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Lesbian, gay, bisexual, and transgender families and health

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Abstract

Research consistently demonstrates that family relationships are key determinants of health, but most research on health and families focuses on a heterosexual and cisgender context. Sexual and gender identities often are overlooked or erased in family and health research. We present an overview of the current state of research on LGBT families and health, using a life course approach and pointing to the ways that LGBT people's experiences of families occur within a broader social structural context, with implications for their health and the health of their family members. We focus on parenthood, parent–child ties, intimate relationships, and caregiving. We also identify two theoretical obstacles for studies of LGBT families and health as well as important research areas for moving forward, such as the inclusion of non-binary and queer identities in our studies of family and health. Incorporation of LGBT and other queer families and family forms into our health research interrogates assumptions within family and health research and offers insight into how to move the field forward.

1 | INTRODUCTION

Family relationships are a key determinant of morbidity and mortality. Most research to date focuses on the benefits of families for health (Carr & Springer, 2010; Umberson, Thomeer, & Williams, 2013). For example, married people have better health on average than single people, partly due to the social, legal, and economic benefits of marriage (Thomeer & Short, 2018). At the same time, family relationships can have negative impacts on health (Carr & Springer, 2010). For instance, parents have worse health than adults without children, likely because of the financial strain and overall stress that is associated with childrearing (Umberson, Pudrovska, & Reczek, 2010). Generally, supportive family relationships benefit mental and physical health, whereas stressful family relationships are detrimental to health (Umberson & Karas Montez, 2010). Families also serve as key sites for many health-related practices, including caregiving. Mental and physical health and health behaviors (e.g., drinking alcohol and exercising) often spread within families, such that the health of one family member has health implications for other family members (Pachucki, Jacques, & Christakis, 2011; Thomeer, 2016).

Families are a pervasive institution across diverse global communities, yet most research on families and health focuses on a heterosexual and cisgender context (e.g., considering the health benefits and costs of heterosexual

marriage or examining health within the parent–child tie without consideration of sexual orientation or gender identity). According to recent estimates, 4% of U.S. adults identify as lesbian, gay, or bisexual (LGB), and 0.6% identify as transgender (Flores, Herman, Gates, & Brown, 2016; Gates, 2014). Further, as of 2015, almost 2 million U.S. adults are in same-sex relationships, and between 2 million and 3.7 million children are being raised by lesbian, gay, bisexual, and transgender (LGBT) adults (Gates, 2015; Gates & Newport, 2015). Social science research has begun to consider what these family forms and relationships mean for people's health. This nascent body of work, however, is troubled by numerous data limitations (for overview of some of these issues, see Umberson, Thomeer, Kroeger, Lodge, & Minle, 2015) and faces two theoretical obstacles.

First, research on family and health has been conducted within a rapidly changing sociopolitical landscape. Historically, most LGBT people and their families faced high levels of stigma, as outlined in Meyer's minority stress framework (1995) and supported by empirical research (Institute of Medicine, 2011). According to this framework, minority populations experience both unique minority stressors (e.g., discrimination and internalized homophobia) and general stressors in ways that negatively impact health (Meyer, 1995). LeBlanc, Frost, and Wight (2015) expand this model to consider stressors experienced at the individual level, the couple level, and—as we highlight—the family level through widespread marginalization of LGBT people and same-sex families (see also Frost et al., 2017). Moreover, structural level stigma—such as the presence or absence of statewide antidiscrimination policies—significantly impacts health (see Hatzenbuehler, 2017; Hatzenbuehler et al., 2014).

Recent gains made at the structural level may have lessened the frequency, intensity, and impact of stigma-related stressors for LGBT families. For example, same-sex marriage only became legal throughout the U.S. in 2015; increased public awareness about transgender individuals may have reduced stigma faced by gender identity minorities; and LGBT children come out to their families at younger ages than in previous cohorts and often to much less resistance (Russell & Fish, 2016). Yet sociopolitical change has not been uniformly positive; recent public debates about (and passages of) legislation rolling back protections for LGBT people, for example, may have increased LGBT individuals exposure to stigma (Tucker & Meier, 2016; Veldhuis, Drabble, Riggle, Wootton, & Hughes, 2017). In the face of these rapid developments, it is imperative that we place past studies on LGBT families and health within their historical context and conduct future research with attention to these changing sociopolitical structrures.

Second, most theories on families and health have been developed from decades of family and health research within a heterosexual and cisgender context, and whether or not these theories are extendable to LGBT family contexts remains an open question. Scholars have called for an intersectional approach to family research, both to point out what groups are often overlooked within family and health research as well as to draw attention to the intersecting structural forces that oppress and privilege certain family forms in ways that matter for health (Lodge, Paine, & Umberson, 2017; Moore & Stambolis-Ruhstorfer, 2013). Related to this call are steps to “queer” family research, interrogating and expanding existing family theories through the inclusion of sexual and gender minorities (Oswald, Kuvalanka, Blume, & Berkowitz, 2009; Umberson, Thomeer, & Lodge, 2015). In our overview of the family and health literature, we identify ways in which inclusion of LGBT families queers our existing paradigms and discuss how best to accomplish this goal moving forward.

To highlight these theoretical obstacles, we provide an overview of the current state of research on LGBT families and health, drawing on a life course perspective, which posits that the most salient family relationships shift across each stage of life (Elder, 1994). We differentiate between research on sexual minorities and research on gender identity minorities, as most research is conducted separately with these two groups, reflecting their different social context—but also, typically, ignoring intersections between them (Herman, 2016). After summarizing work on the health of both children raised by same-sex couples and transgender parents (also considering the health of the parents themselves) and how relationships with parents shape the health of LGBT children, we review work on LGBT adults, including how intimate relationships and familial caregiving impacts health. We conclude by discussing the importance of accounting for shifting structural contexts and queer intersectional analyses in order to advance the field of LGBT families and health.

2 | LGBT PARENTS AND HEALTH

A key strand of research related to LGBT families considers the health of children raised by same-sex couples—and to a lesser extent, the health of the parents themselves. Most of this research compares health outcomes of children raised by same-sex couples to children raised by different-sex couples. Building on understanding of minority stress as well as traditional family and health paradigms, there are reasons to expect that children raised by same-sex couples might have different health outcomes than children raised by different-sex couples. As suggested by a minority stress framework (Meyer, 1995), LGBT parents and their children face high levels of discrimination from a variety of sources, including extended family, other parents, schools, and pediatricians, and discrimination is linked to worse health (Perrin et al., 2013). During the study periods for most research on same-sex parenting and children's health, same-sex marriage and even adoption was prohibited in most states, meaning same-sex parents had fewer legal protections and encountered more legal obstacles than different-sex parents (Goldberg, Gartrell, & Gates, 2014). These barriers may have contributed to less stable relationships for same-sex parents, and parental relationship instability has been shown to negatively impact children's health (Perrin et al., 2013).

Moreover, according to a traditional family and health paradigm, being raised by two women or two men may have different health consequences for children than being raised by a man and a woman (see Reczek & Umberson, 2012). Although some have hypothesized that two mothers or two fathers are detrimental for a child's well-being (Drury, 2014), others suggest that the egalitarian parenting arrangements more common among same-sex couples may result in increased levels of parenting attention from both parents, resulting in health benefits for children (Perlesz et al., 2010; Prickett, Martin-Storey, & Crosnoe, 2015). Some even suggest that two women as parents may be beneficial for the health of children, as women tend to focus more on the health and well-being of their family members than men (Reczek & Umberson, 2012).

Alternatively, some scholars reject a traditional family and health perspective. Instead, they use an intersectional approach to argue that we must account for different paths to parenthood, sociodemographic and racial/ethnic differences, and family instability when studying the health outcomes of children raised by same-sex compared to different-sex parent households. Such differences, they argue, explain disparities (Manning, Fettro, & Lamidi, 2014). This is deemed the "no differences" hypothesis. Any observed differences, these scholars argue, are driven by selection among same-sex couples with children—especially socioeconomic selection (Gates, 2012)—not causal links between parents' sexuality and children's health outcomes. Most recent studies support the no difference hypothesis, finding that the health of children raised by same-sex couples is similar to the health of children raised by different-sex couples after controlling for demographic and socioeconomic differences as well as relationship stability (Farr, 2017; Manning et al., 2014; Patterson, 2017).

For instance, studies using the National Longitudinal Lesbian Family Study and a matched sample conclude that children raised by lesbian couples from birth have similar psychological well-being as children raised by heterosexual couples (Gartrell & Bos, 2010; Van Gelderen, Bos, Gartrell, Hermanns, & Perrin, 2012). An analysis of the National Survey of Children's Health, a nationally representative study, matched continuously coupled lesbian women to different-sex couples and found no difference in children's general health or emotional difficulties (Bos, Knox, van Rijn-van, & Gartrell, 2016), and an analysis of the National Health Interview Survey (NHIS; another nationally representative dataset) concluded that children in same-sex married households have similar health as children in different-sex married households—just as children in same-sex cohabiting households have similar health as children in different-sex cohabiting households (Reczek, Spiker, Liu, & Crosnoe, 2016). These studies point to the issue of changing social structures, suggesting that differences found in previous studies between same-sex and different-sex parenting may reflect same-sex couples' lack of access to marriage.

There is almost no research on the health of children with transgender parents or even strong theory on what to expect (Stotzer, Herman, & Hasenbush, 2014). One older study using a purposive sample of 18 children of transgender parents found that having a transgender parent did not affect children's developmental milestones (Freedman, Tasker, & di Ceglie, 2002). As with same-sex couples, there are many different paths to parenthood for transgender

adults, making studying the health of their children especially difficult (Pyne, Bauer, & Bradley, 2015). In the case of a parent transitioning with minor children, children's well-being was found by one study to be impacted by whether or not the cisgender parent was transphobic or alternatively accepting of the transgender parent (White & Ettner, 2004).

What about the health of LGBT parents? Consistently, parents have been shown to have worse health than non-parents, due in large part to the emotional, physical, and financial stress of having children (Umberson et al., 2010), yet little attention has been given to sexual and gender identities of parents with most studies assuming heterosexual and/or cisgender identities. Some small studies have found that same-sex parents do report similarly high levels of stress as different-sex parents (Goldberg et al., 2014; Goldberg & Smith, 2014), although Bos et al. (2016) found that lesbian couples reported significantly more parenting stress than heterosexual couples. Examining the intersection of parenthood and gender is also important for understanding how children impact health. Analysis of the American Time Use Surveys concludes that gay fathers spend less time in self-care activities than heterosexual fathers, whereas lesbian mothers spend more time engaging in self-care than heterosexual mothers (Augustine, Aveldanes, & Pfeffer, 2017). We do not know how this translates to long-term health outcomes. Further, although the health of transgender and sexual minority parents remains largely unexamined, because they face more discrimination than cisgender and heterosexual parents (including difficulties gaining child custody in courts), this may lead to more parenting stress and perhaps worse health (Pyne et al., 2015).

3 | LGBT CHILDREN AND RELATIONSHIPS WITH PARENTS

Shifting focus from LGBT parents to LGBT children, the past decades of research consistently demonstrate that many LGBT children face rejection from parents after coming out (Chung, Oswald, & Wiley, 2006; Grossman, D'augelli, & Salter, 2006) and that rejection from parents is highly associated with a wide array of negative health outcomes (Bouris et al., 2010; Russell & Fish, 2016; Ryan, Huebner, Diaz, & Sanchez, 2009), in line with a minority stress framework. For example, young LGB adults who report higher levels of family rejection during adolescence are 8.4 times more likely to report having attempted suicide (Ryan et al., 2009). Separately, transgender children who are rejected by parents are at higher risk for physical, emotional, and sexual abuse, which have long-term negative health consequences, including greater risk of attempting suicide and engaging in risky sexual behavior (Grossman et al., 2006; Grossman & D'Augelli, 2007; Grossman, D'augelli, & Frank, 2011). This continues into adulthood, as a study of transgender and gender non-conforming adults found greater risks of suicide attempts and drug and alcohol abuse among those rejected by their families (Klein & Golub, 2016).

At the same time, as we would expect based on shifting social contexts and an intersectional perspective, not all LGBT children face rejection. Some report high levels of support and acceptance from their parents, although work on support and acceptance often focuses on LGB youth and overlooks transgender children (Russell & Fish, 2016) or groups LGBT youth together and neglects to differentiate between groups, often because of small sample sizes (Simons, Schrager, Clark, Belzer, & Olson, 2013). Studies consistently show that parents' support for their LGB children can provide a buffer against other sources of stress (e.g., bullying at school), leading to fewer health issues including lower rates of depression and less risky sexual behaviors compared to peers who lack familial support systems (D'Amico & Julien, 2012; Freitas, D'Augelli, Coimbra, & Fontaine, 2016; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). For example, a study of LGB adolescents found that acceptance from one's mother after coming out serves as a protective factor against risky substance use (Padilla, Crisp, & Rew, 2010). Likewise, limited studies suggest that parental acceptance and support is key to protect against poor mental health and suicidality among transgender children (Grossman et al., 2011; Olson, Durwood, DeMeules, & McLaughlin, 2016; Simons et al., 2013). These relationships continue to be important later in the life course; one study of lesbian and gay adults found that more acceptance from parents lessened negative psychological impacts of internalized homophobia (Feinstein, Wadsworth, Davila, & Goldfried, 2014). But, as Bouris et al. (2010) note, most research focuses on how parents negatively impact their children, rather than considering resiliency on behalf of the children themselves or positive impact from parents.

Moreover, a lack of attention to intersectionality—in particular, the similar or different experiences of children across racial/ethnic and socioeconomic groups—comprises an urgent gap in this literature (Russell & Fish, 2016).

Research on LGBT children and health primarily focuses on parent–child relationships, but, according to a family systems approach (Kreppner & Lerner, 2013), there are other family ties that should be considered, including grandparent–grandchild ties and siblings. For LGBT grandparents, being able to disclose sexual and/or gender identity to grandchildren, as well as feel supported by grandchildren, is an important aspect of overall well-being (Orel & Fruhauf, 2013). A study of 79 gay grandfathers, for example, found that grandfathers who felt supported in their sexual identity by their adult children and their grandchildren reported better mental health (Tornello & Patterson, 2016). In addition to considering the health of LGBT grandparents, future research should also consider how the grandparent–grandchild tie impacts the well-being of LGBT grandchildren. We also expect that rejection from siblings and non-disclosure to siblings is associated with worse health outcomes for LGBT people, just as seen in parent–child ties, but this has not been closely examined (Rothblum, 2010).

4 | LGBT ADULTS IN INTIMATE RELATIONSHIPS

After childhood, health influences from parents decline in importance, and other relationships—such as intimate relationships—become more salient. Studies find that intimate relationships, especially marriage but also cohabiting and dating relationships, have important implications for health (Umberson & Karas Montez, 2010). They are a key source of social support, social control, and other resources (e.g., financial resources and health insurance), and more committed and legally supported relationships (e.g., marriage) are more beneficial for health (Umberson & Karas Montez, 2010). Yet conventional understanding that intimate relationships benefit health through previously identified and tested mechanisms is based almost exclusively on studies of heterosexual and cisgender couples. Questions about what marriage and cohabitation mean for the health of LGBT adults have only recently received attention, mostly on same-sex couples.

Most population-level studies on same-sex relationships and health were conducted prior to the overturn of the Defense of Marriage Act (DOMA), meaning that most studies have not considered the benefits of same-sex marriage—only same-sex relationships. These studies support the traditional understanding of relationships and health, generally concluding that same-sex cohabiting relationships are less beneficial to health than different-sex marriage relationships but more beneficial to health than being single or in a different-sex cohabiting relationship (Gonzales & Henning-Smith, 2015; Liu, Reczek, & Brown, 2013). For example, a large study of NHIS found that same-sex cohabiting adults have a higher risk of smoking than different-sex married adults (Reczek, Liu, & Brown, 2014). Studies that have been able to consider marriage find that same-sex married adults have better health than same-sex cohabiting adults and similar health as different-sex married adults (Reczek et al., 2014; Wight, LeBlanc, & Lee Badgett, 2013). There is generally little attention to whether the benefits of same-sex relationships vary by gender, race, or other sociodemographic categories, although preliminary evidence indicates that they do (Liu et al., 2013). For example, regarding gender, an analysis of the American Community Surveys found that same-sex cohabiting women have worse health than same-sex cohabiting men and different-sex cohabiting and married couples (Baumle, 2014).

What, then, are the mechanisms linking intimate relationships to better health among same-sex couples? Recent research has primary tested processes identified from studies of different-sex couples, for example, social control (i.e., indirect and direct efforts to improve someone else's health, Umberson, 1992), and finds these same processes operate within same-sex couples (Reczek, 2012; Reczek & Umberson, 2012). In Reczek and Umberson's (2012) study of same-sex cohabiting couples, they found that gay and lesbian couples discuss ways in which their partner improves their health (e.g., encouraging reductions in alcohol consumption). But whereas heterosexual couples' health work is often marked by gender inequality, Reczek and Umberson found that same-sex couples frequently engage in cooperative health work, such that both spouses simultaneously work to improve one another's health. Yet, congruent with findings from studies of heterosexual couples, intimate relationships are not universally good for health (Umberson,

Williams, Powers, Liu, & Needham, 2006). Gay and lesbian couple's also contribute to one another's unhealthy habits (Reczek, 2012). For instance, couples may eat junk food when together, even if they would avoid junk food on their own.

With same-sex couples, we also must expand beyond traditional family and health models and consider other factors, most notably discrimination and stigma. Same-sex couples face higher levels of discrimination and minority stress than different-sex couples, with negative implications for their relationship well-being and their overall health (Cao et al., 2017; Frost et al., 2017). On the macro level, same-sex marriage bans were a source of structural stigma, the absence of which improves well-being of sexual minority children and adults, regardless of partnership status (see Hatzenbuehler et al., 2014). In a series of natural experiments, researchers concluded that same-sex marriage bans compromised the health—especially the mental health—of sexual minority people (Hatzenbuehler et al., 2012; Hatzenbuehler et al., 2014; Hatzenbuehler, McLaughlin, Keyes, & Hasin, 2010). The effect of reducing structural stigma may even extend beyond the target group (in this case, sexual minorities); one study found a 7% reduction of all youth suicides in states that allowed same-sex marriage (Raifman, Ellen, Bryn Austin, & McConnell, 2017).

The literature on transgender couples and health is more limited, and, to date, most of it focuses on transgender people in relationships with cisgender people of a different gender (e.g., transgender men coupled with cisgender women) (Moore & Stambolis-Ruhstorfer, 2013). Intimate partner relationships are sources of social support and identity affirmation for transgender people (Nuttbrock et al., 2009; Pfeffer, 2016), and transgender married people report lower levels of perceived discrimination than cohabiting or previously married transgender people (Liu & Wilkinson, 2017). Most research in this area has focused on health benefits of relationships during the transition period. An international study of female-to-male transgender people found that partnered transgender adults reported fewer depressive symptoms than their single counterparts (Meier, Sharp, Michonski, Babcock, & Fitzgerald, 2013). Yet transitioning within a relationship places unique stressors on relationships, which may yield negative health consequences for both partners (Lenning & Buist, 2013; Meier et al., 2013). In the same vein, cisgender partners of transgender adults report performing significant amounts of gendered emotion work for the purpose of helping transgender partners materialize and affirm their identities, both during and after the transition process (Pfeffer, 2008). This stress is in addition to any discrimination transgender people and their partners may face, likely carrying negative health consequences. In these ways, gender identity minorities face stressors in their adult relationships, which sexual minority individuals do not—yet these stressors are not well understood.

A key limitation in this area of research is that we do not know the health implications of relationship dissolution for LGBT people, in part due to data issues and shifting sociopolitical environments. Research on heterosexual married couples consistently shows that divorce and widowhood contributes to worse health, at least in the short term, largely through the stress of relationship dissolution and the loss of resources associated with marriage (Umberson et al., 2013). Research suggests that same-sex couples break up and divorce at similar rates as different-sex couples (Rosenfeld, 2014), but we do not yet know if the health consequences of relationship dissolution are similar. One reason to expect differences is that same-sex couples in marriage-like relationships prior to the legalization of same-sex marriage navigated relationship dissolutions without legal supports or recognition, which may have contributed to worse health outcomes (Goldberg, 2010).

5 | LGBT FAMILIES AND CAREGIVING

A critical way that families impact health is through providing care and support during illness and at the end of life, and, although this is an important resource for care receivers, providing care carries physical and mental health and mortality risk for (heterosexual and cisgender) caregivers (Yee & Schulz, 2000). Yet caregiving is also highly prevalent among LGB populations, as about one third of sexual minority adults provide informal caregiving and many care for parents (Fredriksen, 1999). Some research suggests that LGB adult children actually provide more care—or at least

more extensive care—for their parents than their heterosexual siblings, even in the context of homophobic rejection (Price, 2011; Reczek & Umberson, 2016). Traditional understanding of family and health notes that caregiving is beneficial to care receivers but largely detrimental to the health of caregivers themselves (Yee & Schulz, 2000). This is replicated among LGB caregivers, who experience high rates of psychological distress regardless of whether caring for a spouse, a parent, or another loved one (Hash, 2006). Insight into the health implications of caregiving among gender identity minorities comprises a key area for future research. To date, we know very little about the experiences of transgender individuals when it comes to caregiving, although Pfeffer (2016) finds that intensive support from partners plays a key role in experiences of social and medical transition processes.

Yet, in opposition to expectations of family care among heterosexual and cisgender adults but in line with the minority stress paradigm, even though LGB adults provide care for extended family members, they do not tend to receive care from these individuals, and instead, studies find that LGBT adults with care needs rely on partners, spouses, and friends (Cantor, Brennan, & Shippy, 2004; Fredriksen-Goldsen, 2007). As an additional unique dynamic, same-sex couples in which one partner provides care to the other are at high risk for discrimination (Brotman et al., 2007), and experiencing discrimination is a risk factor for depression among same-sex caregiving couples (Fredriksen-Goldsen, Kim, Muraco, & Mincer, 2009). Other studies of same-sex couples and caregiving identify unique health dynamics within these populations as compared to different-sex couples. For instance, men and women in same-sex marriages provide more emotional care for their spouse than men and women in different-sex marriages, and women in same-sex marriage provide and receive more instrumental care than any other group (Umberson, Thomeer, Kroeger, Reczek, & Donnelly, 2017). Women in same-sex relationships also describe themselves as more invested in their care work than men in same-sex relationships, with likely mental and physical health implications for both caregivers and care receivers (Thomeer, Reczek, & Umberson, 2015; Umberson, Thomeer, Reczek, & Donnelly, 2016).

An additional focus of research is on expectations for future care among LGBT adults, especially given changing social structures. Heterosexual and cisgender couples tend to expect to rely on parents, children, and formal systems for care, but LGBT adults are less likely to be married or have children, more likely to be estranged from extended family, and more likely to expect to experience discrimination from formal systems, such as nursing homes (Cartwright, Hughes, & Lienert, 2012; Hash & Netting, 2007). A qualitative study of 45 gay, lesbian, and heterosexual mid-life couples found that same-sex couples tend to have advance directives and detailed plans for their future care because of their concerns about discrimination from family members, not having family members to rely on for care, and lack of legal protections (Thomeer, Donnelly, Reczek, & Umberson, 2017).

Researchers have also examined the role of friends in caregiving among LGBT adults, with scholars arguing that this care is fundamental within LGBT communities but often invisible and not well supported by outside institutions or other people (Muraco & Fredriksen-Goldsen, 2011; Shiu, Muraco, & Fredriksen-Goldsen, 2016). Friends are often overlooked in studies of family and health more generally, although it is likely they impact family and health dynamics across many different populations. Qualitative work on care received from friends finds that both caregivers and care receivers obtain benefits from care arrangements, although the caregiving process alters relationships in fundamental ways (Muraco & Fredriksen-Goldsen, 2011). Although among LGBT adults, caregiving for a friend is associated with lower caregiving demands than caring for a family member or intimate partner, it is also associated with less support and, in turn, more depressive symptoms (Shiu et al., 2016). Friends may be especially important for the health of transgender people during and after transition processes, although this is not well studied (Meier et al., 2013).

6 | FUTURE RESEARCH AND CONCLUSION

Over the past few decades, researchers have made important contributions to the LGBT families and health literature, increasing our understanding of the implications of family relationships for the health of LGBT individuals and their family members and challenging previous work that assumes a heterosexual and cisgender context. As this research

continues, it must take into account rapidly changing social structures, as well as socioeconomic and demographic diversity, and continue to interrogate and challenge traditional understanding of family and health.

Research on families and health within an assumed heterosexual and cisgender context may overlook important elements and dynamics within families, and the inclusion of LGBT people and their families can offer an important corrective. As one example, the family and health literature needs more research on the role of families of choice (i.e., voluntary social relationships with non-blood or marriage-related individuals that serve the same function and purpose of "traditional families," Mouzon, 2014), especially for the health of LGBT individuals. Research on families of choice among Black adults indicates these relationships positively impact health, perhaps more so than traditional family relationships due to their voluntary nature (Mouzon, 2014). Research should investigate whether these same processes exist among LGBT families of choice, moving beyond legal or biological family categories. Researchers have begun to consider this in regard to caregiving (Muraco & Fredriksen-Goldsen, 2011), but what health impacts do families of choice have at other stages of the life course?

Building on insight gained from work that "queers" the family (Oswald et al., 2009), imposing traditional family and health paradigms founded upon binary understanding of sexuality and gender on studies of LGBT families may lead us to erase important differences among sexual and gender identity minorities. Most studies of LGBT families focus on lesbian and gay individuals (and to a lesser extent, transgender individuals) to the detriment of our broader knowledge about those who do not identify within dominant binary categories, for example bisexual, pansexual, queer, genderqueer, and non-binary individuals. Future studies should ask, for example, do family relationships carry the same health implications for queer individuals as they do for lesbian and gay individuals? Likewise, although non-binary gender identities are becoming increasingly common (Richards et al., 2016) and within transgender populations, gender non-conforming individuals may be at highest risk of discrimination (Miller & Grollman, 2015), studies tend to group all transgender people together without attention to specific identity or gender presentation. This lack of specificity further troubles most research on same-sex couples and same-sex parenting and health, which presumes a lesbian, gay, or heterosexual identity as well as a cisgender identity without explicitly addressing these identities. Thus, for example, bisexual individuals within different-sex relationships are largely invisible within analyses, and the impact of gender identity on health and family is likewise unknown. Research on the health impact of mixed-orientation relationships or intimate relationships between two transgender partners is also largely non-existent. Among LGBT groups, more generally, people who challenge traditional gender and sexuality dichotomies—most notably bisexual people, genderqueer people, and "mostly" heterosexual people are at heightened risk for mental and physical health issues (Institute of Medicine, 2011), yet research has not considered what this may mean for family relationships and health.

Similarly, there is considerable heterogeneity within LGBT families in terms of the oppressions and privileges faced, and this has important implications for health (Institute of Medicine, 2011). Most research on LGBT families and health has neglected racial, ethnic, and socioeconomic differences, but given the well-known disparities in health and family across these groups, this constitutes an urgent gap for future research. Currently, it is unclear how findings on LGBT family health do or do not apply to non-White and non-middle class LGBT individuals and families. How do race/ethnicity and socioeconomic status shape the health of LGBT people in the family context? In addition to a lack of understanding about the diverse experiences of LGBT people of different socioeconomic and demographic groups, additional sources of diverse experiences should be addressed in future research. As a life course perspective suggests, the health consequences of sociopolitical change likely depends on age and cohort, requiring future scholars to use careful age-period-cohort analysis to parse the health impacts of our changing social contexts (Yang, 2008). Likewise, gaps in our understanding of the role played by regional and geographic variation should be addressed in future research, perhaps through the use of quasi-natural experiments (Hatzenbuehler, 2017) and multi-site comparative studies (Brown-Saracino, 2015).

Research in LGBT families and health provides opportunity to both transform how family is defined and create a more inclusive and representative definition of what family is and can be, in ways that matter for health and well-being. A comprehensive overview of the research on LGBT families and health points to the current strengths as well

as shortcomings in our understanding of families and health and by moving away from the heterosexual and cisgender narratives provides opportunity to challenge and recreate dominant assumptions and theories about families and health. We urge scholars to take up an intersectional queer approach and attend to changing structural factors in order to address urgent gaps in knowledge and advance the field of LGBT families and health.

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