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An Exploration of Lesbian Maternal Bereavement

Joanne Cacciatore and Zulma Raffo

Research on parental bereavement has focused historically on single or partnered cross-gendered (heterosexual) bereaved parents. No previous studies have examined the unique experiences of same-gendered bereaved parents. This multiple-case study focused on child death in same-gendered-parent families. The goal of this study was to yield information that will expand the existing body of knowledge regarding parental bereavement and add to the scant literature on lesbian parenthood and the challenges that lesbians may face as a marginalized group. The study used in-depth interviews with six self-identified lesbian mothers who had experienced the death of a child at various ages and from various causes. Results suggest that lesbian bereaved mothers experience a type of double-disenfranchisement after their losses and that social support is often insufficient to meet their psychological needs. Because previous research has not been published on this specific population, the findings may be worthwhile for the lesbian and gay parenting community, community advocacy groups, and the clinicians who serve them.

KEY WORDS: bereavement; child death; disenfranchised grief; gay and lesbian families; mourning

The bereavement literature includes a considerable amount of research conducted on parental bereavement in cross-gendered (heterosexual) families (Donnelly, 1982; Knapp, 1986; Miles, 1978; Rando, 1986); however, prior to the present study, no research had been conducted on same-gendered (homosexual) bereaved parents. The death of a child has profound psychological effects on the family system, and it is a unique grief experience. This uniqueness may be attributed to the belief that children bury their parents and parents should not have to bury a child (or children) (Wheeler, 2001). Yet already marginalized, nontraditional families may face even greater challenges during the experience of parental bereavement, for a number of different reasons.

Some relationships are not socially sanctioned. Thus, there may be disenfranchisement of the family unit and any children, whether by birth, adoption, or foster care. Social factors already present may complicate these families’ lived experiences through, for example, disownment from family or lack of recognition for a partner or children in the relationship (Kurdek, 2001). Gay and lesbian individuals experience bereavement differently than their heterosexual counterparts, in part due to disenfranchisement.

Disenfranchised grief occurs when a relationship is not recognized, a loss is not recognized, and a griever is not recognized (Doka, 1989). Homosexual families often face societal stigma and are “disqualified from full social acceptance” (Goffman, as cited in Siegal & Hoefer, 1981). This stigma often makes bereavement more difficult, because homosexuals are dealing not only with the loss of a loved one, but also with social nonrecognition of their loss. This invalidation may result in dire consequences for the individuals involved. Grieving may be protracted and intensified as the mourner suffers damage to his or her self-esteem. Feelings of guilt or shame may also lead to self-destructive behavior (Siegal & Hoefer, 1981). Though much remains unexplored in the area of maternally bereaved lesbian mothers, these social factors may influence both their sense of marginalization and the intensity of their isolation during bereavement.

LITERATURE REVIEW

Stigmatized Relationships and Stigmatized Deaths

Lesbian couples are increasingly deciding to become parents (Gabb, 1999; Patterson, 1995), resulting in what has become known in contemporary literature
as the “lesbian baby boom.” The number of children born to or adopted by gay and lesbian parents is estimated to be between four to 14 million (Patterson, 1995). As an increasing number of lesbian and gay couples become parents, a certain percentage of their children will die from various causes, making them bereaved parents. However, their already stigmatized relational status may complicate their bereavement experience. Specifically, according to Meyer (2003), within the framework of minority stressors, maternal mental health can be compromised by variables such as homophobia and exclusive heterosexism. This status leads to disenfranchisement as a result of the sociopolitically contentious milieu surrounding lesbianism, particularly as it relates to parenthood.

Doka (1989) defined disenfranchised grief as “the grief that persons experience when they incur a loss that is not or cannot be openly acknowledged, publicly mourned, or socially supported” (p. 4). Furthermore, Doka (1989) suggested that there are five categories of loss: lack of recognition of the relationship, lack of acknowledgment of the loss, exclusion of the grieveer in discussions or rituals, circumstances of the death, and grieving styles. At the same time, disenfranchisement impedes access to sources of support by excluding the mourner from an active role in dying and funeral rituals (Doka, 1989). For example, as a group, lesbian widows and gay widowers experience disenfranchised grief as a result of their partners’ deaths. Whipple (2006) noted that “society does not accept [lesbian] relationships, and losses are consequently not recognized . . . plus there are very few support groups . . . and even fewer written resources” (p. 140). Given this deficiency, Whipple said, further research is needed to inform social services agencies of the unmet needs of bereaved lesbians.

Another facet of lesbian life in which disenfranchisement may occur involves children. Since the early 1980s, lesbians and gay men have been raising children in increasing numbers. Their families have been created through previous heterosexual relationships; through lesbians and gay men choosing to have biological children together, either by donor insemination or surrogacy; through adoption and foster care; and through children from previous lesbian or gay relationships. Social stigma can often affect these nontraditional families with children (Hare, 1994). For example, second-parent or coparent adoptions are currently allowed in only nine states (see http://www.mautnerproject.org). Although laws do exist in many states to protect lesbians and gay men from workplace or housing discrimination, some states prohibit second-parent adoptions. Appleby and Anastas (1998) suggested that even “many people who seem ready to accept gay, lesbian, and bisexual people as individuals unfortunately have difficulty with the idea of gay, lesbian, and/or bisexual people as parents” (p. 177). According to Benkov (1994), gay and lesbian parents face “two of the most powerful facets of homophobia: abhorrence of any association between homosexuals and children; and the belief that gay men and lesbians exist in opposition to family life” (p. 31).

**Strengths-based Perspective on Nontraditional Families**

Other studies have revealed many similarities between homosexual and heterosexual families and elucidated their unique strengths. Lesbian mothers do not appear to experience more parenting stress or self-esteem issues than their nonlesbian counterparts (Fulcher, Sutfin, Chan, Scheib, & Patterson, 2002; Tasker & Golombok, 1997). Also, the division of labor in lesbian families tends toward an egalitarian model, with both partners sharing domestic duties and child caring more frequently than is the case in heterosexual couples (Dalton & Bielby, 2000; Hadley & Stuart, 2009). Because lesbian parents may not be able to rely on extended family as a source of support for their childbearing and child rearing, a “chosen family” (Weston, 1991), which may include other gay men and lesbians, may be important sources of support to these parents, sometimes more so than actual family members (Appleby & Anastas, 1998). Finally, most lesbians who decide to become mothers do so with explicit intention. Lesbians often incur economic, social, and psychological risk to become parents. Thus, their children are often born into homes of great desire and love, because the investments and sacrifices on the parts of their mothers have been significant (Chabot & Ames, 2004; Ross, 2005).

A review of the available literature seems to establish a need for exploration of the experiences of lesbians as bereaved parents. There is a pressing need for research that describes the particular and unique responses to different types of losses, compares reactions outcomes and problems associated with these losses, assesses possible interventions, and describes the critical variables affecting each loss (Doka, 2002).
METHOD

Rationale and Study Design

Because of the limited number of participants, we used a multiple-case study design that allowed for an in-depth exploration of this unique population. A case study “investigates a contemporary phenomenon within its real-life context” (Yin, 1989, p. 23). This process facilitates answers to inquiries of meaning around experience, providing an embrace of understanding of a particular subject. Components central to multiple-case study design include the questions such as “how?” and “why?”, theoretical propositions, logical linkages, interpretations based on iteration between themes and data, consistency in findings, and normative questions about implications (Yin, 1994). In addition, qualitative methods in general provide a place for research participants to have a voice and for researchers to build theory (Rubin & Babine, 2005). According to Stake (1994), case studies aid in providing intrinsic knowledge through descriptive data collection, instrumental knowledge about a particular social issue, and collective knowledge to understand a group of individuals with a specific social problem. The present multiple-case study focused mainly on the collective experiences of maternally bereaved lesbians, constructed by them through language and expression. These methods are consistent with feminist interviewing and data analysis that is woman oriented. Devault (1990) noted that “to fully describe women’s experiences, we often need to go beyond standard vocabulary—not just in our analyses” but also in the interview process, as a type of woman-to-woman listening relationship (p. 99). Member-checking that included reflective listening during the interview ensured accuracy in the recording and interpretation of data. Emergent methods, such as case studies, pursue “uncharted, contingent, or dynamic phenomena” (Charmaz, 2008, p. 155).

Constant comparative analysis (Lincoln & Guba, 1985) guided the analytic process, in which initial codes were developed from the local language (in vivo codes) of the participants. This facilitated the emergence of inductive themes from the participants’ use of language, emotional states, and meanings. The second level of coding examined potential commonalities across the in vivo codes. A matrix was created with interviewee responses, with careful attention paid to intonation and intensity and the corresponding interview questions. This matrix helped us to formulate common themes that were both narrative and paradigmatic (Barone, 1990), identifying linkages in the data. In addition, this method considered macro influences such as the sociopolitical context within which a case was bound. The woman-centered approach to analyzing data “calls attention to the importance of talk and its organized complexity, and provides techniques for capturing and using” linguistics in the analyses (Devault, 1990, p. 110). Once data analysis was completed, internal validity was checked using triangulation, participant checks, and peer examination. In addition, for insight and sensitivity, preliminary findings were discussed with key gay and lesbian informants who were not involved in the study.

Participants and Sampling

Snowball sampling was used, and the sample selection was begun through location of established bereavement organizations; gay and lesbian parenting organizations; gay and lesbian pride organizations; and gay and lesbian-focused newsletters, magazines, and other media venues throughout the United States.

A list of open-ended, semistructured questions was posed to participants. Questions were generally broad, designed to facilitate a process of language self-construction by participants. The guided questions incorporated the following six themes: (1) discussion of the child’s death and the parent’sbereavement (“Tell us about your child and your experiences with [his or her] death”); (2) social support during and after the death and reactions from others (“Tell us about how others reacted [a] during the acute crisis, [b] in the weeks following the death, and [c] in the months and/or years to follow”; “What did others do that was helpful? Not helpful?”); (3) psychobiological reactions to the loss (“What emotions did you experience? How was your physical health?”); (4) rebuilding, reintegration, and reflection (“How have you handled or coped with your loss and grief?”); (5) sense of self and identity (“Who are you now in relationship with your child who died?”); and (6) learning, growing, and teaching (“What do you feel you’ve learned, if anything, from your experiences of loss?”; “Is there anything you’d like others to know about your experience?”). Each interview was recorded and then transcribed. The interviews ranged in length from two to four hours. Only one interview lasted
longer, nearly five hours. Concepts explored through the semistructured questions included the following: circumstances and emotions surrounding the death of the child; social support available to the surviving family, such as school, work, families of origin, and chosen families; and coping. In addition, the themes of rebuilding, recovery, and teaching others were discussed with participants. With permission, a list of bereavement contacts and resources were provided to each interviewee before the start of the interview.

FINDINGS
The participants were six self-identifying lesbians. Three were in the 36- to 45-year-old age range, and the other three were in the 46- to 55-year-old age range. Four identified their ethnicity as Caucasian, one as Jewish, one as Italian-Irish, and one as European-Canadian. One participant identified as Buddhist, one as Jewish, one as Protestant, and three as having no religious affiliation. Two categorized themselves, in terms of income, as being of lower socioeconomic status, whereas the remaining four stated that they were middle class. Two participants had a single child, three had two children, and two had three children, counting the children who died. Thus, two participants had no living children at the time of the study. Four participants were partnered—one having gotten married in Canada—and two were single. All but one of the children had died during the perinatal period or during birth. The other died as an adult as a result of a climbing accident. All the deaths were traumatic and unexpected.

The Death and Bereavement Experience
The pain and suffering, emotionally and cognitively, of these mothers were palpable. Repeatedly, they described feeling hopeless, and at various points during the interviews, all the participants became emotional and tearful as they told their stories of loss and love:

It was excruciating. 

* * *

It was indescribable. 

* * *

It was horrible. 

* * *

To this day I don’t remember going to work . . . to school . . . even driving for two months.

Similarly, each participant also described feelings of shock, numbness, and surrealness:

I was in shock . . . I spent two months sobbing, just sobbing.

* * *

It was so surreal. 

* * *

I was on autopilot.

Other universally identified feelings often associated with grief—such as anger, denial, emptiness, and even suicidal ideation—were also described by most participants:

It was anger . . . [I] couldn’t save her . . . That really laid me out.

* * *

I was annoyed and angry, just so angry. 

* * *

It was always like this constant thought like I could jump off the roof.

Some expressed a complete absence of feelings or said that part of who they were had “died in the process.” Frankl (1978) called this experience an “existential vacuum,” a persistent pattern of psychological enervation in which one experiences life as largely empty and meaningless.

Social Support and Disenfranchisement
All participants commented that, in one manner or another, their sexual orientation played a role in their experience of social support. Two participants stated that they did not attend any support groups because they felt “awkward” or did not want to be “judged by others in the group,” and another who attended a support group did not return because of her sense of discomfort.

There is always that risk of are you going to get that sideways look because you are a gay couple walking into what is all straight people. 

* * *

I just I . . . I felt awkward. Nobody openly said anything and there were a couple of couples that were fairly decent, but I felt their awkwardness with me.

* * *

Well you know, the thing that was different about that is they were all like these couples that
were there. And I felt sort of out of place there, because there I was by myself, and I couldn’t share with them that part of my life ... about being a lesbian because the last thing I needed was to be ostracized because of that.

* * *

I realized that I had censored myself. I censored part of who I am in those meetings, that I was a lesbian.

One participant noted that she took a great risk in terms of her identity in becoming a pregnant lesbian. She described being marginalized by other lesbians for choosing motherhood and was hurt when other lesbians referred to her as a “breeder,” a term, she said, reserved for heterosexual parents. After becoming pregnant, she found a safety niche in the lesbian community: a tight-knit, small group of lesbian mothers. But after her baby died, she no longer felt comfortable in her lesbian mother group because she “didn’t fit in there.” Searching for somewhere where she could be both a bereaved mother and a lesbian, she began attending a local bereaved parents’ support group. Yet she felt she did not “fit in with the couples” who were there either. She could not be her authentic self because she felt she had to hide her lesbianism during group. She, like several of the participants, described a type of double-disenfranchisement:

It felt like “how dare you!” I felt violated and dismissed ... even by other lesbians.

* * *

We, as lesbians, are not accepted by society and in many cases are in fact looked upon as a group of women who should not be having and raising children. People have expressed their belief that we will psychologically damage our children simply because we are gay. Therefore, not only do we have a fear that we ourselves will not be respected or that we will be viewed as “less than” in support group situations, for me, there was a real fear that my child who died would be looked upon as “less than” the children lost by heterosexual couples, that my child would not hold the same “value” as a human being to others because she was born to a lesbian mother. Society can be that cruel. I feel that we, as lesbians, may sometimes avoid group support because we not only feel the need to protect ourselves from harsh words or lack of respect in such a difficult time, we may avoid groups because we also feel the need to protect the memory of our children, to protect them from those who judge our families, those who may not honor them.

Three participants stated they had reservedly good experiences in a mutual-help support group for bereaved parents, though they noted some discomfort. One spoke about her experience but noted that this was unique to the culture of her city, which already had an active gay and lesbian community. In this instance, another lesbian couple was also present at the support group. Another participant stated that the facilitator of her group was also a lesbian.

All the participants recommended some sort of therapy to help deal with the loss, and most sought and received psychotherapy. Several said that the combination of individual counseling, bereavement groups, and having a place to openly share their emotions contributed to their healing process:

The woman who counseled me was a lesbian. . . . I was able to talk about my son without interruption.

* * *

My therapist really gets it . . . she’s a creative arts therapist.

* * *

Counseling can help you both realize how each other is grieving.

Two main factors that seemed to affect participants' satisfaction with their counseling experience were (1) whether the therapist was a bereaved parent and (2) whether the therapist was a lesbian. Hospital care seemed to affect the ways in which these mothers experienced and processed their traumatic losses. All of them emphasized the importance of compassionate psychosocial caregiving from doctors, nurses, social workers, and even family. Yet most did not receive that degree of support:

Nobody came in, and I had to keep buzzing the nurse. . . . “Can somebody take care of me?”

* * *

I was really pissed about the hospital [care].

* * *

Some tended to feel that if I became emotional, it meant that I was having a bad day.
“You can have another one... You’re healthy.” I can’t tell you how many people said that to me. I think I did curse at one of them.

The single participant who did perceive universally strong social support around the death of her child said that it made her experience “more manageable,” and she noted that “everybody really rallied around me.” For three of the participants, the support of their partners was crucial in helping them to cope with the loss. One of the partners shaved her head in response to their baby’s death, a ritual that signified mourning for the couple.

Rebuilding, Reintegration, and Reflection
Each participant stated that this event was life changing for her, and each believed that it would leave a lasting impact on her sense of self. Five stated that they would never be the person they were before their child’s death, describing life as a “new normal.” Ritual and remembrance—including things from hand molds to memorial services—appeared to play a key role in the integration of loss for all six participants:

On her birthday, we get a little birthday cake and balloon... we will do that every year.

* * *

We both got tattoos, memorial tattoos.

* * *

I felt the need to sculpt her head, her face.

* * *

I have a little locket that I wear with a photo of him.

In particular, all five of the mothers whose babies died discussed the features uniquely common in perinatal death, including the physical nature of pregnancy and becoming pregnant as a lesbian, giving birth, breastfeeding, emotional and hormonal changes, and the paradox of saying hello and goodbye simultaneously:

I got to keep her for five to six hours... I was nodding off but didn’t want to miss anything.

* * *

I held her... Here she had been, a part of my body... It was her and me.

* * *

There was no place to put [my partner’s] information on the death certificate... and, well, that’s just not right.

* * *

I woke up, and the sun came through the window, my belly was gone, she was gone, and I put my hand on my stomach, and that’s when I got out of bed and walked to the window and started to cry. It was just so surreal.

* * *

I can’t just get pregnant like everyone else.

The mothers took time in their narratives to reflect on meaning, both for themselves and for others. One mother noted that she learns things every day from her baby daughter who died, stating in regard to her child that “she makes me remember who I am” and “she taught me what love is.” A few mothers anguished over society’s ongoing preconceived notions of the nuclear family, and they openly discussed how societal attitudes from both heterosexual and homosexual others affect them:

I mean, we’re still people. We just want to have a family, and we, and we want love in our lives, and just because we have an affinity toward the same sex doesn’t mean that it changes our biological urges to procreate.

* * *

There is always that risk... like gay people shouldn’t be raising children. And so there are those questions in your mind: Are these the people we have to fight all the time? The people we have to stay away from, vote against, protect our children from?

One participant reflected on compassion from others, particularly medical staff, as meaningful and helpful. Others struggled with the apparent absence of empathic, patient-centered care. This translated into messages that participants felt were important for both practitioners and families:

As soon as her names comes out of my mouth, they tense up. I wish it was easier for people to be more comfortable with grief.

* * *

Doctors need to get some training or something.

* * *

Facilitate and advocate for training your people and talking with people who have been through
this kind of thing. If you don’t know how to handle it, figure out how to handle it.

* * *

I think also to realize that you’re not going to both grieve the same way. To talk about that and getting to talk about the differences in how you’re grieving and understand each other and not feel like . . . you know . . . that one of you doesn’t care or that one of you cares more than the other.

* * *

No other differences really matter. Everybody’s differences are erased. It’s like all the other parts of you just disappear and you’re there, just there, as a bereaved parent.

DISCUSSION

Overall, the experiences of bereaved lesbian parents were more similar to those of heterosexual bereaved mothers than different. Their emotional expressions, circumstances of death, relational challenges, and needs appear similar to those of many bereaved parents in general. Social support and services are essential in aiding clients who are dealing with grief, in particular after a child’s death (Grothe & McKusick, 1992; Osterweis, Solomon, & Green, 1984; Stowell, Branlett, Gueldner, Gritzacher, & Martin, 1991). The idea of a “new normal” is a common theme in research on heterosexual bereaved parents as well (Cacciare, 2008). For the partnered couples in this study, there appeared to be differences in the ways that each individual experienced and expressed her grief. For these participants, it was imperative that each partner be prepared for differences in grieving styles. Again, counseling helped partners understand one another and provided a place where differences could be discussed openly.

Often, bereaved parents note lack of social support in the aftermath of loss, sometimes leading to disenfranchisement (Doka, 1989). If this is true for heterosexual couples, gay and lesbian couples are likely to face even greater challenges and, perhaps, a type of double-disenfranchisement wherein, as Doka (1989) observed, chronic invalidation—socially, legally, and psychologically—of their relationship (and thus, implicitly, the grief experience) further ostracizes them. This can complicate their bereavement experience, because “the lack of sanction for this type of relationship prolongs the grieving process” (Siegal & Hoefer, 1981, p. 518). Lesbians and gay men need to be able to express their feelings and emotions in a safe environment that alleviates feelings of isolation. When working with the gay community, nongay clinicians should have a basic understanding of gay and lesbian issues, especially the effects of stigma on bereaved individuals (Dworkin & Kaufner, 1995). Successful interventions for gay bereaved individuals include group methods, development of social supports, community, and political action (Dworkin & Kaufner, 1995).

The lesbian bereaved parent community is likely to increase in numbers as more and more lesbians elect to become pregnant or adopt children. As discovered in this study, this subculture faces twofold marginalization. First is a sense of disenfranchisement from other lesbians “for whom contact with men and sperm . . . is inconsistent with lesbian identity” (Epstein, 2002, p. 47). Second, there exists a general marginalization experienced by many bereaved mothers, particularly after perinatal death (Cacciare, 2008, 2009). These factors, of course, occur in addition to the marginalization they may already face from their families and society in general. Lesbians who use social services often complain that their family structure or pattern is not recognized or valued (Gildersleeve & Platzer, 2003). Being a bereaved lesbian parent is a type of double-disenfranchisement.

LIMITATIONS

Although the findings of this study are useful, and no other studies like it have been conducted, there are limitations that may better guide future explorations of this topic. The case-study method is used to explore, describe, and explain phenomena in the context of participants’ lived experiences. Yet results are often not generalizable (Stake, 1994; Yin, 1989). Thus, although the experiences of these six participants are important and meaningful, they may not necessarily be representative of the greater gay and lesbian community. All participants in this study were lesbians. Understanding the perspectives of homosexual bereaved fathers would be extremely beneficial for researchers and clinicians. Finally, although this study contained a variety of different ethnic groups, some minority groups were not represented.

IMPLICATIONS FOR SOCIAL WORK PRACTICE

A collective-focused, multiple-case-study design assists clinicians and academics in better understanding a subculture’s needs, both those met and
The participants in this study provided cohesive data that could be used to drive treatment and policy and that is client centered and appropriate for nontraditional family systems. Common to all participants was the importance of education and culturally competent practice when working with the gay and lesbian population. Thus, as the definition and structure of the nuclear family evolve, clinicians should revisit their personal biases and beliefs about homosexuality and parenting. In addition, bereavement-specific training is necessary to the provision of compassionate care to gay and lesbian families grieving the death of a child. Each participant expressed, in one way or another, how she longed to feel safe and comfortable in the therapeutic setting. Proper academic and clinical training for this doubly disenfranchised group will help prepare practitioners to provide such a place. It is important for the gay and lesbian parenting population to have a represented voice in policymaking. For example, one participant expressed her dismay when filling out her baby’s Certificate of Birth Resulting in Stillbirth. The document contained places for “Mother” and “Father.” She noted that perhaps a satisfactory alternative, requiring both a policy and an attitude change, would be “Parent 1” and “Parent 2.” Some feminist thinkers have posited a redefinition of parenthood. Polikoff (1990), for example, suggested a legal reconstruction of the definition of parenthood to include anyone in an intentionally functional parental role.

The present study also demonstrated the hesitancy of lesbians to fully disclose their identity, even within their own social groups, for fear that they may be seen differently or that their grief may be minimized. It is important for practitioners to realize the challenges facing lesbian families and to validate their experiences. Clinicians should become familiar with local gay and lesbian support services and make contact with local bereaved parent support groups prior to referral to ensure that a group is friendly to alternative family systems.

The Sheffield Health and Social Care Trust (2008) issued recommendations consistent with these findings that can be augmented when working with bereaved lesbian mothers: It is necessary to

- include homosexual families in strategic planning for bereavement support;
- include this population explicitly in service provider policies and language and to use models of intervention that are free of heterosexual language;
- seek training and education, specifically on alternative family systems and traumatic bereavement;
- understand the potential increased risk of suicidality and self-harm for many disenfranchised individuals after traumatic loss;
- create and maintain a sensitive milieu that is mindful of positive images that reflect diversity in relationships;
- provide resources that address both nontraditional families and bereavement issues;
- consider mental health issues comorbid with traumatic loss and social isolation that may result from double-disenfranchisement;
- include partners and families of choice actively in interventions;
- engage in ongoing consultation with the lesbian and gay communities, the bereaved parent community, and their caregivers; and,
- for academics, initiate more emergent and sensitive research with this population.

In sum, the message from the lesbian mothers in the present study is that practitioners should be compassionate and honest (regardless of the seriousness of a child’s prognosis), proactively engage in bereavement education with nontraditional families, be willing to challenge traditional definitions of family and social roles, and consider systemic oppression in the context of supporting nontraditional families. It is crucial for caregivers to recognize and validate the unique struggles of lesbian bereaved families, particularly during crisis itself, by depathologizing then validating and legitimizing these families, each individual’s motherhood, and their losses. Social workers, in particular, carry a professional responsibility to advocate for and assist those who have been pushed into the shadows. This research study provides a glimpse into the world of bereaved lesbian parents. Though more social science research on this population needs to be conducted, this study may provide the basis for new discussions among social workers who will heed the urging to become better informed service providers to this underrepresented group.

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