the treatment is systematic and intentional, helping therapists to make moment-by-moment decisions in the room. At any given moment, the therapist knows what the next step is and why they have chosen to use one intervention instead of another or focus on one topic or process instead of another. For example, the therapist will know why, at a particular moment, they chose to shift from asking the young adult about how they feel when their father makes homophobic comments to asking the father how he feels hearing how hurt his child is when he makes those comments. At the same time, the flow of the session is organic

and natural. The therapist intuitively feels the undercurrents of each family member's emotional world and skillfully moves the process forward in a responsive manner.

The therapist is the one with the map in hand, and they are responsible for leading the family through this landscape. They are empathic and sensitive while, at the same time, steadfast in keeping family members focused on the core, meaningful, but often difficult and painful topics at hand. They are respectful of family members' ambivalence and fears but do not acquiesce. In that sense, ABFT-SGM is best defined as client sensitive rather than client centered. The therapist's role is to guide and support family members as they walk down this path together. That said, the manner in which the therapy unfolds is based on the unique characteristics of each family. Although the structure of the treatment tasks and processes are generally the same across cases, the pace, crossroads, twists, and turns will be different for each family.

When first learning ABFT-SGM, most therapists feel awkward. This is natural and expected whenever one learns a new skill or approach. But once therapists learn the model and have treated a family or two, they typically feel a sense of excitement. They feel like they finally have a clear, coherent theory of change and a systematic practical map for how to repair or improve family relationships. In our trainings, we (GMD and RBZ) frequently hear feedback to the effect of:

I do many of the things that you are talking about and have showed me. But now, I am able to put it all together. I know what I am trying to do, where I want to help the family get to, what the next step in the treatment needs to be, and how to go about it.

CORE FEATURES OF ABFT-SGM

This section describes some of the core features of ABFT-SGM. It highlights how the treatment is LGBTQ+ affirmative, relationship focused, noncoercive, and developmentally and culturally sensitive.

LGBTQ+ Affirmative

ABFT-SGM is an LGBTQ+-affirmative therapy. We, as therapists, respect and honor the young adult's lived experience and how they make meaning of that experience. We adopt the language the young adult uses to describe themselves. ABFT-SGM therapists are committed to helping young adults live as openly and authentically as they choose. Also, we do not view the relationship between parents and their young adults as symmetrical.

The treatment is founded on an explicit ethical position that parents have a fundamental responsibility to help their young adult become who they are and want to be, to feel safe in the world, and to be proud of themselves and their accomplishments. It is not the role of the young adult to fulfill their parents' dreams and expectations. Although we do take the position that young adults should treat their parents with compassion and respect, and consider their parents' values, needs, sensitivities, and limitations as they make decisions and move forward, the primary goal of the treatment is to help parents better understand; respect; and, when possible, embrace and affirm their young adult's identity.

Attachment as a Driving Motivation

A basic assumption in ABFT-SGM is that regardless of their age, deep down, young adults yearn to be seen, understood, prized, loved, respected, and supported by their parents, even if those feelings and longings have been buried under years of hurt and frustration. ABFT-SGM therapists also assume that, deep down, parents want their young adult to be happy, safe, and successful in life. That they want to support, guide, and encourage them as well as take joy in their growth, independence, and achievements.

This is true even for parents who, at the start of treatment, are highly distressed, rejecting, and avoidant. We attribute parents' nonacceptance to fear, not malice. We assume that parents who come to us for therapy love their young adult and want the best for them; that they want to do better but either do not know how or are too scared to take the steps they know they need to take.

Noncoercive

ABFT-SGM should in no way be coercive. From the outset of treatment, therapists make it clear to parents that we respect their values, religious beliefs, and customs. We do not try to force parents to become more accepting of their young adult's sexual or gender identity than they feel like they can or want to be, nor do we judge their attitudes or behaviors. Instead, we present treatment as an opportunity for parents to explore their experience of having an LGBTQ+ young adult as well as how their attitudes and behaviors have affected their young adult and their relationship with them.

ABFT-SGM is a chance for parents to reach out and hear their young adult's experience and help their young adult to feel heard, respected, and connected for the sake of both their young adult and for the relationship.

While most parents do become less rejecting and more accepting over the course of treatment, some do not. In some cases, parents become better able to hear and validate their young adult's legitimate needs but still feel unable to meet those needs (such as referring to their young adult using their chosen name and preferred pronouns). In such cases, the treatment focuses on how to create safer, more caring, and mutually respectful relationships while helping the young adult mourn and let go of some of their unfulfilled hopes.

Developmentally Sensitive

ABFT-SGM for LGBTQ+ young adults and their nonaccepting parents is an adaptation of ABFT for depressed adolescents, (G. S. Diamond et al., 2014). Such an adaptation was needed, in part, because young adults are in a different developmental stage than are adolescents, and the nature of their relationships with their parents is quite different. Whereas adolescents are typically still living with their parents, are financially dependent on them, and are subject to their parents' rules and monitoring, young adults have usually left home. In most cases, they have begun to take on the tasks of adulthood, such as forging a career path; gaining financial independence; establishing a peer support network; and, perhaps, forming meaningful romantic relationships with significant others.

Because young adults are financially, behaviorally, and psychologically more autonomous than adolescents, and further along in their identity development (including their sexual and gender identity development), the power dynamics in the relationship change. Young adults are usually more confident about who they are and what they need. This frees them to be vulnerable and express their unmet needs to be cared for, recognized, and appreciated in ways that adolescents often cannot do. At the same time, they are better able to set limits. They are less afraid of being engulfed and losing their separateness. They are able to express their feelings and needs while simultaneously seeing their parents as independent people in their own right. This leads to more mutually respectful and collaborative relationships (Koepeke & Denissen, 2012). Current research findings regarding the nature of young adult–parent relationships inform the goals of ABFT-SGM.

Culture and Context

To be effective, ABFT-SGM must be delivered in a manner that is sensitive to the racial, ethnic, cultural, and religious identities and experiences of the

young adult and their family. Therapy with a White evangelical family from Alabama whose gay young adult son still lives close to home and has not yet come out to his extended family will likely look different from therapy with a Black liberal family from Chicago whose genderqueer young adult is living openly in New York City and is an activist for LGBTQ+ rights. In Israel, work with an ultraorthodox Jewish family from Jerusalem will look different from work with a secular liberal family from Tel Aviv. Cultural factors influence family values and goals as well as which issues and processes are more or less salient in each case. In some cases, conversations might focus on family members' reconciling their religious beliefs with their love for their young adult and desire to have them closer. In other families, issues such as parents' standing in their community, fear of social exclusion, and shame are front and center. In yet other cases, conversations revolve around the safety and welfare of the young adult and social justice.

With racial and ethnic minority families, ABFT-SGM therapists explore the effects of bearing multiple stigmatized, deprived identities. For example, people of color often face both racial discrimination and heterosexism/cissexism in their everyday lives as well as racial discrimination in LGBTQ+ spaces (Balsam et al., 2011; McConnell et al., 2018). Intersectionality theory (Crenshaw, 1991), rooted in Black feminist experiences and thought, provides a helpful lens through which to examine how various forms of discrimination (e.g., racial, ethnic, religious, heterosexism, transphobia) overlap for people with multiple marginalized identities, leaving them disempowered, alienated, and vulnerable in the different arenas of their lives. For example, in Israel, an Arab Muslim lesbian is likely to feel marginalized and vulnerable for being Arab when in her apartment in Haifa and in predominately Jewish LGBTQ+ spaces, and marginalized for being LGBTQ+ when visiting the Arab village in which she was raised and her family of origin still resides.

Talking about the young adult's experience of being discriminated against and alienated in multiple systems as well as the challenges they face attempting to integrate the different and seemingly conflicting aspects of themselves (e.g., being an orthodox Jew and being gay) is important. Such conversations help parents better understand what their young adult is up against. Talking about these things can elicit parental compassion, empathy, and motivation to better support and protect their young adult. It can also help parents better see and admire their young adult's strengths, values, resilience, and sense of agency (Harvey & Stone Fish, 2015). Likewise, speaking openly with parents about their own struggle to reconcile their religious beliefs and racial and ethnic identity with being the parent of an LGBTQ+ young adult is essential to the process of facilitating acceptance and deepening the connection between parents and their young adult.

ABFT was originally developed while working with primarily urban, economically disadvantaged African American and multiracial depressed and suicidal adolescents and their families (G. Diamond et al., 2003; G. M. Diamond et al., 2012). A number of papers have since been published that illustrate how cultural factors are explicitly considered in ABFT with racial and ethnic minority lesbian, gay, and bisexual adolescents (Ibrahim et al., 2018; Levy et al., 2016). In recent years, our (GMD and RBZ's) team in Israel has worked primarily with White and Brown middle-class Israeli Jewish families. Some of these families were secular; others were religious. Some lived in large urban centers; others lived in more conservative suburban or rural communities. Most of the clinical examples in this book come from our work with these young adults and their parents. Although the guiding principles of the treatment, overall treatment goals and tasks, and therapist intervention strategies are similar across populations, the family's race, ethnicity, religious beliefs, and community milieu make each case unique.

Acceptance as a Continuum

ABFT-SGM therapists understand that different parents begin treatment at different points on the acceptance continuum. Even in the same family, two parents may be in very different spots in terms of their level of acceptance and the way that they cope with their young adult's minority identity. Parents may also have different treatment goals and levels of motivation. Therefore, what might be considered a successful treatment outcome varies greatly, depending on the given family or parent.

For example, in the case of a father who begins therapy proclaiming that he is a sworn homophobe and that nothing is going to make him believe that homosexuality is natural, a good outcome might be his being able to hear and appreciate how hurtful his homophobic comments are to his son, empathize with his son's feelings, and commit to being more careful when speaking. At the other end of the continuum might be a father who begins treatment by stating that he accepts his daughter's same-sex orientation and does not understand why she feels unheard, invalidated, or alone. In such a case, a good outcome might involve a series of heartfelt conversations during which the daughter recounts moments or interactions in which she felt hurt or invalidated, and the father responds by earnestly trying to understand, self-reflect, take responsibility, and explore what he can do so that his daughter does not feel that way in the future.

Importantly, for families that begin treatment on the more rejecting, cut-off, or conflictual end of the spectrum, what may seem like small steps toward

more tolerant, open, safe, and caring relationships can be as meaningful to the young adult as the types of dramatic shifts sometimes seen in families that began treatment further along on the acceptance continuum. No matter where families begin their journey, even just a couple steps forward can mean the world.

SCOPE AND LIMITATIONS OF ABFT-SGM

A number of caveats should be kept in mind regarding the scope and limitations of ABFT-SGM.

Focused Treatment

ABFT-SGM is a focused family-based treatment specifically designed to promote parental acceptance and improve young adult–parent relationships. The treatment is not meant to be a panacea—a solution for every presenting problem. Some of the family members who come to us for therapy are facing an array of life challenges that cannot be fully addressed in the context of ABFT-SGM. For example, some parents present with high levels of marital distress: conflicts that preceded and are rooted in dynamics unrelated to their young adult’s coming out. Other parents may have a history of mental health challenges, such as a history of severe depression. Some young adults may be struggling with untreated social anxiety, complex trauma, or substance abuse. Other young adults are grappling with body issues; intimacy issues; or, more generally, figuring out who they are and what they want in life.

When indicated, therapists will help family members find support and guidance beyond the context of ABFT-SGM. Sometimes this means helping them find an individual therapist, a couples therapist, or other professionals with whom to consult either before the treatment begins, while they are participating in ABFT-SGM, or after the treatment ends. Although ABFT-SGM is often conducted as a stand-alone intervention, in many cases, it is delivered as part of a more extensive, broader treatment plan.

Designed to Treat Ongoing Parental Rejection

ABFT-SGM was designed for, and tested with, families in which parents continue to reject their young adult’s sexual or gender identity months or years after learning of their young adult’s identity. ABFT-SGM is not necessarily the intervention that families need just after their young adult has come

out for the first time. For some parents, the period immediately after their young adult comes out is emotionally charged and turbulent. They may be shocked, confused, terrified, and generally overwhelmed. What many of these parents primarily need during this period is support, validation, normalization of their feelings, psychoeducation, and reassurance that things will become more manageable with time. They need to regain their equilibrium, down-regulate, use their natural support systems, read, and educate themselves. In most cases, parents' natural coping mechanisms kick in. They quickly gain perspective, and the welfare of their child takes front and center. With the support of accepting extended family and friends, and by keeping in mind the larger picture, most families find their way back to each other without the need for therapy.

Many parents find support groups, such as PFLAG, to be beneficial during this process. Others turn to family therapists who have experience helping families navigate the coming out process. Indeed, a number of excellent books and articles provide wonderful clinical guidance for family therapists working with families during the initial coming out stage (e.g., Harvey & Stone Fish, 2015; LaSala, 2010; Savin-Williams, 2001; Stone Fish & Harvey, 2005). However, for those parents who remain stuck in their shame, fear, anger, and sense of loss—sometimes even years after their young adult's coming out—a more focused treatment, such as ABFT-SGM, may be a good option.

OVERVIEW OF THE BOOK

This book is intended for master's- and doctoral-level clinicians who have at least some training and experience in family therapy. This is not an introduction to family therapy. Delivering this treatment also requires that therapists have at least basic knowledge about sexual orientation, gender identity, sexual and gender identity development, and minority stress. For family therapists who are less familiar with this material and have less experience working with sexual and gender minority clients, reading and training in this field is recommended. It is also highly recommended that therapists who want to learn and practice ABFT-SGM use supervision to explore their own beliefs and biases about sexual and gender minority individuals.

The next chapter presents the theoretical framework and empirical support for the model. Chapters 3 through 7 present the five tasks of the treatment and the microsteps used to navigate each task. Case examples are presented to exemplify how to conduct each task. These examples come from the families we (GMD and RBZ) and our colleagues have treated in our research studies

and private practice. Family members consented to have their material included in this book, and identifying details have been altered to protect the privacy of the clients. We chose cases in which family members showed at least some progress in treatment—that is, they made at least some meaningful steps toward acceptance and relational repair. This is because it is easier to learn how to apply a model when you have examples of what it looks like when the treatment unfolds as intended. In that sense, these examples provide ideal performance maps. Chapter 8 discusses special issues that arise in working with families of sexual and gender minority young adults and their nonaccepting parents, such as addressing religious beliefs and the role of siblings in the treatment. We also discuss how to work with particularly difficult cases.

We are forever indebted to the families that agreed to participate in this project over the years. Their willingness to let us in as they struggled to make sense of and come to terms with their young adult's identity and worked to build closer, more satisfying relationships was a sacred trust. At times, we felt their frustration, fear, and despair. But mostly, we witnessed their courage, love, and dedication to each other, which was nothing short of awe inspiring. Young adults garnered the courage to open up and be vulnerable. Parents, often for the first time, listened openly, empathically, and without defending themselves. They heard and connected with their child's pain and unmet needs. During such moments, young adults felt heard, prized, connected, and protected. Sometimes we all cried. At other times, we laughed together. In most cases, families finished the therapy feeling like they had found one another again.