

2012

In or Out? Ambiguous Loss and Boundary Ambiguity in Families During the Coming Out Process

Tarryn R. Moor
Wright State University

Follow this and additional works at: https://corescholar.libraries.wright.edu/etd_all



Part of the [Psychology Commons](#)

Repository Citation

Moor, Tarryn R., "In or Out? Ambiguous Loss and Boundary Ambiguity in Families During the Coming Out Process" (2012). *Browse all Theses and Dissertations*. 662.

https://corescholar.libraries.wright.edu/etd_all/662

This Dissertation is brought to you for free and open access by the Theses and Dissertations at CORE Scholar. It has been accepted for inclusion in Browse all Theses and Dissertations by an authorized administrator of CORE Scholar. For more information, please contact corescholar@www.libraries.wright.edu, library-corescholar@wright.edu.

**IN OR OUT? AMBIGUOUS LOSS AND BOUNDARY AMBIGUITY IN
FAMILIES DURING THE COMING OUT PROCESS**

PROFESSIONAL DISSERTATION

SUBMITTED TO THE FACULTY

OF

**THE SCHOOL OF PROFESSIONAL PSYCHOLOGY
WRIGHT STATE UNIVERSITY**

BY

TARRYN R. MOOR, Psy.M.

**IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE
OF
DOCTOR OF PSYCHOLOGY**

Dayton, Ohio

September, 2013

COMMITTEE CHAIR: Heather Wilder, Psy.D.

Committee Member: James Dobbins, Ph.D., ABPP

Committee Member: Daniela Burnworth, Ph.D.

Copyright by
Tarryn R. Moor
2012

WRIGHT STATE UNIVERSITY
SCHOOL OF PROFESSIONAL PSYCHOLOGY

June 30, 2012

I HEREBY RECOMMEND THAT THE DISSERTATION PREPARED UNDER MY SUPERVISION BY **TARRYN MOOR** ENTITLED **IN OR OUT? AMBIGUOUS LOSS AND BOUNDARY AMBIGUITY IN FAMILIES DURING THE COMING OUT PROCESS** BE ACCEPTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PSYCHOLOGY.

Heather Wilder, Psy.D.
Dissertation Director

La Pearl Logan Winfrey, Ph.D.
Associate Dean

Abstract

This study investigated the family dynamics that occur following a child's disclosure of his/her same-sex sexual orientation. In particular, this study aimed to gain information regarding the possible presence of boundary ambiguity and subsequent ambiguous loss within families after their child/children comes out. Participants included individuals who identified as caregivers (i.e. parents, guardians) of a gay, lesbian, or bisexual child. Participants were given a survey in which many items were adapted from previous boundary ambiguity scales, in addition to qualitative items to fully capture the participants' experiences. Findings suggested that a majority of participants did not experience ambiguous loss or boundary ambiguity during the coming out process. While many endorsed feelings of loss, the family dynamics that followed the child's disclosure did not appear to have a drastic shift. Moreover, results indicated that there is a statistically significant shift in caregivers' perceptions regarding their child's same-sex sexual orientation over the course of time. This study provides information for clinicians conducting individual and/or family therapy wherein a child identifies as gay, lesbian, or bisexual.

Table of Contents

Chapter I	1
Chapter II: Literature Review	3
Historical Context	3
Societal Views and Stigma	6
Cultural Stigma	7
Religion	10
Individual's Experience	11
Coming Out	11
Barriers to Coming Out	12
Individual's Experience of Loss	13
Family's Experience	15
Caregiver's Experience When a Child Comes Out	15
Child's Experience When a Parent Comes Out	19
Ambiguous Loss and Boundary Ambiguity	19
Ambiguous Loss	20
Boundary Ambiguity	24
Intersection Between Ambiguous Loss, Boundary Ambiguity, and Culture	25
Chapter III: Methods	28
Participants	28
Materials	29
Procedures	31
Chapter IV: Results	33
Demographics	33
Quantitative Analysis	34
Qualitative Analysis	38
Chapter V: Discussion	43
Clinical Implications	44
Limitations	47
Future Directions	49
Appendix A	51
Appendix B	56
Appendix C	60
Appendix D	62
Appendix E: Tables	63
References	67

Dedication

This work is dedicated to my family. You all have been by my side throughout my journey through life. Here is to the next chapter...

Acknowledgements

First a foremost, thank you to my family for your unconditional love, support, and care packages that have made the long-distance seem less far. Your encouragement has got me through many academic projects and cold winters in Ohio. I love you all with all my heart.

I would like to especially thank my parents for always believing in me and for encouraging me to pursuit my dreams no matter how big they may have seemed. Mom, thank you for being my biggest fan. You were right, it “all worked out” and, looking back, all the worrying probably was not worth it. Papa, thank you for motivating me during times in which my motivation level was low or I questioned my abilities. Your words always seemed to find a way to get me back on track, as well as smile.

A special thanks goes to my graduate advisor, Dr. Heather Wilder. You believed in me and my ideas from the very beginning and this project would not have been possible without you being a part of it. You have helped me find my voice and, more importantly, learn how to use it. Words could never fully capture how much I appreciate all you have done for me.

Thanks to the members of my dissertation committee for agreeing to be a part of this project and for all the feedback you have provided over the past few years. Dr. Daniela Burnworth, I greatly appreciated your presence during our meetings as your nods and smiles always seemed to bring a sense of calm over me. Dr. James Dobbins, thank you for always finding a way to make time to meet and talk with me. Working with you helped me realize my passion for working with adolescents and families. I am honored to have had the opportunity to work with you.

Thanks to my friends for being another source of support and distracting me from anything school related, when needed. I appreciate your patience with my busy schedule and occasional visits and/or calls that inevitably brightened my day.

Lastly, thank you to my classmates who have been along for this ride called graduate school. I never thought we would see the day in which there are no more quarters to count down. We are the only ones that will ever know what this experience was truly like and I am glad that you all were my fellow passengers.

Chapter I

Given the societal stigma attached to identifying as lesbian, gay, or bisexual (LGB), individuals often carefully consider to whom and when they will disclose their same-sex sexual orientation. When individuals “come out,” or disclose their same-sex attraction to their family members, a variety of responses can ensue. These responses typically fall on a continuum ranging from absolute acceptance to absolute rejection. Instances in which a family’s responses are congruent with the latter, the family dynamics inevitably change. For some families, the rejection of another family member’s same-sex sexual orientation can lead to a relationship cutoff wherein the individual is removed from the family unit physically and/or emotionally. This particular process has the potential to be perceived as a loss of a family member either by the family member who has disclosed, the family member who has rejected a LGB family member, or both.

As a result of the perceived loss that can develop, it is important to understand how this can impact members of the family, as well as the family system as a whole. Within a family system, roles are typically assigned and/or taken on by members of the family (Minuchin, 1974). Over time, each member becomes accustomed to the role(s) that s/he has been given or assumed. When boundaries within the family become unclear as to who is in or out of the family, it has been suggested that boundary ambiguity is present (Boss & Greenberg, 1984; Boss, 2006). Boundary ambiguity often results from a perceived loss within the family system. The way in which families respond to a

perceived loss of a family member varies depending on the family's level of emotionality and ability to cope with distress. Roles within the family may shift, or be modified, in order to adapt to the perceived loss of a member of the family (Boss, 2002, 2006). However, unlike the traditional sense of loss (i.e. death), it has been suggested that a perceived loss can often be more difficult for individuals to cope with due to the uncertainty that is frequently present. Boss (2002, 2006) refers to this type of loss as an *ambiguous loss*. The project will attempt to examine a) whether family members, particularly caregivers (i.e. parents, guardians), experience an ambiguous loss and b) if families experience a shift and/or uncertainty regarding boundaries within the family following a child's same-sex sexual orientation disclosure. The final objective of this project is to discuss the clinical implications for working with LGB individuals and/or their families.

Chapter II

Literature Review

Historical Context

Sexual orientation is commonly divided into three main categories: homosexual, heterosexual, and bisexual. Although this classification system is frequently used today, the term *homosexuality* was not originated until 1869 (Mondimore, 1996). This is, in part, due to the fact that the ancient Greeks and Romans did not utilize a categorization system to classify sexual identity. Yet, the creation of the word *homosexuality* was developed as a response to the increased discussion as to whether same-sex relationships should be outlawed. Following suit, the topic of homosexuality also sparked the interest of researchers towards the end of the 1800's. The research that resulted from this period suggested that homosexuality was abnormal and that this form of "pathology" was a correlate to criminal behavior (Mondimore, 1996). Therefore, members of society were given the message that engaging in same-sex relations was wrong and should be abstained from. This greatly influenced societal views on homosexuality for many years to come.

This newly socially constructed view of homosexuality reigned as the dominant belief system for much of the 20th century, eventually finding its way into the Diagnostic and Statistical Manual of Mental Disorders (DSM). Homosexuality was considered a mental disorder until the early 1970's. As a result, conversion (or reparative) therapy, which employs therapeutic interventions designed to alter a client's sexual orientation,

was supported as a form of psychotherapy until 2009. Recently, the American Psychological Association's (APA) Task Force on Appropriate Therapeutic Responses to Sexual Orientation announced that conversion therapy could not be supported empirically and, more importantly, could result in more harm than benefit to the client (American Psychological Association, 2009). Regardless of this stance by the APA, no formal sanctions have been set forth for those conducting conversion therapies. Without formal sanctions, this form of therapy can still be utilized by psychologists and community organizations at their discretion. Moreover, the message that sexual orientation is something that can be fixed and/or changed continues to be communicated to the greater society.

Although homosexuality is no longer considered a mental disorder, the belief that having a same-sex sexual orientation is 'abnormal' still exists. This belief system is reinforced and maintained, in part, by the message given to society from the United States (U.S.) government that having a same-sex sexual orientation is not acceptable. This is apparent in the laws in a majority of the states within the U.S., which prohibit same-sex marriage. Under Article IV, Section 1 of the U.S. Constitution, "Full Faith and Credit shall be given in each State to the public Acts, Records, and judicial Proceedings of every other State" (U.S. Constitution, 1790). Full Faith and Credit was enacted in 1790 to assure that all states in the union would recognize marriages performed in other states and provide benefits thereof. However, this protection was invalidated by the creation of the Defense of Marriage Act (DOMA) in 1996, to prevent single states from effectively legalizing same-sex marriage for all other states, as they would have to honor them due to Full Faith and Credit clause. According to DOMA, marriage is currently

defined as a union between one man and one woman (Defense of Marriage Act, 1996). As a result, same-sex marriages that have been honored in one state or country are banned from being acknowledged in states where same-sex marriage is not allowed. Conversely, all heterosexual marriages continue to be protected and honored under the Full Faith and Credit clause. By putting DOMA into affect, the government sends a strong message regarding their stance on same-sex relationships, as it takes an overwhelming majority to overturn a constitutional amendment. At the time of this writing, the only states in the U.S. that grant same-sex couples the full benefits of marriage include: Connecticut, Iowa, Massachusetts, New Hampshire, New York, and Vermont. There are a small percentage of additional states that will recognize same-sex marriages. Although, legal benefits that are associated with matrimony (i.e. adoption, insurance policies) are generally excluded. It is important to keep in mind that government officials in this country often use moral beliefs to justify decisions, and are greatly influenced by the beliefs of the citizens who vote them into office. Religion frequently shapes the views of both, and can be another source of messages that can impact the acceptance of a same-sex sexual orientation. This will be discussed in greater detail in later sections.

Another source of societal messages regarding same-sex relationships derives from the military system in the U.S. in the form of the “Don’t Ask, Don’t Tell” policy. This policy was introduced in 1993 (10 U.S.C. § 654: US Code - Section 654, 1993) and prevented individuals who identify as LGB from openly serving in the U.S. military forces. Grounds for dismissal from the military included any instance(s) in which an individual disclosed his/her same-sex sexual orientation and/or overtly engaged in

affectionate behavior with an individual of the same sex. It should be noted that investigations could be launched based on any arbitrary suspicion of having a same-sex sexual orientation. In cases wherein the individual was deemed guilty, consequences consisted of being charged of “conduct unbecoming” and eventual dismissal from military service. Similar to other societal forces mentioned previously, this military policy explicitly sent the message that identifying as LGB is something that should be kept to one’s self and something that should not be encouraged. The Don’t Ask, Don’t Tell policy was enforced up until September 20, 2011, when it was repealed.

In similar fashion, it was not until 1990 when Congress passed the Hate Crime Statistics Act, wherein it became mandatory for law enforcement officials to begin recording hate crimes that were the result of prejudice towards the ethnicity, religion, and/or sexual orientation of an individual or group. According to the 2008 Uniform Crime Reporting Program statistics, sexual orientation accounted for 16.7% of all single-based hate crime motivation (U.S. Department of Justice, 2008). An overwhelming majority of these hate crimes related to the sexual orientation of the victim were the result of the perpetrator’s anti-homosexual views. While these statistics were mandated to be recorded, hate crime laws did not, until very recently, provide protection to individuals who identify as lesbian, gay, bisexual, and transgender (LGBT). The Matthew Shepard and James Byrd, Jr. Hate Crimes Prevention Act was created to address this issue. However, due to the stigma and prejudice attached to LGBT issues, the law took many years to pass. Thus, this Act was not put into effect until 2009 (Local Law Enforcement Hate Crimes Prevention Act of 2009).

Societal Views and Stigma

Given the historical evolution of sexuality, and in particular non-heterosexual sexuality, one begins to understand the degree to which the religious, medical, and political realms have shaped societal views on sexual orientation. In turn, these perceptions that develop over time emerge into stigmas that society attaches to individuals who do not identify as members of the dominant culture (i.e. heterosexual).

Cultural Stigma. Cultural stigma refers to the depreciation that non-dominant cultural group members experience (Dovidio, Major, & Crocker, 2000). Furthermore, this form of stigma is solely based on the individual's membership of a particular cultural group. When considering culture, it is important to emphasize that sexual orientation differs from other cultures in that it is a concealable stigma, meaning that one's same-sex sexual orientation is not necessarily obvious to others during initial meetings. As a result of the cultural stigma related to sexual orientation, individuals may feel as though they need to "pass" as heterosexual in order to avoid the consequences that can follow disclosing one's sexual orientation to others (i.e. discrimination, rejection, alienation). Furthermore, it is imperative to understand the history of how society has viewed homosexuality in order to better understand the assumptions and expectations parents may have for their children, as well as how those assumptions developed and may have translated into LBG-related stigma.

It is this cultural stigma, which leads to the development of heterosexism, homophobia, and internalized homophobia. *Heterosexism* refers to an individual's preference toward opposite-sex intimate relationships. This belief system typically leads individuals to make the assumption that heterosexuality is the norm, which lends itself to overlooking a LGB individual's sexual identity. By making this assumption, an

evaluative judgment is inherently made, in which heterosexuality is valued and same-sex relationships are devalued. This is problematic in that LGB individuals begin to internalize this belief system, which is not congruent with their self-concept. In a review of the literature, Szymanski, Kashubeck-West, & Meyer (2008) discussed the psychosocial correlates related to increased levels of internalized heterosexism, which included lower self-esteem, lack of social support, depression, and suicidal ideation. Due to the oppression that results from heterosexism, those who identify as heterosexual maintain their status within the dominant culture and continue to hold the power and privilege within society.

While heterosexism implies one's preference towards heterosexuality, *homophobia* is indicative of an individual's irrational fear and avoidance of individuals with a same-sex sexual orientation (Fone, 2000). Homophobic individuals often hold negative attitudes towards individuals who identify as LGB or those they believe are members of the LGB community. Both heterosexist and homophobic belief systems can lead individuals who identify as LGB to take in these oppressive messages that the dominant culture sends and begin to believe them. In addition, homophobia can lead individuals to engage in overt discriminatory behaviors (e.g., verbal insults, physical harm, etc.) that are rejecting and oppressive to the LGB population.

Internalized homophobia occurs when LGB individuals internalize the stigma and prejudice that society has associated with same-sex sexual orientations. Upon continually receiving heterosexist and homophobic messages from society, these negative societal views begin to become part of the individual's self-concept and can potentially result in harm to the individual. Research suggests that individuals who have been marginalized

by society over long periods of time have a difficult time forming a positive self-image (Frable, Wortman, Joseph, 1997) and show lower levels of self-esteem (Frable, Wortman, & Joseph, 1997; Peterson & Gerrity, 2006). Additional psychological difficulties that have been found to be associated with internalized homophobia include feelings of depression, anxiety, guilt, and suicidality (Meyer & Dean, 1994). It is important to make a distinction between the previously mentioned terms and gain an understanding as to how they can contribute to the discrimination and distress that LGB individuals experience.

While cultural stigma has been shown to have effects on individuals who identify as LGB, research also indicates that those who have a relationship with stigmatized individuals also experienced stigma as a result of their association with an LGB individual. Sigelman & Howell (1991) studied this form of cultural stigma by association in male college students. Participants were introduced to one of two situations: a college male who either voluntarily or involuntarily rooms with a college male who identified as gay. Results from this study indicated that voluntarily associating with a gay male increased the likelihood of participants making the assumption that the individual had same-sex tendencies, or desires. Additional studies have shown that family members of LGB individuals are also likely to report feeling as though they are stigmatized by association (Gochros, 1985). For some family members, this may take form as embarrassment and/or wondering how others will perceive them as a result of their child's sexual orientation. Mallon (2010) noted that some siblings of LGB individuals might experience an uneasiness related to whether others will begin to question their sexuality.

Religion. While the main diversity variable being focused on in this discussion is sexual orientation, it is important to acknowledge the impact that other diversity variables can have when they intersect with sexual orientation. For those who are religious, religion can play a central role in the formation of one's beliefs about what is moral and immoral. Accordingly, individuals often feel justified in their belief system and continue to hold onto these beliefs despite the oppressive nature towards those who identify as LGB. While there are gay-affirmative religious organizations, a majority of religious organizations are not accepting of same-sex relationships. Given this climate, it is common for LGB individuals who are religious to begin to internalize the disapproving messages they receive from their religion. As hypothesized, Meyer and Dean (1998) found that LGB individuals who identified as being religious showed higher levels of internalized homophobia than those who were not religious. In contrast, those who belonged to a gay-affirming religious organization displayed similar levels of internalized homophobia to those who do not identify as being religious. It is this internalized homophobia that can influence religious LGB individuals to "pass" and, instead, align one's self with the dominant culture (i.e. heterosexuality). The integration of one's religious and sexual identities may lead to dissonance and conflict. However, some individuals are able to find ways in which the two intersecting identities can be integrated. Dahl and Galliher (2009) investigated the factors that influence an individual's ability to integrate their religious and sexual identities. Of the factors noted within the study (e.g. self-acceptance, biblical/religious knowledge), family support emerged as a factor that influences successful integration one's sexuality and religious identities.

Jennings (2003) suggests that there are three responses that religious parents typically display following a child's disclosure of being LGB, and they are as follows: completely giving up one's religious beliefs, holding onto one's stringent religious beliefs, or finding a way to hold onto aspects of one's religion while incorporating acceptance of child's sexual orientation. It is possible for a parent to exhibit all of these responses in instance wherein the parent's religious beliefs and attitudes have evolved and adapted over time.

Individual's Experience

Coming Out

The phrase "coming out" is in reference to an individual's awareness and recognition of his/her same-sex sexual attraction, as well as the decision to disclose their LGB identity with others (Malik & Lindahl, 2011). This process is one that is often repeated throughout the individual's life, as the decision regarding what setting(s) s/he is able to come out to is continuously evaluated based upon how safe the individual feels within a particular setting. According to Cass' Homosexuality Identity Formation model (1979), LGB individuals may begin to distance themselves from family and friends during the identity acceptance stage. This differentiation often occurs as a response to wanting to explore one's established LGB identity privately. However, as with the formation of any identity, each individual's experience is unique and does not always follow a linear manner, or prescribed model. One's identity can shift when going through the coming out process and is often influenced by personal factors (e.g. maturity, culture), as well as environmental factors (e.g. prejudice, discrimination).

As mentioned previously, LGB individuals may feel as though they need to “pass” as heterosexual to avoid prejudice and/or discrimination from others. The act of passing can be associated with negative connotations (e.g. “in the closet” or “hiding”) and/or viewed as a form of denial of one’s self. Yet, it can also serve as a functional strategy to face the oppression that results from being a member of the non-dominant group. Smith (1997) indicates that passing can avoid exclusion and isolation from others, which can potentially occur following a disclosure of one’s sexual orientation. It is important to emphasize that if avoidance is a technique that continually and solely utilized, the individual will also continue to suppress parts of the self. Consequently, his/her self-concept can be affected and, ultimately, prevent the individual from living life as his/her authentic self. In a study looking at the potential effects of passing, Fuller, Chang & Rubin (2009) found additional benefits of passing such as avoiding confrontation, maintaining privilege and privacy, and prevention of one’s sexuality from becoming a focal point to others. The costs that individuals reported experiencing involved feeling inauthentic and angry, restriction and/or loss of romantic relationships, and devoting excess time and mental energy to putting on false pretences.

Barriers to Coming Out. During the coming out process, it is important to consider the barriers that may exist that prevent individuals from disclosing a non-heterosexual identity to others. As mentioned before, individuals may be out in one setting but not in other settings. Hesitation towards being out in certain settings can be due to a fear of rejection, discrimination, abandonment, being misunderstood, or seen as/treated differently (Kort, 2008; Mallon, 2010). Generally, the mere idea of having a conversation with one’s parents related to sexuality can be unpleasant and, in turn, is

sometimes avoided all together (Malik & Lindahl, 2011). One particular barrier for LGB individuals is related to the fear of how their family will react to their same-sex sexual orientation. Since families are frequently a source of social and financial support, the risk of losing these support systems can result in ambivalence as to whether or not to disclose this information to one's family.

Ryan et al. (2009) examined the relationship between a family's level of acceptance in relation to the health of White and Latino LGB young adults. Here, the health of the participants was based on levels of depression, suicidal ideation and attempts, substance use/abuse, and risky sexual behavior. The researchers found that participants with worse health outcomes reported experiencing higher levels of rejection from their family. Of the total sample, Latino men who identified as gay or bisexual were found to have the highest rates of familial rejection and poor health outcomes. Alternatively, Ryan et al. (2010) found that individuals who came from families that were more accepting of their same-sex sexual orientation displayed greater levels of self-esteem and support. In addition, the LGB child had better health outcomes (i.e. less suicidality and substance use/abuse) than those LGB children whose families were not accepting of their sexual orientation. These studies suggest that familial reactions towards a child's same-sex sexual orientation can have a significant impact, both negatively or positively, on a child's emotional and physical health.

Individual's Experience of Loss. Berzon (1988) suggests that a grieving process may occur when individuals are in their own process of coming out. Here, the loss may be in relation to the *heterosexual blueprint*, or the fantasies and privileges associated with being heterosexual in society (e.g. marriage, adoption, legal benefits). As a result,

Thompson (1996) has proposed a five-stage model that integrates and addresses loss as part of the coming out process for lesbians. In Stage One, the individual begins to accept the fact that she no longer identifies with the dominant culture. In doing so, the individual also acknowledges the privilege that is given to those who are heterosexual which may create feelings of anger and/or sadness. Stage Two involves understanding the loss(es) that one may experience and attempting to assimilate to the LGB culture. Thompson (1996) indicates that this is a period of searching for the individual, where she may become angered by the specific privileges she loses, as well as feeling some distress related to determining when and with whom to come out. Fittingly, individuals also begin to test out new social settings. This exploration often occurs as a way of leaving their old identity behind and moving forward with their newly acknowledged identity. For many individuals this can create feelings of ambivalence and fear, as they are heading into territory that is commonly unknown. Next, in stage three, the individual begins to experience the pain associated with the loss and begins the grieving process. By allowing one's self to grieve, the individual can then begin to let go and move toward a more positive experience as a lesbian. If the individual continues to avoid the feelings of pain, this can build up and can affect their ability to engage in meaningful, intimate relationships with future partners. In Stage Four, the individual starts to acclimate to living life as a lesbian. This typically consists of the individual celebrating and embracing her identity as a lesbian. This can involve anything ranging from telling others about their identity to actively participating in LGB events. Lastly, Stage Five entails integrating one's lesbian identity into the greater LGB community and, more broadly, society. It should be noted that individuals do not always go through the stages

in a linear manner, and can even experience stages simultaneously or not at all (Thompson, 1996). With Stage Five in particular, one's internalized homophobia may prevent the individual from being a part of the lesbian community. In addition, openly associating with the LGB community may also put individuals at risk for discrimination, which can affect his/her decision to integrate one's identity with the community. For those who do integrate the two, they are able to process their idiosyncratic experiences of identifying as LGB, as well as gain an additional support system.

Family's Experience

Caregiver's Experience When a Child Comes Out

As mentioned previously, caregivers' reactions related to a child's disclosure of a same-sex sexual orientation vary. Research suggests that familial reactions include astonishment, guilt, shame, fear, worry, discontent, relief, support, and/or anger (Mallon, 2010). For families that view a child coming out as LGB as a crisis, their response will likely be similar to how they have responded to other crises over the course of time (Savin-Williams, 2001). Malik & Lindahl (2011) suggest that parental reactions towards a child's disclosure of his/her same-sex sexual orientation may be exaggerated due to their own lack of knowledge. Additionally, some parents may delay their reaction(s) as a result of believing that their child's disclosure of being LGB is "just a phase," or have an unspoken understanding that their child's LGB identity will not be discussed at all (Mattinson & McWhirter, 1995). For those who are accepting of their child's sexual orientation, it is likely that their relationship will not be negatively impacted and, in some cases, may become closer because family members can be more genuine with one another.

In cases wherein the caregivers experience anger, or even hostility, towards the idea of their child identifying as LGB, the family system will likely be impacted. Mallon (2010) indicated that some parents may push for their child to enter therapy, which is often focused on dealing with the child's sexuality "problem" or repairing the child's sexual identity (e.g., conversion therapy). In more extreme cases, parents that are not accepting of the child's sexual orientation may respond in removing the LGB child out of the household and/or family system. According to the National Coalition for the Homeless (2009), approximately 20% of homeless youth identify as LGBT, which is ten percent higher than the general lesbian, gay, bisexual, and/or transgender youth population. This percentage provides some support for the existence of a subset of parents whose reactions towards their child identifying as LGB are unreceptive and punitive.

In their 2000 study, Herdt and Koff identified three domains that families frequently experience after a child's same-sex sexual orientation: disintegration, ambivalence, and integration. Disintegration occurs when families are not responding well to their LGB child and experience a great amount of guilt. In this phase, parents likely are having minimal to no contact with their children and sometimes experience discord within the family system. The ambivalence phase is one in which parents have mixed feelings about their child's same-sex sexual orientation and are vacillating between being accepting and dealing with lingering discomfort related to their child coming out. While conflict may still be present, it is more often associated with facing reality (e.g., introduction of the child's partner to the family). Lastly, integration occurs when families are open and accepting of their child's LGB status. Family relationships

tend to be closer and the need to suppress discussions regarding the child's sexual orientation is no longer present (Herdt & Koff, 2000). Depending on the composition of the family system, some families may not experience each of these phases and/or may stay fixed in one phase. However, as time passes, many families go through these phases and eventually come to a place where they are able to successfully integrate their child's LGB identity into their family system.

Family members of LGB individuals may also experience a perceived loss when their son/daughter or sibling comes out (Mattinson & McWhirter, 1995; Herdt & Koff, 2000; Gottlieb, 2003). The loss can be related to, but is not limited to, a perceived loss of trust and/or control, status, community, or role within the family system (Gottlieb, 2003). Parents may experience loss that is associated with the debunking of their *heterosexual family myth*, or expectation of how family members will live out their lives (Herdt & Koff, 2000). For example, the feelings of loss may arise as a result of erroneous beliefs that LGB individuals cannot achieve life milestones similar to that of heterosexuals. For some, fantasies or myths are based on socially constructed myths of what it means to identify as LGB. Jensen (1999) noted that parents of lesbian women sometimes have difficulty associating their daughter with their preconceived notions of lesbians and mourn their daughters' non-adherence to what they believe are traditional female gender roles. Whatever the source of the perceived loss(es) may be, it is essential for health care providers to help families better understand their potential loss(es) and to mourn, if needed.

Kort (2008) noted that families who have difficulty accepting their child's LGB identity may go through a process similar to that of Kübler-Ross' Five Stages of Grief

Model (1997). In these instances, family members may deny or invalidate their child's disclosure by believing their child's same-sex sexual orientation is situational. Some may become angry, depressed, and/or begin to bargain with the child as means of coping (e.g. becoming hyper-religious as a means of "changing" the child's sexual identity). Eventually, many parents are able to accept their child for who s/he is and no longer mourn the previously-held heterosexual family myth. Savins-Williams (2001) cautions parents from immediately latching on to this ideation. He explained that parents should understand that they may not experience each stage and/or may go through the stages in an unspecified manner. In addition, parents may feel as though they are abnormal if they do not feel the emotions that are prescribed in the Five Stages of Grief (Kübler-Ross, 1997), which could complicate their process.

Overall, the research regarding the processes families go through when an individual comes out is mixed. While some believe the process involves a period of mourning and grief, some suggest that that familial process involves acclimatization and integration of child's new identity. DeVine (1984) offered a five stage model of familial reactions following a child's disclosure of a same-sex sexual orientation. This model proposes that families respond in the following ways: subliminal awareness, impact, adjustment, resolution, and integration. While this model does address mourning, particularly in the resolution phase, the emphasis appears to be reaching the point of integration wherein the family is accepting of the child's LGB identity and the system is not longer rigid and/or closed off (DeVine, 1984).

Despite the fact that the much of the current research related to family reactions in response to a child coming out has focused on the negative family dynamics that can

ensue, it is also important to highlight that there are subsets of parents who are open and accepting of the child's same-sex sexual orientation. Thomas & Schwarzbaum (2011) shed light to this population, indicating that parents who are flexible in their worldviews can use this as a strength to advocate against oppressive forces that their LGB children and family may encounter.

Child's Experience When a Parent Comes Out

Gottlieb's (2003) work with sons who have gay fathers suggested that children with gay or lesbian parents can encounter a wide range of emotions during the coming out process. These emotions included anger, astonishment, confusion, shame, or for some, relief. Gottlieb (2003) asserted that these emotions can be experienced simultaneously, or independent of one another. More importantly, the duration and intensity in which individuals experience these emotions varies from a concise period of time to one that is more enduring.

In a similar type of study, Davies (2008) interviewed adult daughters whose mothers disclosed their same-sex sexual orientation to them past the age of adolescence. Of the six daughters interviewed, five of the six participants indicated that they maintained a healthy relationship with their mothers. Only one participant reported not being able to accept her mother's future partners. Another participant's response suggested that there was a sense of loss in one's belief system since everything that was once believed to be true was now perceived as being false.

Ambiguous Loss and Boundary Ambiguity

Ambiguous loss and boundary ambiguity are terms that have been used as a way of viewing Hill's ABC-X model of family stress (1958) in a different way. Hill's model

proposed that family stress would be conceptualized by focusing on the event and/or stressor (A), the family's available resources and/or strengths (B), the meanings that are constructed and attached to the event/stressor (C), and the stress/crisis that potentially occurs (X). The sections below will demonstrate how ambiguous loss and boundary ambiguity theories have been applied to Hill's ABC-X model.

Ambiguous Loss

Boss (2002, 2006) theorized that an ambiguous loss occurs when a level of uncertainty is present in a perceived loss by an individual. Here, ambiguous loss is viewed as being the A factor, or the event and/or situation that may lead to distress. Moreover, the ambiguity that is derived from not knowing whether a perceived loss is absolute results in a delayed coping process for the individual experiencing the loss. Due to this delay, the individual develops distress and can become immobilized in a state of uncertainty, contemplating whether s/he should continue to grieve or move on with their life. Feelings of hopelessness, confusion, guilt, and ambivalence are common responses to this form of loss. These feelings can impact one's relationships with others, ability to process emotions and/or complete tasks, and confusion regarding familial roles. In some cases, the individual may finally come to the decision to move on, but is unable to identify ways in which s/he should move forward. This form of loss differs from the more traditional form of absolute loss (i.e. death) in that the lack of finality which surrounds the ambiguous loss can make it more difficult for the individual to cope effectively. In addition, the lack of ritualistic acknowledgement of a loss makes the grieving process for an ambiguous loss more difficult to deal with, as rituals frequently bring some form of closure for individuals.

Boss (2006) suggests that there are two types of ambiguous loss. Type I arises when a physical loss is experienced but a psychological presence remains. An example of this would be a loved one who has gone missing. The missing individual is not physically present with the system, yet, is very much present psychologically. Members within the system become frozen in a state of uncertainty and are unsure as to whether or not they should keep hoping that the loved one will reappear or accept the individual's absence as a loss (Boss, 2006). Other examples include divorce, adoption, and a child given up or lost at birth.

Type II of ambiguous loss occurs when a physical presence exists, but the psychological presence does not (Boss, 2006). An example of this would be family members coping with the difficulty of taking care of a parent diagnosed with dementia. Although the parent is physically present, the effects of dementia often lead to the parent being psychologically absent. Additional examples of this type of ambiguous loss include Alzheimer's disease, traumatic brain injuries, AIDS, autism, depression, addiction, or chronic mental and/or physical illnesses (Boss, 2006).

It is also possible for an individual to experience both types of ambiguous loss simultaneously. Boss (2006) illustrates this in a case example in which the client was plagued with her mother's dementia as well as her husband's recent disappearance as a result of the 9/11 attacks. Another example of this dual type of loss can be when a child experiences an absence of one parent due to divorce, while also experiencing the loss of the other parent due to depression or substance abuse. Individuals experiencing both types of ambiguous loss often feel doubly abandoned, which one could imagine would be more complex to deal with as compared to a singular loss.

Research focusing on ambiguous loss and boundary ambiguity has been applied to a number of different populations. Carroll, Olson, & Buckmiller (2007) provide a thorough thirty year review of relevant research. This paper will provide a small sample of the studies that have been conducted in this research domain to demonstrate the various ways in which researchers have examined this concept. Dupuis (2002) observed the ambiguous loss that occurred in a child coping with a loved one diagnosed with dementia. Sixty-one adult men and women who had parents diagnosed with dementia were interviewed about their experience of caring for the loved one with this disorder. A majority of the participants consistently discussed similar methods of coping. For example, most participants reported utilizing avoidance and acceptance as ways in which they were able to cope with the psychological loss of their parent. Here, type two of ambiguous loss is illustrated in that the children report experiencing a physical presence and psychological absence of a parent.

Lee and Whiting (2007) studied ambiguous loss experienced by foster care children by interviewing the children and then giving them Blacky pictures, which illustrate a dog interacting with his/her family. The children were instructed to describe what was going on within the pictures. The researchers identified themes of loss responses indicative of ambiguous loss within both the transcripts of the semi-structured interviews and the narratives given by the foster children. Many of the narratives revealed themes of being trapped in a state of guilt, avoidance, ambivalence and of not knowing whether or not to move on.

Although limited, ambiguous loss research involving the LBG population has also been conducted. Allen (2007) discussed the ambiguous loss process that women

experience as a result of termination of a same-sex relationship. Participants were women who had been involved in a same-sex relationship, who were unable to receive the legal benefits of marriage and therefore, involuntarily lost custody of their children once the relationship ended. The women who were interviewed reported feeling a loss due to the unwillingness of their former partners to grant them interaction with their own child. In addition to the loss of the child, the deterioration of the family unit was also identified as problematic for the individual experiencing the ambiguous loss (Allen, 2007). Similar to the study mentioned above, this depicts an ambiguous loss in which there is a psychological presence and physical absence experienced by these mothers who involuntarily lost custody of their children. Other LGB-related studies have examined women who were involved in mixed-orientation marriages and older same-sex couples (Hernandez & Wilson, 2007; Dziengel, 2012).

Lastly, a research design that most closely relates to the intent of this study is one that observed the ambiguous loss that emerged following an individual's decision to convert religious practices. Roer-Strier, Sands, & Bourjolly (2009) interviewed African American mother and daughter dyads, in which the daughters were in the process of converting from varying forms of Christianity to Islam. Through the use of open-ended questioning, the mother-daughter dyads were asked to discuss their experience of the adjusting to the change associated with the daughter's religious conversion. In addition, the interview questions assessed the mother and daughter perceptions of their familial relationships. Results from this study indicated that the daughter's conversion typically elicited an emotional reaction from her mother, with emotions including shock, guilt, and anger (Roer-Strier, Sands, & Bourjolly, 2009). The mothers also reported having a need

to justify, or make sense of, their daughter's decision to convert religions. Here, some believed that there would still be hope that their daughters would come back around to identifying with their original Christian beliefs (Roer-Strier, Sands, & Bourjolly, 2009). An additional key piece to this study is that changes in responses over time were assessed to gauge whether there was a difference in perceptions from initial decision to convert to the present. The researchers found that most families reported being more accepting of their daughter's conversion and increased their respect for this decision over time. These results suggested that the process of adjusting to a family member's new identity can lead to great distress within the family and can leave family members feeling as though they have experienced a loss. While the daughters were physically present, the mothers' perceived their daughter's conversion to be a psychological loss of the daughter they once knew, as well as a loss of the expectations that they had for their daughter that were related to Christianity (e.g. having grandchildren raised as Christian, religious celebrations, etc).

Due to the lack of finality surrounding an ambiguous loss, it can often be quite difficult for individuals to find ways to effectively cope. Boss (2006) offers six treatment goals for therapists working with clients experiencing an ambiguous loss and they are as follows: finding meaning, tempering mastery, reconstructing identity, normalizing ambivalence, revising attachment, and discovering hope. These will be discussed in greater detail in the discussion section, which will address how this research can apply to working with clients in the therapeutic setting.

Boundary Ambiguity

Boundary ambiguity is a term that is used when boundaries within the family become vague as a result of not knowing who is in or out of the family system (Boss & Greenberg, 1984). Boundaries are likely to become ambiguous when family members experience a loss of someone within the family and have difficulty adjusting their perceptions surrounding the incurred loss. The distinction between ambiguous loss and boundary ambiguity is that ambiguous loss is related to the actual event and/or situation, whereas ambiguous boundaries include the perceptions and meanings that the family members have associated with the loss (C factor). Boundary ambiguity emphasizes that it is the perceptions of the family that ultimately determine boundaries, more so than the actual structure of the family. When there is a disconnect between the perception of who is in the physical versus the psychological family, higher levels of boundary ambiguity usually follow. Moreover, the family's perceptions are often the most influential variable in forecasting how the family will respond to the loss. It is suggested that boundary ambiguity is present in most families; however, family stress and dysfunction results when families live with high levels of prolonged boundary ambiguity (Carroll, Olson, & Buckmiller, 2007). In addition, families that live with high levels of boundary ambiguity for prolonged periods of time are typically at risk for depression, psychosomatic symptomology, and familial discord (Boss, 2006).

Intersection between Ambiguous Loss, Boundary Ambiguity, and Culture

The degree to which families have difficulty coping with an ambiguous loss and boundary ambiguity is heavily influenced by the culture of the family (Boss & Greenberg, 1984; Boss, 2002, 2006). As mentioned previously, much of a family's belief system is shaped by society and what is constructed as being the "norm." Moreover,

situations become more complex when the families are part of subcultures and complications often emerge when an individual or family's subculture does not share similar belief systems of the larger society. Boss (2002) indicates that this may explain, in part, why individuals and/or families of non-dominant cultures become more distressed during times of crisis. For these families, they not only have to cope with the loss, but they also experience additional stress that is related to not being congruent with the dominant culture. Therefore, it is essential for health care providers to understand the cultural intricacies that make up a family (e.g. diversity variables, level of acculturation, etc.) as a way of examining how the family is likely to respond to the stress associated with potential ambiguous loss and boundary ambiguity.

The purpose of the present study is to better understand the ways in which families respond to a family member's disclosure of his/her same-sex sexual orientation. More specifically, this study seeks to examine whether caregivers' responses resemble an ambiguous loss, proposed by Boss (2002, 2006). If so, this study will also aim to observe the potential boundary ambiguity that results from the ambiguous loss. Given previous notions that family members, as well as the LGB individual, can experience a sense of loss following the coming out process, this study seeks to answer the following research questions:

- Will families report experiencing reactions consistent to those exhibited as a response to an ambiguous loss following a child's same-sex sexual orientation disclosure?
- Do families experience boundary ambiguity following a child's same-sex sexual orientation disclosure?

- Will families experience higher levels of ambiguous loss and boundary ambiguity initially following disclosure in comparison to levels as time passes?

Chapter III

Methods

Participants

Research participants were recruited to participate through electronic mail, which was hosted on a secure webserver. The requirement to participate in the study was the individual's self-identification as a caregiver (i.e. parent, guardian) to an individual who identifies as gay, lesbian, or bisexual. Individuals who did not meet this requirement were not allowed to access the survey. Sixty six total individuals accessed the survey. Of the total number who accessed the survey, 53 identified themselves as caregivers and gave consent to participate in the study. Of the 53 who initially gave consent to participate in the study, eight surveys were discarded because of incomplete responses. This resulted in a final sample of 45 caregivers.

Participants were obtained through the use of mailing lists, online discussion groups, multiple organizations (i.e. PFLAG, college campus gay-straight alliances, churches) and personal email networks of this researcher. Moderators of the e-mail groups and organizations were sent an email describing the study along with a request to forward the email on to any individuals they knew who met the study's requirement. The email contained a link that took potential participants to the introduction and informed consent page of this survey. Given the variety of methods of recruitment, the final number of potential participants the survey ultimately reached through these methods is unknown.

This survey was hosted on an online website. All data transfer was protected with 128-bit encryption technology. The survey did not ask participants for identifying information, but did inquire about general demographic information to better understand the diversity of the sample. Outside of the primary investigator, no other individuals had access to information that could identify the participants. The ISP addresses of the participants of this study were not used to identify them and were not traced back to their location. Due to the lack of identifying information, the form of data collection utilized in this study was not viewed as a risk to the confidentiality of participants. Subjects who were concerned about the purpose of the study and/or information given were directed to contact the primary investigator for further information and clarification. Participants were not compensated for their participation. All individuals who participated in this study were required to provide informed consent in accordance with the American Psychological Association's ethical guidelines.

Materials

Before completing the survey, each participant received an electronic informed consent form outlining the format of the questionnaire and survey, and acknowledged his/her right to conclude the survey at any point without being penalized. Upon providing informed consent, participants were provided a demographic survey. The demographic survey requested information about both the caregiver, as well as demographic variables of the caregiver's child. The rationale behind obtaining a broad range of demographic information from the participants was to gauge whether or not membership in a particular cultural group (i.e. gender, ethnicity, age, sexual orientation,

religion/spirituality, etc.) influenced the caregiver's perception of and relationship with the child. Refer to Appendix B for the demographic survey that was utilized in this study.

Once the demographic survey was completed, participants were directed to the qualitative portion of the survey, which consisted of a 34-item questionnaire. Participants were instructed to read each question and rate their opinion on a 6-point Likert scale (i.e. 1=*Strongly Disagree*, 2=*Moderately Disagree*, 3=*Somewhat Disagree*, 4=*Somewhat Agree*, 5=*Moderately Agree*, 6=*Strongly Agree*). It should be noted that question 34 had an additional response of *No Change/Not Applicable* due to the nature of the question (i.e. I miss the child I used to know). The questionnaire used in this study was adapted from two different boundary ambiguity scales: Boss, Greenberg, and Pearce-McCall's Boundary Ambiguity Scale for Parents of Adolescents Leaving Home (1990) and Pearce-McCall and Boss' Boundary Ambiguity Scale for Adolescent and Adult Children of Divorce (1990). Reliability for the Boundary Ambiguity Scale for Parents of Adolescents leaving home is .74, with significant correlations between the scores of husbands and wives (husbands: $r = .29$; wives: $r = .37$). Reliability for the Boundary Scale for Adolescent and Adult Children of Divorce is .75. In addition, the scale was deemed as having construct validity after being reviewed by clinicians and researchers who are familiar with familial issues, particularly those related to divorce. The adapted version of the questionnaire used in the current study was administered to each participant to measure boundary ambiguity and perceived loss present within the family. More specifically, this version was adapted to measure the potential boundary ambiguity and ambiguous loss that develops when a family member comes out, whereas previous versions have been oriented towards a variety of domains such as parents of adolescents

leaving home, adolescent and adult children of divorce, and divorced adults, to name a few (Boss, Greenberg, & Pearce-McCall, 1990; Pearce-McCall & Boss, 1990; and Boss & McCall, 1990). Statements in the adapted version included “It is unclear how the relationships between my extended family (grandparents, uncles/aunts, cousins) will be affected by [my child] coming out” and “When my child first came out, I kept alive hope that this was a phase s/he going through.” Each question was asked in a retrospective and current manner. This format was used to determine whether a change in caregivers’ perceptions over time was present.

The final part of the survey was qualitative in nature. To fully capture the experience of caregivers, participants were asked to complete 9 open-ended questions. Questions ranged from asking participants about potential diversity variables that may have played, or still play, a role in their level of acceptance of their child’s sexual orientation (i.e. What, if any, cultural factors played a role in your acceptance of your child as gay, lesbian, or bisexual when s/he first came out to you?), to a direct question regarding feelings of loss (i.e. Have you experienced any feelings of loss since the time in which your child came out to you?). Questions were formatted in this way to obtain the caregivers’ thoughts and feelings in their own words, which helped to better understand their experience following their child’s disclosure of his/her same-sex sexual orientation.

Procedure

Individuals who qualified to participate in the study were granted access to the questionnaire online. Prior to completing the questionnaire, each participant was provided an informed consent in electronic form (see Appendix C), which is in accordance with the ethical requirements of the American Psychological Association.

Prior to completing the questionnaire, demographic information of the participants was assessed (see Appendix B). Participants were then given the questionnaire, in which they were instructed to rate items on a 1-6 point scale (1=*Strongly Disagree*, 2=*Moderately Disagree*, 3=*Somewhat Disagree*, 4=*Somewhat Agree*, 5=*Moderately Agree*, 6=*Strongly Agree*), as well as answer open-ended questions regarding their personal experience(s). At the conclusion of the study, each participant was debriefed through the use of a narrative (see Appendix D), which explained the intent of the questionnaire and what this researcher plans to do with the results. Subjects who had any further questions and/or concerns were then instructed to contact the primary investigator and/or faculty advisor of this study.

Chapter IV

Results

Demographics

A variety of demographic information was obtained regarding the caregiver, as well as his/her daughter or son. Gathering information about both caregiver and child was important to obtain as a way to further analyze other potential factors that could contribute to family dynamics following a child's disclosure.

Demographic Variables of Caregivers. 45 participants completed the survey. The sample consisted of 34 females and 11 males (females = 75.6%; males = 24.4%). Ages of the participants ranged from 37 to 77 years ($M = 60.6$ years). With regards to ethnicity, the sample consisted of 6.7% Asian American, 2.2% Biracial, 4.4% Hispanic or Latina/o, 2.2% Native American or American Indian, and 84.4% White/Caucasian. Sexual orientation of respondents was as follows: 2.2% bisexual women, 8.9% gay males, 86.7% heterosexual women or men, and 2.2% lesbian women. Regarding religious beliefs as a child, participants self-identified as 93.3% Christian and 6.7% did not identify with a religion. Of the individuals who identified as being religious when they were younger, 33.3% identified as having liberal beliefs, followed behind 23.8% liberal/moderate, 26.2% moderate, and 16.7% moderate/conservative. Currently, the sample self-identified as being 77.7% Christian, 2.3% Jewish, and 20.9% did not identify with a religion. Of the participants who currently identified as being religious, 58.3% identified as having liberal beliefs, followed behind 25% liberal/moderate, 11.1%

moderate, and 5.6% moderate/conservative. 97.6% of the population identified as being 97.6% HIV negative. Of the overall sample, 54.8% indicated that they currently resided in a suburban location, compared to 23.8% urban and 21.4% rural.

Demographic Variables of Caregivers' Children. As mentioned above, demographic information regarding the sample's children were also obtained to better understand potential contributing factors of the family dynamics following the child's disclosure. With regards to gender, the sample's children consisted of 31% female and 69% male. Religious beliefs as a child were reported as being 85.7% Christian, 2.4% Jewish, and 11.9% did not identify with a religion. Of the caregiver's who identified their children as being religious when they were younger, 31.6% identified their children as having liberal beliefs, followed behind 21.1% liberal/moderate, 28.9% moderate, 5.3% moderate/conservative, 2.5 conservative/orthodox, and 10.5% indicated that they did not know the degree of their child's religiosity when younger. Currently, the sample identified their children as being 40.5% Christian, 2.7% Jewish, and 56.8% did not believe their child identified with any religion. Of the children identified as being religious, 70% were viewed as having liberal beliefs, followed behind 5% moderate, 5% conservative/orthodox, and 15% of caregivers did not know the degree of religiosity for their children. The sample of caregivers reported that 90.7% of their children were HIV negative, while 9.3% identified their child's HIV status as being unknown. Participants indicated that their children live in predominantly suburban and urban areas (suburban=46.5% and urban=44.2%), with few living in rural locations (rural=9.3%).

Quantitative Analysis

Since the questionnaire in the present study was adapted from previous scales that measure boundary ambiguity, validity and reliability information is lacking. As a result, a formal scoring method was not used in interpretation of the results. Rather, individual items were examined and compared to their present counterpart (i.e. past versus current views related to their experience of their child coming out wherein M_i = mean of *initial* views following disclosure and M_c = mean of *current* views). Paired sample t-tests were utilized in determining whether there was a shift in participants' perceptions over time regarding their child coming out. A complete list of means (M) and standard deviation (SD) calculations is available in Table 1E (refer to Appendix E). Items related to the previously outlined hypothesis questions will be discussed in the following sections. In addition, it is also important to highlight that participants were allowed to skip test items if they chose to do so. As a result, the total number of participants' responses to qualitative items ranged from 36 to 40.

When gauging the presence of ambiguous loss, the researcher examined items that specifically addressed caregivers experience of difficulty with the actual event of their child coming out, feeling as though they needed to keep hope alive that their child's same-sex sexual orientation was temporary, and feeling as though they no longer knew who their son/daughter was. Here, participants responses were rated on a 6-point Likert scale wherein 1=*Strongly Disagree*, 2=*Moderately Disagree*, 3=*Somewhat Disagree*, 4=*Somewhat Agree*, 5=*Moderately Agree*, and 6=*Strongly Agree*. Results in these domains suggested that participants initially experienced some difficulty related to their child coming out, but this difficulty appeared to dissipate over time ($M_i = 4.32$, $M_c = 1.56$). The paired t-test conducted indicated that the shift in perceptions from initial

disclosure to present was statistically significant ($p < .01$). When asked about difficulty related to acceptance of their child's LGB identity, participants did not seem to experience much difficulty in this area ($M_i = 2.80$, $M_c = 1.10$). However, there was a statistically significant shift in their perceptions as they experienced even less difficulty over time ($p < .01$). Additionally, there was a statistically significant shift in perception of keeping hope alive that one's child was "going through a phase," ($p < .01$). It should be noted, however, that participants generally did not endorse having a strong expectation of this at the outset of their child's disclosure ($M_i = 2.55$, $M_c = 1.08$). Similarly, a paired t-test revealed that over the course of time, participants' belief that they knew who their children were increased ($M_i = 2.33$, $M_c = 4.95$; *note: items were asked in different manner, e.g., Initial: "When ____ first came out, I felt I did not know who s/he was." Current: "Currently, I feel that I know who _____ is."; $p < .01$*). Participants were also asked if they currently missed the child that "they used to know" (note: this did not have an initial counterpart question). By and large, the majority of participants indicated that there had not been a change and/or did not long for a child's former presence ($M = .975$, $SD = .8912$).

Regarding boundary ambiguity, items that focused on family relationships and dynamics were examined to determine the presence, as well as extent, of boundary ambiguity in families following a child coming out. Participants showed a statistically significant shift in their perceptions of the presence of a strained relationship between themselves and their children following him/her coming out ($p < .01$). However, there generally did not appear to be high degrees of discord between the participants and children initially or currently ($M_i = 2.08$, $M_c = 1.16$). Similarly, participants did not

generally report experiencing difficulty talking with their children at either point following their children coming out ($M_i = 2.16$, $M_c = 1.23$), but the shift over the course of time was found to be statistically significant ($p < .01$). When asked if they felt their families would miss out on important future occasions (e.g., weddings, newborn children, etc.), participants responses indicated that they were more certain over time that their family would not miss out on these special events ($M_i = 3.44$, $M_c = 1.79$). The paired t-test conducted indicated that the shift from initial disclosure to present was statistically significant ($p < .01$). Similarly, participants showed a statistically significant increase over time in their certainty that they would be able to accept their children's partner, or future partner ($M_i = 2.03$, $M_c = 1.36$; $p < .05$). It is important to note that participants generally felt their children were part of the family ($M_i = 5.87$, $M_c = 5.87$). On average, participants endorsed believing that they would have and currently have a close relationship with their children. This was noticed in their responses that gauged whether they felt uncertain if they would have a close relationship with the children initially following disclosure ($M_i = 1.64$), as compared to whether they currently have a close relationship with the children ($M_c = 5.56$). These items were oppositely worded (i.e. "When ____ first came out, it was unclear whether we would be able to have a close relationship because of his/her sexual orientation" versus "Currently, I have a close relationship with ____."), so scores on these items had to be reversed accordingly. It is important to note that there was a statistically significant shift when comparing their initial and current perceptions ($p < .01$). Additionally, there appeared to be a statistically significant increase in the participants' endorsements of having good feelings about their family systems ($M_i = 4.67$, $M_c = 5.61$; $p < .01$).

There also appeared to be a shift in participants' perceived comfort level talking with others regarding their child's LGB identity with family and friends, as well as happiness related to their child being out. Here, participants' comfort levels with talking with others appeared to be statistically significant in that they evolved from not feeling as though they could talk to others, to being able to have dialogue about their children's LGB identities (talking with other family members: $M_i = 3.15$, $M_c = 4.95$, $p < .01$; talking with friends: $M_i = 3.56$, $M_c = 5.08$, $p < .01$). When asked about feeling happy that their child was out, participants generally appeared to be somewhat happy at both time frames; however, there was a statistically significant increase in happiness over time ($M_i = 3.82$, $M_c = 4.74$; $p < .01$). Results from the present study indicated that there was not a statistically significant shift in perceptions related to worrying about child's safety ($M_i = 3.33$, $M_c = 3.08$; $p > .05$). These results suggest that, on average, participants did not endorse worrying about their child's safety following him/her coming out or over time. Conversely, there did appear to be a statistically significant shift in participants' feelings of being comfortable in their child's environment (i.e. home or room) over the course of time ($M_i = 5.05$, $M_c = 5.53$; $p < .05$). Lastly, participants were asked about whether they felt they were prepared for their child coming out (note: this item did not have a current perspective, rather focused on the participant's experience after the initial disclosure). Participants generally felt as though they were not very prepared for their child's coming out ($M = 3.26$).

Qualitative Analysis

Qualitative questions ranged from querying about potential loss to diversity variables that may have impacted the level of acceptance of the LGB identity of the

participant's child. Similar to the quantitative items, participants were allowed to skip items. Therefore, the total number of responses to the open-ended questions ranged from 32 to 38. Themes that were identified within the responses to each question are summarized in Table E2 (refer to Appendix E). Highlights from the open-ended questions will be discussed below.

To begin, there appeared to be a vast shift in caregivers' attitudes towards their children's same-sex sexual orientation. Participant's initial attitudes following their children coming out were generally distressing in nature (e.g., worried, fearful, sad, confused, shocked). Some indicated that they felt that they did not have enough information or as though they were "ignorant." However, there was a subset of participants who initially were relieved and were not surprised by their children coming out. When these initial reactions were compared with participants' current attitudes towards their children's same-sex sexual orientation, results indicated that their overall impressions shifted towards acceptance and being "okay" with their children's LGB identity. While a small percentage of caregivers indicated that they worried and were fearful for their LGB children, it was apparent that a majority of participants identified more with current feelings such as happy, love, and being proud of their LGB children. Moreover, participants also expressed their love towards their children. Although not included in the chart (due to low frequency), some participants expressed current feelings of sadness and/or wishing that their child was heterosexual.

To examine potential feelings of loss, participants were asked if they experienced these feelings at any point in time since their children's disclosure of their same-sex sexual orientation. Responses to this question indicated that many participants

experienced feelings of loss to varying degrees, as well as at different points in time. For example, some participants suggested that they experienced loss initially but over time those feelings dissipated. In comparison, a smaller proportion of participants indicated that they did not experience any feelings of loss.

Regarding cultural factors that impacted participants' level of acceptance over the course of time since their children's disclosure of same-sex sexual orientation, a majority of participants did not identify specific factors. Those who did identify the impact of their membership to a cultural group(s), the following variables were identified as playing a role in participants' acceptance: education level (e.g., advanced education helped in understanding child's sexuality), gender (e.g. mother felt she accepted child's LGB identity more so than child's father), previous interaction with LGB individuals (e.g., more positive interactions increased their ability to accept their child's sexual orientation), liberal views (e.g. felt this increased openness), conservative views (e.g., perceived limited degree of openness), religion (e.g., religious views not accepting of LGB relationships), sexual orientation (e.g., being heterosexual and not understanding same-sex orientations), socioeconomic status (e.g., reported being of middle-upper class led to increased acceptance). While some participants indicated that the above-mentioned cultural variables still impact their level of acceptance, a majority of participants reported that their cultural variables do not currently impact their level of acceptance of their LGB children. In addition, some noted that the increase in societal acceptance of LGB individuals has further increased their acceptance.

As discussed earlier, religion can be a source that creates dissonance for parents because there is often a disconnect between one's religious beliefs and acceptance of

same-sex sexual orientations. The current study suggested that many of the participants did not believe their religion and/or spiritual beliefs impacted their ability to accept their children's LGB identity. Moreover, some viewed their religion as being a source of support and helpful during their child's coming out process. For example, one participant indicated that certain church leaders and members were very accepting of LGB individuals and this helped in furthering their acceptance of their child. Others indicated that they believed in the "love and mercy" components within their religion, which they believed adhered to their child no matter what his/her sexual orientation may be. On the other hand, some participants expressed experiencing difficulty reconciling their religious views with their children's same-sex sexual orientation. For some, this impacted their level of acceptance in a negative manner, while others endorsed experiencing a "struggle," but not allowing it to influence their acceptance of their children.

The final open-ended question was used to examine whether there were any other factors that participants felt played an important role in their personal and/or familial experience of a child coming out. While there were a total of 32 responses to this question, the factors that came up multiple times consisted of: having unconditional love for one's child, participating in support groups for parents of LGB children, receiving informal and/or formal education, and previous interactions with positive LGB role models. These factors were identified as helping participants throughout the coming out process. Participants also spoke to the difficulties that impacted their experiences. Here, the stigma that was attached to other family members, particularly the LGB child's siblings, was an identified difficulty for participants. One participant indicated that his/her great efforts to protect and support the family's LGB child, may have left the

family's heterosexual child feeling unsupported while being faced with stigma and prejudice by association (i.e. having a LGB sibling).

Chapter V

Discussion

Based on the information received from the current study, it appears that caregivers do not experience ongoing feelings of loss following a child's disclosure of his/her same-sex sexual orientation. However, many of caregivers did endorse experiencing a loss at some point in time following their children's disclosure of their sexual orientation. The decrease in feelings of loss may be related to the reported increase in acceptance that a many of caregivers reported having currently. A majority of the sample indicated that they currently accept and/or are content with their child's same-sex sexual orientation. When these current views were compared with their views initially following their child's disclosure, the results indicated that there is a statistically significant shift in these views from experiencing difficulty to arriving at a place of acceptance. Feelings that were reported initially following a child's disclosure of a same-sex sexual orientation included: worried, fearful, sad, confused, shocked, relieved, and happy. Despite experiencing these feelings and showing statistically significant shifts in their perceptions over time, boundary ambiguity within the family system generally did not appear to be present for many of the families. For example, participants did not endorse having significantly strained relationships with the children, experiencing high degree of uncertainty as to who was in or out of the family, or a great about of wondering whether their family would miss out on future life events (e.g., wedding, newborn children) as a result of their child coming out. While ambiguous loss and boundary

ambiguity appeared to be present in some families, the frequency in which this occurred was not large enough to generalize. However, the results from the present study do suggest that caregivers' perceptions of their LGB children coming out appear to shift over time towards a more positive, accepting direction.

Clinical Implications

Much of the literature regarding treating LGB individuals and/or their families recommend that health care professionals provide families with psychoeducation related to LGB issues (Savins-Williams, 2011; Mallon, 2010; Ryan 2009; 2010; Malik & Lindahl, 2011). More specifically, providing information regarding the impact that non-accepting behaviors and attitudes towards a LGB child can have on his/her overall well-being (Ryan, 2009; 2010). Many suggest encouraging parents to join a supportive group that will increase their knowledge and provide social support. In some cases, a fellow caregiver may act as a role model for other parents who may be struggling with their child's sexual orientation.

Depending on where the child is with his/her coming out process, the family system may also need education and support related to their own coming-out process (Mallon, 2010). For example, one could role-play with parents to help them visualize what their coming out process will be like. Health care providers should also stress the importance of family members having dialogue with one another about each of their coming out processes and with whom they want to discuss these issues. Some LGB children may not want to be out to certain individuals or groups, thus parents should respect this as a way of ensuring the child's space, as well as safety (Herdt & Koff, 2000).

It is also helpful for clinicians to predict the exaggerations of certain symptoms within some family, particularly those who are not accepting of their child's same-sex sexual orientation. Kort (2008) gave the examples of families increasing their degree of religiosity and/or drinking, as well as relationships that were previously injured becoming more distant. These families systems may show a tendency to blame the increase of symptoms within the family on the child's disclosure of his/her sexual orientation. Therefore, it becomes essential for clinicians to prepare families for this and to clarify any misattributions of the behaviors taking place within the family system.

Clinicians could also help parents reframe the child's coming out as the child's active attempt to have an open and authentic relationship with his/her parents. Malik & Lindahl (2011) emphasize parents being patient during their child's coming out process, as well as being aware of their biases and prejudices that have internalized. By continuing to monitor these internalizations, parents can decrease the likelihood that they will engage in oppressive behaviors towards their child. Furthermore, Herdt & Koff (2000) suggest that the real fight should not lie within the family; rather, consist of the family unity combating the societal forces that are not accepting of same-sex sexual orientations. As with many situations in life, adjusting one's identity (i.e. being a parent to a sexual minority child) can take time. Savins-Williams (2001) note that parents should not put a great amount of pressure on themselves to quickly be at a place of full acceptance. Just as their child went through a process of integration his/her LGB identity, parents must remember that are also permitted to have a process of their own. As results from the present study have shown, caregivers' initial perceptions tend to shift over time and often move towards a more positive, accepting place.

While most participants in the present study did not appear to experience characteristics that mirror an ambiguous loss and/or boundary ambiguity, there were a small subset of parents whose experiences did. For these individuals, Boss (2006) provides six goals for addressing this form of loss and they are as followed: finding meaning, tempering mastery, reconstructing identity, normalizing ambivalence, revising attachment, and discovering hope. Boss suggests that it is important to make sense of what is occurring within the individual and/or family system. This may consist of merely naming the problem (e.g., loss of the heterosexual family myth), having a ritualistic ceremony, or even though one's religious/spiritual belief system. Tempering mastery involves being able to balance one's need for complete control over life events with understanding the inherent limits in control one has. Due to the increased uncertainty that occurs when a loss is ambiguous, it becomes important for individuals to learn to live with the uncertainty and ambivalence that can be present. Consequently, these feelings of ambivalence can benefit from normalization. Acknowledging the ambivalence and depathologizing these feelings can lessen the likelihood that individuals will experience shame and/or guilt. Boss (2006) suggests that a reconstruction of identity may need to occur as well. She proposes that roles within the family may need to be discussed and/or become less rigid (e.g. more flexible gender roles). In some cases, revising one's attachments may be used as a method of adjusting to the previously constructed relationships within the family. The revision of these relationships may be a result of the change in perception of the family member and/or the relationship as a whole (e.g., after child discloses his/her same-sex orientation, parent questions their relationship

because he/she does not understand why the child help this secret). Finally, Boss (2006) encourages individuals to discover hope in their current life circumstances. When the belief that there can be a positive outcome to the distressing situation and/or event is not present, individuals may experience helplessness and/or despair. However, this hope needs to be realistic because when it is not (e.g., “Maybe therapy can change his/her same-sex sexual orientation.”), the individual will likely have difficulty building his/her resilience. Clinicians, as well as individuals experiencing an ambiguous loss, will benefit from incorporating these goals into their process of dealing with this unique form of loss.

Limitations

One of the limitations of this study is related to the participants accessed for the study. Due to the survey being conducted online, those who do not have access to the Internet were not able to participate in the study. In addition, most of the caregivers that were accessed reported currently having a good relationship with their child. Thus, the majority of those who completed the survey appear to be more accepting of the child’s same-sex orientation, as they took the time to fill out the survey and gave their experience of being a caregiver to a LGB child. While the information obtained from these participants is invaluable, the study may not represent the subset of parents who are not accepting of their child’s same-sex sexual orientation. The study’s inability to obtain participants from each end of the continuum (i.e. acceptance and non-acceptance) speaks to the initial rationale for doing the present study. It is possible that the caregivers that were unable to be accessed, or were accessed but chose not to participate in the study, no longer have a relationship and/or have a strained relationship with the child. One could

hypothesize that the subset of caregivers who were unable to be reached may experience more boundary ambiguity and ambiguous loss if their relationship with the LGB child has been severely strained, or in worse cases, completely cutoff. Given the previously mentioned barriers, accessing the subset of caregivers who have a strained relationship with their LGB child is quite difficult but should be attempted in future studies.

While the current study aimed to put emphasis on the caregivers' opinions regarding their child's sexual orientation, it is possible that other extraneous factors may have influenced their viewpoints. As a result, the change in family dynamics may not be related to the child's disclosure of his/her same-sex orientation. Rather, concurrent events within individuals and the family may have been more impactful on family dynamics (e.g. child going to college, child moving away, divorce, death, etc.). For example, when asked about feelings of loss regarding his/her child's sexual orientation, one participant's response indicated that s/he was simultaneously experiencing the death of a parent and that the feelings of loss were more so related to grieving his/her parent's passing. Therefore, the present study was unable to account for other potential variables that may have resulted in boundary ambiguity or ambiguous loss. Also, since the current study was retrospective in nature, it is subject to recall bias. Consequently, the data obtained from this study may not fully, and accurately, capture the caregivers' experiences of their children coming out as LGB due to the lapse in time since the child initially came out.

Lastly, due to the adaptation of the questionnaire used, validity and reliability will need to be measured for future studies that seek to investigate the same domains. Items were examined individually and compared to their retrospective counterpart to gauge a

shift in attitudes since there was a lack of validity and reliability with the questionnaire used in the present study. In addition, the questionnaire that was utilized will likely need to be modified for future studies, as a few of the items were identified as being redundant to participants. For example, the qualitative items have three questions related to religion/spirituality. Based on participants' responses (i.e. "same as above, or not applicable"), it was evident that the information attempting to be obtained from certain test items could be condensed for future uses of the survey.

Future Directions

Based on the results of this study, it is clear that further research in this area needs to be conducted. More specifically, the current literature would benefit from research that looks at the caregiver's experience of having a LGB daughter/son in the context of ambiguous loss and boundary ambiguity. While the primary focus of the current study was on the caregiver's experience, research that focuses on the counter side (i.e. the child's experience following his/her same-sex sexual orientation) should also be expanded upon. This would provide clinicians, as well as LGB individuals and their family members, with insight into how each side (i.e. individual versus family member) may experience the coming out process. Clinicians could then begin to integrate this information into treatment with the individual and/or family and help normalize the experiences that individuals and families go through when a child discloses his/her same-sex sexual orientation. Similarly, individuals and families could use the information to help better understand their own experiences, as well the experience of others. This increase in awareness of others could potentially lead to the development of empathy for their child or family members' experience.

It should be noted that much thought and consideration went into whether to include transgender individuals into the current study. Ultimately, the study's focus was limited to caregivers of lesbian, gay, and bisexual children. The rationale behind excluding caregivers of transgender individuals was because the investigators felt that the caregiver's experience, despite having some similarities, may have differences that would be difficult to account for within the present study. Thus, another area that would greatly benefit from future research would be to examine the family dynamics of caregivers of transgender children. This information would provide clinicians, as well as individuals and their families, with information about an individual or family's experience of a family member coming out as transgender. One may hypothesize that there may be my shift in boundaries and feelings of loss due to the greater transition that occurs with many transgender individuals (e.g. name change, physical changes, etc.).

Appendix A

Boundary Ambiguity Scale for Parents/Caregivers of Lesbian, Gay, and Bisexual Children

(adapted version from Boss, Greenberg, and Pearce-McCall, 1980;
Pearce-McCall and Boss, 1990).

The following statements are about the changes in your family after your child disclosed that s/he is gay, lesbian, or bisexual. For the purposes of this study, coming out will be defined as the point in time when your child disclosed their sexual orientation to you and/or members of your immediate family. As you read, imagine child's name in the empty space in the sentences below. Using the scale provided as your guideline, choose the number that best reflects how you feel. There are no right or wrong answers.

Year of child's birth: _____

Year child came out: _____

For questions 1-33, use the following scale as a guide in answering:

- 1= Strongly Disagree
- 2= Moderately Disagree
- 3= Somewhat Disagree
- 4= Somewhat Agree
- 5= Moderately Agree
- 6= Strongly Agree

1. When my child first came out, it was difficult for me.
2. Currently, it is difficult for me since my child has come out.
3. When my child first came out, I had difficulty accepting _____ as LGB.
4. Currently, I have difficulty accepting _____ as LGB.
5. When my child first came out, I kept alive hope that this was a phase s/he going through.
6. Currently, I keep alive hope that this is a phase that s/he is going through.

7. Prior to _____ coming out, I used to worry about his/her safety.
8. Currently, I worry about _____'s safety.
9. When _____ first came out, I felt I did not know who s/he was.
10. Currently, I feel that I know who _____ is.
11. When _____ came out, our relationship became strained due to his/her sexual orientation.
12. Currently, my relationship with _____ is strained because of his/her sexual orientation.
13. When _____ first came out, I found it difficult to talk to _____.
14. Currently, I find it difficult to talk to _____.
15. When _____ first came out, I was happy s/he came out.
16. Currently, I am happy that _____ is out.
17. When _____ came out, I felt comfortable talking about him/her being LGB with other family members.
18. Currently, I feel comfortable talking about _____ being LGB with other family members.
19. When _____ came out, I felt comfortable talking about him/her being LGB with my friends.
20. Currently, I feel comfortable talking about _____ being LGB with my friends.
21. When I previously thought of _____ and important future occasions (e.g. weddings, newborn children, etc.), I wondered if my family would miss out.
22. Currently, when I think of _____ and important future occasions (e.g. weddings, newborn children, etc.), I wonder if my family will miss out.
23. When _____ first came out, I felt comfortable in my child's home (OR child's room, if s/he still lived at home).
24. Currently, I feel comfortable in my child's home (or child's room, if s/he still lives at home).

25. When _____ first came out, it was unclear whether we would be able to have a close relationship because of his/her sexual orientation.
26. Currently, I have a close relationship with _____.
27. When _____ first came out, I had a good feeling about our family.
28. Currently, I have a good feeling about our family.
29. When _____ first came out, I considered him/her as a part of the family.
30. Currently, I consider _____ as part of the family.
31. When _____ first came out, I felt I would never be able to accept _____'s partner (or future partners) as part of our family.
32. Currently, I feel that I'll never be able to accept _____'s partner (or future partners) as part of the family.
33. Looking back, I felt I was prepared for my child coming out.

For questions 34, use the following scale as a guide in answering:

- 1= Strongly Disagree
- 2= Moderately Disagree
- 3= Somewhat Disagree
- 4= Somewhat Agree
- 5= Moderately Agree
- 6= Strongly Agree
- 0= No Change or N/A

34. I miss the child that I used to know.

Please answer the following questions regarding your experience as a parent/caregiver of a gay, lesbian, or bisexual child. If a question does not apply to you, please indicate by responding "Not Applicable (N/A)."

How did you feel when your child first came out to you?

How do you feel now about your child's sexual orientation?

Have you experienced any feelings of loss since the time in which your child came out to you?

What, if any, cultural factors played a role in your acceptance of your child as gay, lesbian, or bisexual when s/he first came out to you? (When answering questions on cultural factors in this survey, please include any of the following which apply to your situation: race, gender, socioeconomic status, geographic variables, sexual orientation, etc. Religion will be addressed in a separate question.)

What, if any, cultural factors currently impact your level of acceptance of your lesbian, gay, or bisexual child?

If you identify as religious/spiritual, how does your religious organization feel about lesbian, gay, and bisexual individuals?

How did your religion impact the level of acceptance you felt for your child when s/he first came out to you?

How does your religion currently impact your level of acceptance of your lesbian, gay, or bisexual child?

Are there any factors that impacted your experience that were not captured in the questions that were answered previously? If so, what are those factors?

Appendix B

Demographic Survey Questions

Age _____

Race

- Black or African American
- Asian
- Hispanic or Latino/a
- White / Caucasian
- Native Hawaiian and Other Pacific Islander
- American Indian and Alaska Native
- Other _____
- Bi-Racial List: _____

Gender

- Biological Woman
- Biological Male
- Transgender Male to Female
- Transgender Female to Male
- Intersexed

Sexual Orientation

- Heterosexual
- Lesbian woman
- Gay male
- Bisexual woman
- Bisexual male
- Other _____

Religion of origin (the religion you identified with as a child)

- Catholic
- Other Christian
- Muslim
- Jewish
- Wicca, Feaery, Earth, or Goddess
- None
- Other _____

If religious, how would you rate your degree of religiosity on a scale 1-5 (1= liberal, 3=moderate, and 5=conservative/orthodox)? _____

Current religious identification

- Catholic
- Other Christian
- Muslim
- Jewish
- Wicca, Feaery, Earth, or Goddess
- None
- Other _____

If religious, how would you rate your degree of religiosity on a scale 1-5 (1= liberal, 3=moderate, and 5=conservative/orthodox)? _____

HIV status

- HIV Positive
- HIV Negative

What type of area do you live in?

- Urban
- Suburban
- Rural

In what Country do you currently live? _____

What state or province do you live in (if applicable)? _____

How many gay, lesbian, and/or bisexual individuals are there in your Family?

Please list their relationship to you (Choose all that apply)

- Father
- Mother
- Brother
- Sister
- Son
- Daughter
- Aunt
- Uncle
- Cousin
- Grandfather
- Grandmother
- Other _____

The following information is related to your child:

Age _____

Gender _____

Religion of origin (the religion s/he identified with as a child)

- Catholic
- Other Christian
- Muslim
- Jewish
- Wicca, Feaery, Earth, or Goddess
- None
- Other _____

If religious, how would you rate his/her degree of religiosity on a scale 1-5 (1= liberal, 3=moderate, and 5=conservative/orthodox)? _____

Current religious identification

- Catholic
- Other Christian
- Muslim
- Jewish
- Wicca, Feaery, Earth, or Goddess
- None
- Other _____

If religious, how would you rate his/her degree of religiosity on a scale 1-5 (1= liberal, 3=moderate, and 5=conservative/orthodox)? _____

What type of area does s/he live in?

- Urban
- Suburban
- Rural

HIV status

- HIV Positive
- HIV Negative

Is your child “out” to others about his/her sexuality?

- out to all or most of my immediate family
- out to all or most of my extended family
- Out to all or most close GLBT friends
- Out to all or most close straight friends
- Out to all or most coworkers
- Out to all or most neighbors
- Out to all or most members of my church

At what age did your child disclose his/her same-sex sexual orientation to you?

How did your child identify when s/he first came out to you (e.g., lesbian, gay, bisexual)? _____

How does your child currently identify (e.g., lesbian, gay, bisexual)? _____

How many children do you have that identify as lesbian, gay or bisexual? _____

Child's relationship commitment

- Held ceremony
- Married
- Civil Union
- Wear rings
- Verbal Commitment
- Uncommitted
- Not currently in a relationship
- Other- please describe _____

If your child has been in an intimate relationship, what is the greatest number of years s/he has been in one? _____

Appendix C

Informed Consent Form

Wright State University

Title of Project: Family Dynamics During the Coming Out Process

Principal Investigator: Tarryn Moor, Psy.M.

Other Investigators: Heather Wilder, Psy.D.

Introductory Script:

We invite you to take part in a research study *Family Dynamics During the Coming Out Process* at Wright State University, Dayton, OH, which seeks to better understand familial relationships following the initial disclosure of a child's same-sex orientation. Taking part in this study is entirely voluntary. We urge you to discuss any questions about this study with the investigator(s).

You are invited to take part in this research study if you identify as a parent and/or caregiver of an individual who identifies as lesbian, gay, or bisexual (LGB). This research study is being conducted to better understand the experiences of family members following a child's disclosure of same-sex orientation. Information that is obtained from this study will aid in better serving LGB individuals and their families who seek therapeutic services.

The risks to your privacy in this research are very low.

There is a very small risk that participation in this research may compromise your privacy. Your responses will be submitted over a secure connection, but in rare instances unauthorized third parties have intercepted such information using sophisticated tools.

For this study we have utilized software to protect against third party interception of your information to the best of our ability. Your IP address, although encrypted and secure, could potentially be obtained by a determined hacker. Our survey software allows only the researchers involved in this study access to your information, and this information cannot in any way be associated with you or your IP address in the unlikely event that an outside party accesses it.

Please be advised that your personal computer stores information regarding websites you have visited in your browser's history list. This list can be cleared at any time (see your browser's Help menu for instructions). However, your answers to this survey are only stored on your computer until you close your browser window.

If you chose to participate in this study, you will be asked to complete a survey, which consists of 25 close-ended questions and 8 open-ended questions. Completion of this survey will take approximately 10-20 minutes. Your research records that are reviewed, stored, and analyzed by this investigator will be kept in electronic format by the investigator and will contain no identifying information. In the event that a publication or presentation results from this research, no personally identifiable information will be shared.

Taking part in this research study is completely voluntary and you will not receive any compensation for your participation. If you wish to withdraw from this study at any time you can simply close the Internet browser. Your consent is implied by your participation in this study.

If you have any questions or comments regarding this study, please contact the investigator, Tarryn Moor at moor.5@wright.edu or (937) 775-4300, or Dr. Heather Wilder at (937) 775-4300. Please be aware that if you contact the researcher by email concerning this study, there is a risk that others using your computer or sharing your email account will be able to read your email or the researcher's reply. However, no email contact is required to complete the survey. If you have general questions about giving consent or your rights as a research participant in this research study, you can call the Wright State University Institutional Review Board at (937) 775-4462.

For more information about participation in a research study and about the Institutional Review Board (IRB), please visit the Wright State University's IRB's web site at: <http://www.wright.edu/rsp/policies.html>. Included on this web site, under the heading "Federal/External Regulations and Guidelines," you can access federal regulations and information about the protection of human research participants.

If you would like a copy of this statement, please use your browser's print command to print it before continuing.

Before making the decision to participate in this research you should have:

- Reviewed the information in this form, and
- Had the opportunity to ask any questions you may have.

Your consent to participate below means that you have received this information, have asked any questions you currently have about the research and are freely indicating your desire to participate in this study.

Appendix D

DEBRIEFING FORM

Family Dynamics During the Coming Out Process

The purpose of this study was to better understand the process that families go through when a child comes out, or discloses his/her same-sex orientation. More specifically, the researchers wanted to determine whether there were changes in the familial relationships as a result of child's disclosure. While the coming-out process differs for each family, this study's focus was on whether caregivers experienced a perceived loss of the child after their child's initial disclosure. If so, the researchers also wanted to assess if and/or how the relationship may have shifted as a result. This information will be used to increase understanding of coming out on family structure and to inform treatment approaches for families and individuals who are adjusting to these familial changes.

Your research responses that are reviewed, stored, and analyzed by this investigator will be kept in electronic format by the investigator and will contain no identifying information. Additionally, in the event that any publication or presentation results from this research, no personally identifiable information will be shared.

If you have *any* questions regarding this study, its purpose or procedures or, if you are interested in obtaining a copy of the results of this study, please feel free to contact the primary investigator, Tarryn Moor, at moor.5@wright.edu or (937) 775-4300. You may also contact the faculty advisor, Dr. Heather Wilder, at (937) 775-4300. Thank you for your participation!

Appendix E

Tables

Table E1

Mean Ratings of Caregivers' Experiences of Child Coming Out

	<i>M (SD)</i>
1. When my child first came out, it was difficult for me.	4.32 (.236)
2. Currently, it is difficult for me since my child has come out.	1.56 (.201)
3. When my child first came out, I had difficulty accepting _____ as LGB.	2.80 (1.897)
4. Currently, I have difficulty accepting _____ as LGB.	1.10 (.502)
5. When my child first came out, I kept alive hope that this was a phase s/he going through.	2.55 (1.907)
6. Currently, I keep alive hope that this is a phase that s/he is going through.	1.08 (.350)
7. Prior to _____ coming out, I used to worry about his/her safety.	3.33 (1.859)
8. Currently, I worry about _____'s safety.	3.08 (1.575)
9. When _____ first came out, I felt I did not know who s/he was.	2.33 (1.826)
10. Currently, I feel that I know who _____ is.	4.95 (1.891)
11. When _____ came out, our relationship became strained due to his/her sexual orientation.	2.08 (1.707)
12. Currently, my relationship with _____ is strained because of his/her sexual orientation.	1.16 (.823)
13. When _____ first came out, I found it difficult to talk to him/her.	2.16 (1.748)
14. Currently, I find it difficult to talk to _____.	1.23 (.902)
15. When _____ first came out, I was happy s/he came out.	3.82 (1.943)
16. Currently, I am happy that _____ is out.	4.74 (1.956)
17. When _____ came out, I felt comfortable talking about him/her being LGB with other family members.	3.15 (1.814)
18. Currently, I feel comfortable talking about _____ being LGB with other family members.	4.95 (1.555)

19. When _____ came out, I felt comfortable talking about him/her being LGB with my friends.	3.56 (1.861)
20. Currently, I feel comfortable talking about _____ being LGB with my friends.	5.08 (1.650)
21. When I previously thought of _____ and important future occasions (e.g. weddings, newborn children, etc.), I wondered if my family would miss out.	3.44 (1.774)
22. Currently, when I think of _____ and important future occasions (e.g. weddings, newborn children, etc.), I wonder if my family will miss out.	1.79 (1.418)
23. When _____ first came out, I felt comfortable in my child's home (OR child's room, if s/he still lived at home).	5.05 (1.555)
24. Currently, I feel comfortable in my child's home (or child's room, if s/he still lives at home).	5.53 (1.404)
25. When _____ first came out, it was unclear whether we would be able to have a close relationship because of his/her sexual orientation.	1.64 (1.460)
26. Currently, I have a close relationship with _____.	5.56 (1.334)
27. When _____ first came out, I had a good feeling about our family.	4.67 (1.660)
28. Currently, I have a good feeling about our family.	5.61 (.974)
29. When _____ first came out, I considered him/her as a part of the family.	5.87 (.811)
30. Currently, I consider _____ as part of the family.	5.87 (.811)
31. When _____ first came out, I felt I would never be able to accept _____'s partner (or future partners) as part of our family.	2.03 (1.814)
32. Currently, I feel that I'll never be able to accept _____'s partner (or future partners) as part of the family.	1.36 (1.112)
33. Looking back, I felt I was prepared for my child coming out.	3.26 (2.048)
34. I miss the child that I used to know.	.975 (.8912)*

Note. Participants rated each item on a 1-6 likert scale (1 = strongly disagree, 2 = moderately disagree, 3 = somewhat disagree, 4 = somewhat agree, 5 = moderately agree, and 6 = strongly agree)

* The likert scale utilized on this item was modified (i.e., 0 = no change, 1 = strongly disagree, 2 = moderately disagree, 3 = somewhat disagree, 4 = somewhat agree, 5 = moderately agree, and 6 = strongly agree).

Table E2

Qualitative Themes of Caregivers' Experiences of Child Coming Out

	Frequency Count*
35. How did you feel when your child first came out to you? (<i>n</i> =38)	
Worried and/or fearful	13
Relieved and/or happy	10
Sad	9
Confused	7
Shocked/stunned	5
Not surprised	4
Did not have information/felt ignorant	4
36. How do you feel <u>now</u> about your child's sexual orientation? (<i>n</i> =38)	
Accepted/okay	24
Happy	6
Love child	5
Worry and/fearful	4
37. Have you experienced any feelings of loss since the time in which your child came out to you? (<i>n</i> =38)	
Yes (at some point in time and/or currently)	21
No	14
38. What, if any, cultural factors played a role in your acceptance of your child as gay, lesbian, or bisexual when s/he first came out to you? (<i>n</i> =37)	
None (or not applicable)	17
Education level (i.e. advanced education)	5
Gender	4
Previous interaction with LGB individuals	3
Liberal upbringing and/or views	3
Conservative location and/or upbringing	3
Religion	2
Sexual orientation	2
Socioeconomic status	2
39. What, if any, cultural factors <u>currently</u> impact your level of acceptance of your lesbian, gay, or bisexual child? (<i>n</i> =36)	
None (or not applicable)	23

More acceptance from societal	5
Same factors as above (question #38)	4
40. If you identify as religious/spiritual, how does your religious organization feel about lesbian, gay, and bisexual individuals? (n=37)	
Not accepting of same-sex sexual orientation	14
Accepts the person, not the behavior	7
Does not agree and/or struggles with religion's views on having a same-sex sexual orientation	10
Identified organizations within church that are accepting and/or working towards creating change within church organization.	8
View religion's beliefs as being contradictory	4
41. How did your religion impact the level of acceptance you felt for your child when s/he first came out to you? (n=38)	
None or not applicable	14
Helped and/or has been a support	8
Affected level of acceptance to a small-moderate degree	7
Affected level of acceptance negatively	4
Affected level of acceptance to a large degree	3
42. How does your religion currently impact your acceptance of your lesbian, gay, or bisexual child? (n=37)	
None or not applicable	27
Same as above answer (Question #41)	4
Some struggles, but religious views do not currently impact level of acceptance	3
43. Are there any factors that impacted your experience that were not captured in the questions that were answered previously? If so, what are those factors? (n=32)	
Having unconditional love for child	4
Participating in support groups for parents of LGB children	4
Being educated (formally or informally)	2
Having positive LGB role models	2
Difficult to see other children experience stigma related to child's LGB identity.	2

*Note: Total frequency count of each question is greater than *n* size due to the fact that participants were allowed to expressed multiple feelings and/or experiences.

References

- Allen, K. R. (2007). Ambiguous loss after lesbian couples with children break up: A case for same-gender divorce. *Family Relations*, 56(2), 175-183.
- APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation. (2009). *Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation*. Retrieved August 1, 2010, from <http://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf>.
- Berzon, B. (1988). *Permanent partners*. New York: E. P. Dutton.
- Boss, P. (2002). *Family stress management: A contextual approach* (2nd Ed). Thousand Oaks, CA: Sage Publications, Inc.
- Boss, P. (2006). *Loss, trauma, and resilience: Therapeutic work with ambiguous loss*. New York, NY: W. W. Norton & Co.
- Boss, P. & Greenberg, J. (1984). Family boundary ambiguity: A new variable in family stress theory. *Family Process*, 23(4), 535-546.
- Boss, P., Greenberg, J., & Pearce-McCall, D (1990). Boundary Ambiguity Scale: For parents of adolescents leaving home. Retrieved from: <http://www.extension.umn.edu/distribution/familydevelopment/de3763.html>
- Boss, P. & Pearce-McCall, D. (1990). Boundary Ambiguity Scale: For divorces adults. <http://www.extension.umn.edu/distribution/familydevelopment/de3763.html>
- Carroll, J. S., Olson, C. D., & Buckmiller, N. (2007). Family boundary ambiguity: A 30-year review of theory, research, and measurement. *Family Relations*, 56(2).

- Cass, V. (1979) Homosexual identity formation: A theoretical model. *Journal of Homosexuality*. 4(3), 219-235.
- Dahl, A. L. & Galliher, R. V. (2009) LGBTQ young adult experiences of religious and sexual identity integration. *Journal of LGBT Issues in Counseling*, 3(2), 92-112.
- Davies, K. (2008). Adult daughters whose mothers come out later in life: What is the psychosocial impact?. *Journal Of Lesbian Studies*, 12(2/3), 255-263.
- Defense of Marriage Act (1996). *Defense Of Marriage Act" 5/96 H.R. 3396 Summary/Analysis*. Retrieved August 1, 2010, from <http://www.lectlaw.com/files/leg23.htm>.
- DeVine, J.L. (1984). A systematic inspection of affectional preference orientation and the family of origin. *Journal of Social Work and Human Sexuality*. 2, 9-17.
- Dziengel, L. (2012). Resilience, Ambiguous Loss, and Older Same-Sex Couples: The Resilience Constellation Model. *Journal Of Social Service Research*, 38(1), 74-88.
- Dovidio, J. F., Major, B., and Crocker, J. (2000) Stigma: Introduction and overview. In T.F. Heatherton, R.E. Kleck, M. R. Hebl, & J. G. Hull (Eds.), *The social psychology of stigma*. New York: Guilford Press (pp. 1-30).
- Dupuis, S. L. (2002). Understanding ambiguous loss in the context of dementia care: Adult children's perspectives. *Journal of Gerontological Social Work*, 37(2), 93-115.
- Fone, B. (2000). *Homophobia: A history*. New York: Metropolitan Books.
- Frale, D.E.S., Wortman, C., & Joseph, J. (1997). Predicting self-esteem, well-being, and distress in a cohort of gay men: The importance of cultural stigma, personal

- visibility, community networks, and positive identity. *Journal of Personality*, 65(3), 599-624.
- Fuller, C.B., Chang, D.F., & Rubin, L.R. (2009) Sliding under the radar: Passing and power among sexual minorities. *Journal of LGBT Issues in Counseling*, 3(2), 128-151.
- Gochros, J.S. (1985). Wives' reactions to learning that their husbands are bisexual. *Journal of Homosexuality*, 11, (101-113).
- Gottlieb, A. R. (2003). *Sons talk about their gay fathers: Life curves*. New York, NY: Harrington Park Press.
- Herd, G. & Koff, B. (2000). *Something to tell you*. New York, NY: Columbia University Press.
- Herek, G. M. (1984). Beyond homophobia: A social psychological perspective on attitudes toward lesbians and gay men. In J. P. DeCecco (Ed.) *Homophobia: An overview*. New York: Hawthorn Press (pp. 1-22).
- Hernandez, B. C., & Wilson, C. M. (2007). Another kind of ambiguous loss: Seventh-day adventist women in mixed-orientation marriages. *Family Relations*, 56(2), 184-195.
- Hill, R. (1958). Social stresses on the family: Generic features of families under stress. *Social Casework*, 39, 139-150.
- Jennings, K. & Shapiro, P. (2003). *Always my child: A parent's guide to understanding your gay, lesbian, bisexual, transgendered or questioning son or daughter*. New York, NY: Simon & Schuster.

- Jensen, K. L. (1999). *Lesbian epiphanies: Women coming out in later life*. Binghamton, NY: The Haworth Press, Inc.
- Kort, J. (2008). *Gay affirmative therapy for the straight clinician: The essential guide*. New York, NY: W.W. Norton & Co.
- Kübler-Ross, E. (1997). *On death and dying*. New York: Scribner Classics.
- Lee, R. E., & Whiting, J. B. (2007). Foster children's expressions of ambiguous loss. *American Journal of Family Therapy*, 35(5), 417-428.
- Malik, N. M. & Lindahl, K. M. (2011). Coming out as gay or lesbian. In Koocher, G. P. & La Greca, A. M. (Eds.) *The parents' guide to psychological first aid: Helping children and adolescents cope with predictable life crises*. New York, NY: Oxford University Press, Inc.
- Mallon, G.P. (2010). *LGBTQ Youth Issues: A practical guide for youth workers serving lesbian, gay, bisexual, transgender, and questioning youth*. Arlington, VA: CWLA Press.
- Mattinson, A. M. & McWhirter, D. P. (1995). Lesbians, gay men, and their families: Some therapeutic issues. In S. B. Levine (Ed.) *The psychiatric clinics of North America: Clinical sexuality*. Philadelphia, PA: W.B. Saunders Company (pp. 123-137).
- Meyer, I. H., & Dean, L. (1998). Internalized homophobia, intimacy, and sexual behavior among gay and bisexual men. In G.M.Herek (Ed.), *Stigma and sexual orientation* (pp. 160-186). Thousand Oaks, CA: Sage.
- Minuchin, S. (1974). *Families and family therapy*. Cambridge, MA: Harvard University Press.

- Mondimore, F. M. (1996). *A Natural History of Homosexuality*. John Hopkins University Press: Baltimore, MD.
- National Coalition for the Homeless (June 2009). *LGBT Homeless*. Retrieved April 29, 2012, from <http://www.nationalhomeless.org/factsheets/lgbtq.html>.
- Open Congress for the 111th (2009) *H.R.1913- Local Law Enforcement Hate Crimes Prevention Act of 2009*. Retrieved August 1, 2010, from <http://www.opencongress.org/bill/111-h1913/show>.
- Pearce-McCall, D. & Boss, P. (1990). Boundary Ambiguity Scale: For adolescent and adult children of divorce. Retrieved from: <http://www.extension.umn.edu/distribution/familydevelopment/de3763.html>
- Peterson, T.L. & Gerrity, D.A. (2006). Internalized homophobia, lesbian identity development, and self-esteem in undergraduate women. *The Journal of Homosexuality*. 50(4).
- Roer-Strier, D., Sands, R. G., & Bourjolly, J. (2009). Family reactions to religious change: The case of African American women who become Muslim. *Families in Society*, 90(2), 251-260.
- Ryan, C., Russell, S.T., Huebner, D., Diaz, R., & Sanchez, J. (2010) Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing*. Vol 23(4), 205-213. 10.1111/j.1744-6171.2010.00246.x
- 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

- Savin-Williams, R. C. (2001). *Mom, dad. I'm gay. How families negotiate coming out.* Washington, DC: American Psychological Association.
- Savin-Williams, R. C., Dube, E.M. (1998). Parental reactions to their child's disclosure of a gay/lesbian identity. *Family Relations*. 47(1).
- Sigelman, C. K. & Howell, J. L. (1991). Courtesy stigma: The social implications of associating with a gay person. *Journal of Social Psychology*, 131(1).
- Smith, A. (1997). Cultural diversity and the coming-out process: Implications for clinical practice. In B. Greene (Ed.), *Ethnic and cultural diversity among lesbians and gay men.* (pp. 279-300). Thousand Oaks, CA: Sage Publishers, Inc.
- Szymanski, D. M., Kashubeck-West, S., & Meyer, J. (2008). Internalized heterosexism: Measurement, psychosocial correlates, and research directions. *The Counseling Psychologist*. 36(4), 525-574.
- Thomas, A. J. & Schwarzbaum, S. E. (2011). *Culture & Identity: Life stories for counselors and therapists* (2nd ed.). Thousand Oaks, CA: Sage Publications, Inc.
- Thompson, C. A. (1996). Lesbian grief and loss issues in the coming-out process. In C. Alexander (Ed.) *Gay and Lesbian Mental Health.* (pp. 211-222). New York: Haworth Park Press.
- U.S. Const. art. IV, § 1.
- U.S. Department of Justice: Federal Bureau of Investigation (2008). *Uniform Crime Reporting Program Statistics.* Retrieved August 1, 2010, from <http://www.fbi.gov/ucr/hc2008/incidents.html>.

10 U.S.C. § 654: US Code - Section 654 (1993). *Policy concerning homosexuality in the armed forces*. Retrieved September 13, 2010, from <http://codes.lp.findlaw.com/uscode/10/A/II/37/654>.