Clinical Issues with Gay and Lesbian Adoptive Parenting

Mihael Colberg, J.D., C.S.W.

Openly gay and lesbian parented adoptive families comprise an emerging minority group. The majority of these families remain concerned with the parenting of young children. Clinical issues, unique to this population will begin to present themselves as gay and lesbian parented adoptive families reach new developmental stages. This article outlines a model that addresses some of the clinical issues relevant to working with gay and lesbian parented adoptive families. Attention will be paid to three general areas: issues of engagement, issues that arise from both internalized and societal homophobia and issues concerning the structure and development of gay and lesbian parented families.

The engagement process begins with an understanding of the historical context on which we are working. Americans have had to redefine many of the ways in which we have traditionally thought about the nature of family. As our society has become more mobile, we have become less able to rely on our extended families. This has served to both isolate nuclear families and to place additional demands on their members to fulfill roles that, in the past, had been shared amongst siblings, parents, grandparents, aunts, uncles and cousins. The fifties brought television into our homes and the model for family structure became idealized by such shows as "Leave It To Beaver," "Ozzie and Harriet" and "The Donna Reed Show." The sixties and seventies left a legacy of individualism which gave many of us the courage to explore our personal identities and live our lives as the people we are instead of assuming the roles that we felt obligated to fill. This search for personal freedom placed additional burdens on nuclear families. Television programs like "Family," "Julia" and "All In The Family" reflected the fact that Americans were coming to understand that the idealized notion of family did not accurately represent the ways in which most of us were living our lives. Economic forces changed not only the complexion of the work force, but also the nature of family relationships. Today, most two-parent families are dependent upon two incomes. Children spend time in daycare. Almost half of all marriages end in divorce.

During the 1980s, several factors converged to create the opportunity for many gay men and lesbians to build families through adoption. Women's liberation served to help birthmothers demand a more active and dynamic role in creating adoption plans. Gay liberation empowered gay men and lesbians in ways which helped them redefine themselves as people who lived "alternate" rather than "deviant" lifestyles. The appearance of crack cocaine created a group of children who became known as "border babies." As they grew in number, these children began testing the resources available to hospitals and the social welfare system. Similarly, the impact that AIDS would have on our health care system began to be felt. AIDS was affecting not only gay men, but also heterosexual adults and their offspring. Slowly and quietly, homosexual homes were considered as foster homes for "border babies" and HIV infected children. Foster homes evolved into adoptive homes. As time passed, birthmothers began to consider and select gays and lesbians as adoptive parents. Gays and lesbians began to build families through private adoption. Some agencies began to broaden their client bases and included openly gay and lesbian prospective parents.

As the pool of gay and lesbian parented adoptive families has grown, their impact has been felt in a number of ways. States have had to addresses the rights of these families. Courts have had to decide on the rights of gay and lesbian families to adopt singly or as couples. The families themselves

have organized and established themselves as members of the national community. The increased visibility has led to increased vulnerability. During the past several years, gay and lesbian families have both won and lost important legal battles. What is most important to understand is that the political environment surrounding gay and lesbian adoptive families is fluid. Their very right to exist cannot be guaranteed. As this article is written, the potential exists in Washington state for a bill to be introduced into the legislature which would allow children to be taken from their parent's care on the basis of their parent's sexual identity. (Human Rights Campaign Fund Quarterly, Summer 1995) This opens the door for finalized adoptions to become vulnerable to vitiation.

Many of the changes that Americans have faced are unsettling. Many of us grew up during the age of the "idealized American family" and are burdened by the fact that the world that we expected to live in is gone. For many, too much has changed too fast. People do not feel that they have been supported or educated about how to function as a family in today's complex world. We long to "get it right." In fear, many cling to their idealized notions of what a family is supposed to be. Their disappointment is expressed as anger and rejection of those families and individuals who are most easily identified as different. An interesting paradox exists. Although we, as a nation, cherish our freedom and individualism above all else, we tend to discriminate against and pathologize those whose lifestyles are different from our own. This serves to keep us distinguished from "the other" and connected, in theory, to the "norm."

As the engagement process begins, it is important for the clinician to be aware that gay and lesbian parented adoptive families are seen as "the other." Having received a lot of attention from both the media and politicians, they have been portrayed as emblematic of the changes we have faced. They have, as a group, been both rejected and pathologized. It is important, when engaging with gay and lesbian parented adoptive families, to work systemically and to look at the environment in which they live their lives. Gay and lesbian parented adoptive families are not in a safe or hospitable "holding environment." As we have learned from working with other minority populations, a significant amount of stress flows from living under scrutiny, being exposed to discrimination and having the right to exist and to protect one's children when they come under attack. Additionally, studies have shown that minority groups who experience discrimination are less likely to seek and receive help. In order to successfully engage with gay and lesbian parented adoptive families, it is necessary to create a "holding environment" which allows them to feel safe enough to reveal their vulnerability, safe enough to learn about the issues unique to their population and safe enough to engage with the developmental challenges that they will face.

Questions emerge when beginning the engagement process. How can we work together most effectively? What might get in our way and how will these obstacles be addressed? Traditional social work practice dictates that the clinician start where the client is and help them to achieve their identified goals. Most adoption practice varies from this point of view and is more behaviorist in nature. The clients are presented with a program which they must accept or go elsewhere. The model outlined herein offers a hybrid approach. It is based on Dr. Joyce Maguire Pavao's "Brief Long Term Therapy Model" (in press) and is structured to allow the client family to go in and out of treatment as new developmental stages present. The model initially relies upon the creation of a working alliance that helps the client narrate his/her experience. It then helps the client to reframe his/her understanding by placing their experiences into a historical context. Once clinician and client have accomplished this task, the clinician is able to be more successful as he/she introduces the didactic material that explains the developmental challenges that the clients, and their families, are likely to encounter. This process normalizes the challenges and alerts the clients to those points in time when they might benefit from a return to treatment.

This approach addresses the resistance that emanates from a person being told what is right

for them through the creation of a partnership between clinician and client. This serves to mitigate the feelings of being out of control that arise when seeking help and helps clients to remain open to integrating the didactic information that must be conveyed in order to help reframe the ways in which they view themselves and their situation. The model stresses the need to communicate to the client that the issues that they face are complex and that there are no ready answers. It also stresses the need to establish a collegial environment which allows clinician and client to form a partnership, view the landscape of the clients' lives, gain an understanding of the roles that society, their community, their friends and their family play in both supporting and challenging their development as a family, assess available resources and finally make and implement some long-term strategies that allow the family to flourish.

The establishment of a collegial relationship can be facilitated in several ways. First, the clinician should examine and disclose those personal biases which are relevant to their working with the client. This helps clients to view the clinician as a fellow human being rather than as another authority figure. Each of us is engaged in a struggle with judgment and bias. Gay and lesbian parented adoptive families are, today, in a situation which exposes them to both. The clinician who is able to address and discuss his/her personal struggle models for the client that their growth as a family is a process and that they are being communicated with as people of value. This, in turn, supports the client's ability to enter the "holding environment" and reveal themselves.

Engagement is further facilitated as the clinician makes certain that the clients become aware of the historical context in which they are living their lives. As the clinician communicates this information to the client, he/she validates and normalizes many of the client's experiences in a way that helps the client to reframe their experience and feel understood. It is useful to think of gay and lesbian parented adoptions as being transcultural adoptions. These parents are not considered to be a part of the dominant culture even if they were raised in families that were considered part of the majority. As they came to identify themselves as homosexuals, they became, in a sense, "aliens." They live surrounded by a culture that considers them to be "different." They do not enjoy many of the rights afforded other members of society and their differences are often pathologized. The parents' relationship is not legally recognized and typically, only one parent retains any legal relationship to the child. In addition, and as has been well documented, homosexuals have developed their own cultural characteristics and the developmental stages of the homosexual individual differ from his/her heterosexual counterpart. Their children will, statistically, grow up to be heterosexual. As such, the family is comprised of both homosexual and heterosexual members. It belongs, in one sense, to both communities and in another sense to neither. Gay and lesbian adoptive parents need to be supported as they work to help their children learn to value their membership in both communities.

It is the clinician's responsibility to guide the family toward a long-term view of what its needs will be. As people face the challenges in front of them, they tend to lose sight of the overview. If the community is not supportive of a gay and lesbian adoptive family, it seems logical, at first glance, for the family to withdraw and seek a more accepting circle of friends. This might mean that the family befriends and socializes only with other gay and lesbian parented families. This solution might give the parents the support they need at that moment but sets them up for difficulty down the road. If a family becomes too isolated from the dominant culture, they might have a harder time helping their child integrate themselves into their peer group as they begin school. Part of our work is to help clients to understand that their current experience is a snapshot in time and that the goal must be to create a beautiful album. The needs and concerns of the moment must be tempered by an understanding that the needs of the coming years may be significantly different. As the clinician helps the client to see gay and lesbian adoption from a long-term cultural perspective, he/she has the opportunity to join with the client and validate some of their feelings of stress and oppression. The clinician

can begin to "hold" some of the client's feelings and help them to explore their long-term needs. The clinician, by communicating an overview, both validates the client's sense of oppression and offers the hope of learning how to integrate into the community.

During the engagement process, the clinician should use both ecograms and genograms to help the client relate his/her history and life experience. This process serves to facilitate the client's understanding of their immediate environment's strengths and stressors. As the client begins to describe their situation, the ecogram can be assembled. The map that emerges will concretely illustrate both the resources and the drains on those resources that exist. Are the parents "out" at work? Do they have a mixed group of friends? Are their families of origin a source of support or an additional stressor? Is there a parents' organization to which they belong? Do they socialize with other parents? Have the children made disparaging comments? Have teachers responded appropriately? Does the school community seem open to being educated about the issues that gay and lesbian parented adoptive families in their school community? Have their children asked questions about why they live with two same sex parents? Have they asked about adoption? Do the birth parents know that their child has been adopted into a homosexual parented home? Is this an open adoption? If this is a closed adoption, is it possible to open it if desired? The preparation of an ecogram helps the clinician to establish a "holding environment" as they sit with the clients and take a clear look at their resources so that they can begin to plan for the future.

Genograms are another way of fostering the engagement process. The clinician should do two sets of genograms. The first, of the client's nuclear and extended family, helps gain an overview of the patterns and dynamics that have existed over generations. This helps the couple to better understand themselves and each other, which tends to support and deepen their ability to parent as a team. Same sex couples have not been socialized into family roles. Learning about how they decide who is responsible for what is useful as it gives the client the opportunity to pay attention to some of the choices that they have made in a more conscious way. It also serves to identify some of the struggles that the clients may have had with their families of origin. How is their homosexuality integrated into the complexion of the family? Is their relationship sanctioned? How was the decision to build a family through adoption received by various family members? Has the family joined the client on their journey or has it been unable to come to terms with the client's decision to step forward as an openly gay or lesbian parent? The answers to these questions might lead the clinician to invite extended family members to join the clients in session as it is deemed appropriate.

The second genogram relates to the client's "family of choice." Many gays and lesbians have created their own "families of choice." This community works together in many of the ways that families of origin have traditionally interacted. The members have come to rely on each other and the relationships between members may, in fact, contain more intimacy than those between clients and their families of origins. As such, the children will, by being exposed to these relationships, learn a great deal about how members of their family relate to others. It is useful to spend the time with clients doing this second genogram as it helps them to frame and organize some of the ways they think about family dynamics. It also helps the clinician and client to identify any destructive patterns that may have been carried from the family of origin to their interaction with their family of choice, before they are passed on to their children.

Identifying and addressing the role that homophobia plays in the family is an equally important task. Societal, familial and internalized homophobia all play a role in the lives of gays and lesbians. Even the most politically liberal families may harbor prejudice against homosexuals. Parents may come to accept their child's homosexuality but be shocked by the decision to parent through adoption. Homosexuals are expected to be childless. Parents may not have told their friends and colleagues about their child's sexual orientation. The act of becoming a parent "outs"

gays, lesbians, and their families of origin in new ways. It is difficult for a gay or lesbian couple to remain secretive about their relationship and sexual orientation once they decide to parent. Maintaining the secret places an enormous burden on the child and engenders shame in all family members. Secrets are poisonous and demolish self-esteem. Privacy, on the other hand, is important. It is the clinician's responsibility to help the client understand the implications of the decision to parent. Clinicians can help their clients come to a place where they feel comfortable about maintaining their privacy while growing past their need for secrecy. It is helpful to work systematically when working with clients who become stuck and need help in discerning the difference. If possible, work with the clients toward inviting extended family members into sessions so that together, they can learn about the nature of adoption and more specifically, gay and lesbian parented adoptive families. At stake is the child's ability to maintain a relationship with extended family members and feel comfortable with their place in the world. The connectedness that derives to parent, child and grandparent goes a long way toward healing and supporting the development of healthy self-esteem. It also helps the child understand that some family members are heterosexual and some are homosexual, that they are all in the same family and linked together. The clinician should underscore the importance of helping the child to learn to value all of his/her pieces. Differences are present and accepted. Interacting with these differences can serve to help all family members grow in unexpected ways. The positive modeling that derives from watching a family acknowledge and address its remaining homophobia can serve to support the child as he/she develops the skills necessary to negotiate his/her way in the community.

Internalized homophobia plays a significant role in the lives of many gay/lesbian adoptive parents. The clinician who can help a client identify and address internalized homophobia, and its resultant shame, greatly strengthens the client's ability to parent their child as similar issues, related to their child's status as an adoptee, begin to emerge. As mentioned above, society does not support homosexuality and laws speak to whether or not a jurisdiction is allowed to discriminate against this group of citizens. This acts to infantalize gay and lesbian parents. A parent may feel shame, anger, rejection, loss of identity and grief as they become aware that they and their family are being treated differently from heterosexual families. A parent's primary job is to make certain that their child is safe and this is made difficult when a society dictates that the parent and child may have no legal relationship. The feelings of shame and anger engendered by a parent being denied the opportunity to fully execute his/her responsibilities must be addressed. The homeostasis existing in the parents' relationship may suffer from the failure of our society to recognize the integrity of the family boundry. Reactions may take the form of difficulty in achieving intimacy, in the emergence of control issues and in a loss of self-esteem. These feelings tend to become pathologized. The clinician should work to both validate and normalize these feelings as being appropriate responses to the ways in which homosexuals are accepted by society. Paradoxically, adoptees are also infantalized and often wrestle with many of the same feelings. Adoptees are not participants in the decisions made around their placements. They have no control over their access to birth families. They are often denied access to their biological and medical histories. Their birth certificates are rewritten and their records are sealed. Silverstein and Kaplan (1986) detail and discuss seven core issues that adoptees, adoptive parents and birth parents can be expected to wrestle with at various times in their lives. These include loss, rejection, guilt/shame, grief, intimacy, identity, and control. As these feelings present, clinicians have the opportunity to work with gay and lesbian parents in exciting ways. Typically, neither homosexuals nor adoptees are socialized into minority status by their parents. Gays and lesbians generally have heterosexual parents and adoptees most often are raised by parents who entered their families biologically. Homosexual parents who have successfully learned to integrate their minority status and engage with the feelings resulting from internalized homophobia have the opportunity to help their children to coexist with their feelings and grow into emphatic adults.

Parents pay a price when they are secretive about their status. Clinicians need to become aware of whether there are any areas in the client's life where they continue to hide their homosexuality and their status as a gay or lesbian adoptive parent. This, again, should be distinguished from the client's right to privacy. The clinician should also be alert to any discomfort that the client might have with other homosexuals. This may indicate some lack of acceptance by the client of their own sexual orientation and further, may model for the child that there are some parts of themselves which are "bad" and unacceptable. Parents should be supported while they explore any lack of self-acceptance. It is clinically helpful to frame this discussion in terms of helping the parents learn to teach their children how to accept all of the parts that make them who they are. Conversely, clinicians need to help those clients who have rejected the heterosexual world to come to an understanding of their status as a family consisting of both homosexual and heterosexual members. Their child's status as a probable hetereosexual dictates that they need to begin to help the child learn how to maintain connections in both communities. Failure to do so will cause the child enormous pain and could cause them to "split off" their homosexual parents as they explore their heterosexual identity.

Another way that homosexuals can respond to societal rejection is by overachieving. They may strive to do everything a little more successfully than their heterosexual counterparts. They may wear only the best clothes, go to the best restaurants, drive the hottest car, have the most stylish apartment and build the best body. Clinicians should be alert to the fact that adoptees often experience developmental lags. Adopted children have additional information and issues which they must process as they grow. This added challenge may make them appear to lag behind some of their counterparts. The children being parented by gays and lesbians have even more complicated issues with which to contend. Whereas children adopted into heterosexual homes are often able to defer conversations with peers about their status, children adopted into gay and lesbian homes are subjected to scrutiny as they have parents who are visibly different. Processing these differences may take a lot of energy away from other developmental tasks and result in lags. Clinicians should be aware of the pain that this might cause homosexual parents who have reacted to their feelings of rejection and inadequacy by overachieving. The work here is to support the parent while they learn to reframe their feelings about the rate of speed at which their child is developing.

Internalized homophobia can also impact upon the ability to develop and maintain intimacy. The feelings that derive from feeling ashamed and rejected impact on the ability to maintain good self-esteem. Although it is possible to deny the existence of these feelings by maintaining a very structured life where one is able to control the degree of closeness affected in any given relationship, the nature of parenting works against being able to successfully maintain this mode of coping. To maintain a distance from one's child brings great sadness to both parent and child. Each will come to feel that there is something wrong with them. When clinicians are confronted with this issue, they are well served to help the client identify their goals. What kind of relationship do they want to have with their child? The distancing should then be framed as an obstacle which lies in the way of their achieving this goal. As they come to understand the etiology of this defense and experience the sadness and disappointment around its existence, the clinician will have the opportunity to work with the vulnerability that ensues and help the client to foster a stronger and more satisfying connection with their child and with their partner as well.

Clinical work involving gay and lesbian adoptive families must also include a good deal of psychoeducation intended to inform them about the developmental challenges that they are likely to encounter. Although the scope of this article does not allow for a detailed discussion of the various stages encountered by gay and lesbian parented adoptive families, the highlights are listed below. Dr. Joyce Maguire Pavao describes the challenges that are unique to the development of adoptive families. *The Normative Crises in the Development of the Adoptive Family,* Pavao's seminal work served to alert us to the fact that adoptive families differ from those formed

biologically. Her work normalized and depathologized the experiences encountered by families formed through adoption. Gay and lesbian parented adoptive families encounter developmental issues that are unique to their population. The clinician both supports and strengthens the client's ability to parent as he/she teaches the client about the developmental challenges that the family can expect to encounter. As gay and lesbian parents are helped to understand their families' developmental cycles, they are empowered to support their children as they negotiate their way through the next developmental stage and can better identify the times that they and their children will benefit from a brief return to treatment.

Preplacement issues include a reworking of the "coming out" process and a renegotiating to the parent's relationship. As mentioned, homosexuals are expected to remain childless. Both the heterosexual and the homosexual communities have been slow to embrace the concept of gay and lesbian adoptive parenting. As such, as gay and lesbian preadoptive parents disclose their intent to adopt, they may find themselves, once again, at odds with their peer group. Clinicians should address this by helping clients to become conscious of the impact that their change in family status has on their identity. The ways in which families of origin have reacted to their children's homosexuality may also need to be reworked. The entire family becomes exposed as having homosexual members once a gay or lesbian couple decides to parent. The whole family may become exposed to the scrutiny and prejudice previously experienced only by the homosexual members. The clinician can frame this process in a way that may allow the homosexual children to help their parents gain insight into some of their children's struggles. Although painful, the result can be deepening of the parent and child relationship which can, in turn, be a great source of support for the fledgling family.

The couple should be helped to anticipate some of the ways in which its relationship will be changed. There have been no role models for openly gay and lesbian parents. There has been no socialization process for the assumption of parenting roles. Both members of same sex couples have been socialized, by their families and society, into the same roles. This creates some awkwardness but also allows for the clinician to help the couple to make very conscious decisions as to the ways in which they will work together to parent. During this period, it is important for clinicians to strengthen their client's self-esteem through psychoeducation. Validating and normalizing the client's experience strengthens their feeling of empowerment and underscores the fact that they can rely upon the working alliance that has been established between client and clinician.

The law, in most jurisdictions, continues to deny one parent the opportunity to have any legal relationship with the child. This serves to impact upon the couple's power dynamic. One member of the couple suddenly has a good deal more power than the other. How will this change affect the interaction between them? What feelings emerge as this realization hits home? As mentioned, homosexuals are already made to feel powerless in society. The safe haven of their relationship may be disrupted by their inability to equally share in the legal relationship to this child. The clinician should address this issue and help the clients to process their feelings. The entire legal process attendant to placement can be far more laden than for heterosexual couples. The pressure that comes with worrying about the reaction of the birthparents, the judge, and potentially the media and the legislature should be anticipated. Clinicians serve their clients by introducing discussion aimed at helping clients to weigh the advantages of disclosing their status as a same sex couple. Although it may seem much easier for only one member of the couple to step forward and to adopt as a single parent, the implications on the family, over time, should be understood. The clinician can facilitate this process by helping the clients to take a long-term view of their family's needs.

Several key factors arise at the time of placement. Birthparents, in private adoptions, may come under pressure to rethink their decision to place with a same sex couple. This pressure may come just as the birthparent is feeling most vulnerable. Anticipating this, the clinician should help the cli-

ents to discuss this with the birthparent prior to delivery. This discussion affords the clinician the opportunity to help the client and their birthparent come to understand that adoption begins at placement and is a life long process for all concerned. Discussing difficult issues helps lay the groundwork for a relationship based on trust and, over time, the establishment of real intimacy. The support offered by birthparents can go a long way toward supporting the gay and lesbian adoptive parent as they reenter society in their new status. Whereas society generally embraces newly formed heterosexual families, gay and lesbian parented adoptive families are often not afforded a very warm welcome. When this happens they may be left feeling isolated. The clinician can be of great support to parents as they learn to act as ambassadors and work to educate their friends, families and communities about the nature of gay and lesbian adoptive parenting. It is useful to help the client understand that they have done a lot of work to come to where they are and they need to be patient with others as they begin their journey towards acceptance and welcome.

As the child develops an awareness of his/her surroundings, he/she realizes that his/her family structure differs from those of almost everyone else. The child sees that he/she is missing either a mother or a father, something most of the other children have. This can engender feelings of sadness, insecurity and confusion that may tap into feelings shared by gay and lesbian adoptive parents. The clinician can be helpful by framing things in such a way as to facilitate the parent's ability to validate the child's feelings. This, in turn, serves to deepen the trust and connectedness experienced between parent and child. The parent is able to say that while their family is differently structured, it is both valuable and viable. As the child develops cognitively, the parents can help the child learn about the difference between privacy and secrecy as they begin to respond to questions and comments from their peers and others. In order to be most effective, parents need to be supported as they develop their own feeling of ease in their interactions with society.

As the child enters school, they will seek to be accepted by their peers. Their feelings of being different may very well rekindle, for gay and lesbian parents, the feelings that they had during their own school years. The danger here is that the parent will begin to feel the shame that they felt long ago and may experience guilt for causing their child to suffer. The clinician should support the parents and reframe the parents' experience in a way that allows the parents to use their experience as a basis for the development of greater empathy for their child's struggle. Gay and lesbian parents are uniquely situated to be able to build a powerful connection with their child as they help them to negotiate some of the same challenges that they have faced. Parents must also be supported as they work to become visible members of the school community. Curriculums do not, as a rule, include materials that include differently formed families and this can make the child feel invisible. Clinicians should help parents to find ways to have gay and lesbian adoptive families become represented. This calls for some creativity on the part of both parents and clinicians, but is well worth the effort as it works both to support the child's membership in their peer group and validates the parents' feelings of belonging to the school community in an active rather than reactive way.

Adolescence is complicated for all adoptees. It is the time that children become adults and wrestle with who they are in the world. It is also the time children begin to explore their sexuality. The children of gay and lesbian adoptive parents may need to separate themselves from their parents as they explore their heterosexual identities. This process can be very painful for all family members and can be mitigated by the creation of strong connections to heterosexual role models throughout the child's minority. Relationships with birthparents, extended family members and friends can serve to create a "holding environment" which allows the family to both maintain its connection and gain the distance that they may need to work through this developmental stage. This is a time that the family should be encouraged to return to treatment if they feel discomfort. Feelings can get very complicated as the child addresses a stage that, for most homosexuals, was filled with despair and self-loathing. Psychoeducation is an extremely important tool during this stage

as it helps frame much of what is going on in a way that allows some distance from the parent's psychodynamic responses.

The model outlined above briefly describes ways in which the challenges facing gay and lesbian parented adoptive families can be addressed clinically. The establishment of a strong working alliance is essential to the success of this approach. Families are supported as they learn about where they come from, who they are and where they might expect to go. Of course, each family has its own dynamics and clinicians can encourage their client's individuality by establishing a collegial relationship which allows for the family to go in and out of treatment as they feel it necessary. As each period of treatment comes to an end, clinicians should spend some time predicting what the next challenge might be so that the family can be alert for signs that may indicate its arrival. This serves to further support and normalize family development in a positive way and helps the family internalize its therapeutic experiences.

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