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Good and Healthy Parents. Non-Heterosexual Parenting and Tricky Alliances

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Abstract

Does a challenge to heteronormative assumptions on parenting also involve a challenge to an imperative of good parenting bearing the responsibility of raising healthy, well-developed children, endowed with the resources to achieve happiness, and to avoid social and personal pathologies? Or is this notion, and the medicalised frame upon which it is grounded, rather mobilised for the social and legal recognition of diversity in the forms good parenting can take?

Seeing non-heteronormative parenting as an intergenerational issue, involving parents dealing with LGBT children as well as LGBT adults as parents, the article explores the appeal of medical frames in collective self-representations of their advocates, drawing on international literature to read the Italian context. Some problematic implications of this appeal concern who gets voice as legitimate expert, which models of good parenting are sustained, and how they contribute to upholding social hierarchies.

Keywords: same-sex parenting, medicalization, families of origin, Italy, therapeutic culture.

1. Introduction

The article addresses the meanings and workings of clinical frames in self-representations and claimsmaking strategies around parenting and non-heterosexual identities, experiences and rights.

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It asks whether a challenge to heteronormative assumptions on parenting also involves a challenge to an imperative of good parenting bearing the responsibility of raising healthy, well-developed children, endowed with the resources to achieve happiness, and to avoid social and personal pathologies, or whether this notion, and the medicalised frame upon which it is grounded, is rather mobilised for the social and legal recognition of diversity in the forms good parenting can take.

Seeing non-heteronormative parenting as an intergenerational issue, involving parents dealing with LGBT children as well as LGBT adults as parents, we will explore the appeal of medical frames in collective self-representations of their advocates, drawing on international literature to read the Italian context. Some problematic implications of this appeal concern who gets voice as legitimate expert, which models of good parenting are sustained, and how they contribute to upholding social hierarchies. We will finally ask how to detect, and make space for, different understandings of parenting, both individually and collectively.

2. Good and healthy parenting

The move towards domestication of homosexuality which is taking place especially, albeit not only, in Western countries, including the growing social and legal recognition of same sex partnerships and of lesbian and gay parenting, has been discussed in terms of whether it represents a fundamental challenge to the heteronormative foundations of citizenship (Weeks, 2007), or a contribution to their reproduction by upholding the primacy of the privatised nuclear family. Bell and Binnie (2000) have pointed to the problematic compromise involved in claiming for citizenship rights, since access to rights is conditional upon compliance with the obligations of a 'good citizen', which include letting his/her sexuality being '*confined* in all senses of the word: kept in place, policed, limited' while displaying in public a de-politicized and de-eroticized authentic self (Bell, Binnie, 2004). In this respect, claims for partnership and parenting rights resonate with neoliberal forms of social regulation, promoting individual responsibility and the privatization of care (Richardson, 2005).

This move has been interpreted as part of the more general process of familialization of social regulation by which the family is being constructed as 'a place where desires for the fulfilment of the self can be satisfied' (Rose, 1989: 201). In the specific declinations this process takes in times of neo-liberalism and its 'new regime of the actively responsible self' (Miller, Rose, 2008: 214; Richardson, 2005), parents in particular – within the family – are

assigned the responsibility of reproducing normality, endowing their children with the capacity to maximize their self-fulfilment and happiness (Rose, 1996). Parents are thus assigned the responsibility not only for the 'well-being', but for the 'well-becoming' of children, their life chances, which coincide with the capacity of self-optimization: the 'promotion of the self-determining, networked individual, liberated from gendered and classed expectations and ties' (Gillies, Edwards, Horsley, 2016: 225).

Class differences are in this way at the same time erased from view and reproduced in practice. Class assumptions inform the moral agenda of intensive family intervention that has been developing around the idea that bad parenting is 'the most significant and acute cause of childhood problems while good parenting offers a panacea for all social ills' (Dermott, 2012: 1). With poor life chances being ascribed to poor parenting, it has been argued, parenting works as 'a proxy for social class', with a regulatory focus on disadvantaged parents (in particular, mothers) as the way to prevent the intergenerational reproduction of personal and social ills (Gillies, Edwards, Horsley 2016).

This recurrent reference to the metaphor of 'social ills' helps us to recognize the clinical frames underpinning this moral agenda drawing the boundaries between good/healthy and bad/unhealthy/dysfunctional parenting.

This redefinition of parenting and childhood has also been read, mainly with a Foucauldian approach, in terms of the contemporary hegemony of therapeutic culture (Furedi, 2004, 2008), grounded upon emotional determinism in the understanding of wellbeing. Under this lens, parenting is considered for its potential emotional damages upon children, with the development of a 'code of mistrust' involving a growing surveillance on parents' behaviour and emotional deficits, both under the forms of an imperative of constant self-surveillance, and of the need for experts' advice and support (Hoffman, 2010; for a review and discussion of these perspectives, see Brownlie, 2014).

In that same direction, we can draw upon another theoretical perspective, the interactionist approach informing the theory of medicalization mainly developed by Conrad (Conrad, Schneider, 1992; Conrad, 2007) in order to detect the mechanisms at play in the definition of the boundaries of good and bad parenting in medical terms.

This concept has been used in broad terms as for the phenomena it covers (including psychologization, and much of what is described as the rise of therapeutic culture), while at the same time a debate has developed on its validity for the interpretation of current processes (Clarke, 2008; Bell, Figert,

2015). Nevertheless, its strength lays in the clear analytical definition of the mechanisms it identifies, and allows to detect (Conrad, 2015).

Central to this concept is the definitional issue: '"Medicalization" describes a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illness and disorders' (Conrad, 2007: 4). Normality is thereby redefined in terms of 'medical norms' (what is healthy/what is *unhealthy*).

Medicalization as a process works at different levels, including not only the institutional and interactive levels, but also a conceptual one, when 'a medical vocabulary (or model) is used to "order" or define the problem at hand' (Conrad, 1992: 211). This vocabulary has normative implications, since normality gets thereby redefined in terms of medical norms (what is healthy/what is *unhealthy*).

Being the definitional dynamic the crucial one, medicalization scholars argue, 'the greatest social control power comes from having the authority to define certain behaviors, persons and things' (Conrad, Schneider, 1992: 8), reducing them to clinical categories.

The social consequences of medicalization thus concern how social problems and subjectivities are redefined, and the role of medical knowledge, technologies and experts: 'The criticism of medicalization fundamentally rests on the sociological concern with how the medical model decontextualizes social problems, and collaterally, puts them under medical control. This process individualizes what might be otherwise seen as collective social problems' (Conrad, 1992: 224).

Applied to the processes we have described regarding parenting, it means that troubles or nonconformity to dominant moral standards are redefined in terms of unhealthy parenting practices, that bear damages to childrens' present and future health – their well-being as well as their well-becoming. The literature on brain science's influence upon child rearing norms, informing current discourses on the so-called 'neuroparenting' (Gillies, Edwards, Horsley, 2016; Macvarish, 2016) provides a recent example: child investment policies and life sciences are converging in a concern for healthy development needing careful intervention in the early years, out of the assumption that bad parenting practices have enduring effects not only on psychological well-being, but also on the very development of the childrens' brain.

One of the important effects of the process of medicalization is to individualize and depoliticize social problems. At the same time, Conrad (2007) reminds us that this process is also a form of collective action, and that one of the most important engines in the move from badness to sickness have been, and are, social movements and interest groups, often supporting the

pathologization of certain conditions in order to take advantage of its de-stigmatizing potential.

The history of homosexuality is an emblematic example of how collective identities were formed around claims for medicalization, de-medicalization, and, under some respects, re-medicalization (Greenberg, 1988; Epstein, 2003; Conrad, Angell, 2004).

Although this history has been studied and told in relation to the pathologization, and de-pathologization, of the individual's sexual orientation, the struggle around medical frames has also involved (as it still involves today) discourses and practices around relationships, including the intergenerational ones.

In a context of cultural and institutional strength of heterosexuality, parent/child relationships are assumed to be adequately reproducing a heterosexual social order. We can look at two ways in which this assumption can be challenged: from the side of parents, when non-heterosexual subjects perform parenting, and from the side of the children, when non-heterosexual subjects trigger a redefinition of their parents' expectations and role. The latter is perhaps less obvious, and it surely has been less studied, but it is likewise relevant in understanding how normative notions of parenting are mobilised when heterosexuality is put under question (Bertone, Pallotta-Chiarolli, 2015).

Addressing both these sides, in the following paragraphs I will explore the presence of medicalized frames in public self-representation and the use of self-help material by collective actors advocating for non-heteronormative parenting in the Italian context.

3. Putting parenting into the context of Italian heteronormativities

The literature I have been referring to comes from anglophone Western countries, and, as we know, it needs cautious translation in a context like Italy, where an important body of research is starting to provide a nuanced and contextualised knowledge on same-sex parenting (see e.g. Cavina, Danna, 2009; Bosisio, Ronfani, 2015; Everri, 2016), and on parenting non-heterosexual children (Bertone, Franchi, 2008).

Italian studies on non-heterosexual experiences and family relations have pointed to specific traits of heteronormativity in this country, related to the high levels of gender and class inequalities (Bertone, 2013), and to the persistence of hierarchies of family forms (Ottaviano, 2015) which are still entrenched in legal regulation. It has been argued that, given their institutional invisibility, for same sex parents 'the personal, subjective dimension must take on itself the burden of constituting a collective level, forcing the same-sex

family (and those supporting it) to make its private experience a political issue and to become its own guarantor' (De Cordova, Sità, 2014: 406). In this tension between subjective experiences and the missing social and legal legitimation, resorting to a model of intensive parenting based on the responsibility to choose the right caring and educational practices and resources for their children is both a social expectation (Serri, Lasio, Putzu, Lampis, 2016), and a strategy developed by parents themselves to create spaces of recognition around them (De Cordova, Sità, Holloway, 2016). In the quest for social categories to name and legitimize their experiences, same sex parents also deal with the growing strength of the biogenetic paradigm, partly drawing upon it in their genealogical narratives while overcoming it in practice in the fluid recomposition of their kinship representations (Grilli, Parisi, 2016).

Another important feature of the Italian context is its strong intergenerational understanding of family relations, beyond the nuclear family, which relates to a logic of subsidiarity, leaving families (also so-called 'troubled' families) with more room to sort it out themselves. It also relates to a persistence in intergenerational transmission of knowledge in childrearing limiting the cultural impact of expert knowledge, whose pervasive influence should nevertheless not be underestimated (Favretto, Zaltron, 2013). The strength of intergenerational ties also frames the experiences of LGBTQ people who are developing their identities and forming their personal communities while remaining strongly connected to, and often dependent from, their families of origin (Bertone, 2013).

4. Heteronormative parenting under challenge

Knowledge about how non-heterosexual identities and experiences are dealt with in parent-child relationships when it's LGBT children who are bringing this challenge in their families of origin has mainly been left to psychological and health studies. Investigating their visibility strategies in the family and family members' reactions to disclosure and their impact on children's well-being (De Vine, 1984; Waldner, Magruder, 1999; Beeler, Di Prova, 1999; D'Augelli, Grossman, Starks, 2005; Rothman, Sullivan, Keyes, Boehmer, 2012), these studies have, in the end, a practical aim: to provide advice about when disclosure is convenient, and when it might be dangerous, and about which precautions can be taken to reduce risks of distress or victimisation due to negative family reactions.

This aim is shared by a flourishing popular literature where parents of gays and lesbians or experts recount their experience and advice homosexual

youth and family members, in particular parents, about how to deal with disclosure and progress towards a full acceptance and good family relationships (e.g. Muller, 1987; Rafkin, 1996). Research on these advice books points out their therapeutic framing and identifies normalization as a main strategy presented to parents, reassuring them that their child is normal by rejecting what are defined as stereotypes about gender non conformity, sexual promiscuity and the immorality of the homosexual world (Martin, Hutson, Kazyak, Scherrer, 2010). The therapeutic frame also implies a normative, stage-model depiction of family reactions and of the process of acceptance (De Vine, 1996; for a critique see Beeler, Di Prova, 1999), which is interpreted by referring to grieving models – assuming that getting to know about one's child's gay or lesbian identity is always a traumatic experience for parents – and promoted the idea that parents should seek expert help, or self-help settings. Besides informing much research on the families of origin developed around the helping professions (Aveline, 2006), the narrative of 'parents coming out of grief', Broad (2011; Broad, Crawley, Foley, 2004) argues, also characterises parents' organisations like PFLAG (the US organisation of Parents, Families and Friends of Lesbians and Gays), echoing in this way a recurring structure of gay and lesbian coming out stories (Plummer, 2002).

In this framing, 'straight' families are given a rather passive role, as objects of a pressure to change: their only possibilities are progressing along the path towards full acceptance, or stopping at an earlier stage. What is largely neglected is the connection between family reactions and social change, in gay and lesbian experiences and in the interconnected social construction of homosexuality and heterosexuality. In this way, the privileged status of heterosexuality as a social norm not only remains unchallenged, representing the position from which acceptance and inclusion of othered, diverse possibilities can be made, and the conditions to be met in order to deserve such acceptance can be set.

If we look at the history of the organising of the families of origin of LGBT people in Italy, we can see the importance of the production of advice material and of self-help activities, paralleling the organisation's advocacy role. The foundation of Agedo (acronym of Association of parents of homosexuals), the main organisation of families and 'straight allies' of LGBT people, was triggered by a self-help book published in 1991: *Figli diversi* (Different children) written by a mother and her son, a well-known gay activist, journalist and historian (Dall'Orto, Dall'Orto, 1991). Warning parents that homosexuality cannot be changed, the mother reassures them that it's not their fault, and gives some basic advice, mainly on the basis of her own experience. Prejudice is treated as being rooted in a long, global history of intolerance of diversity. The book makes it clear that, rather than being

concerned with defining what homosexuality is and what are its causes, it aims at making room for the diversity of experiences. In relation to clinical knowledge, the concern seems to be here to de-medicalize, by dismissing the uses of psychoanalytic theories to blame parents for their children's homosexuality.

The book seems to correspond to the peculiar features of advice books on LGBT issues that Klesse (2007: 573) has identified in his analysis of gay relationship manuals, emerging 'at the intersections of a politicised self-help culture and commercial psychotherapy. Politicised approaches to self-help (such as consciousness raising, political counselling, switch-boards) have been important elements of lesbian and gay male liberation politics and community creation'.

Looking at changes of the self-help material in time, we can point to the differences with the last guide published in 2016, *Sei sempre tu* (It's always you) (Broggi, Ragaglia, 2016), where the voices of activists, the accounts of their experiences, and socio-historical contextualizations are decentralised, while experts and clinical frames gain centre stage. The book provides thus a very interesting case in which we can detect some of the basic mechanisms of the process of medicalisation.

The book is edited by two psychologists, with a short note by Agedo and a preface by a psychiatrist. Actually, one of the editors also presents herself as an Agedo activist and local leader, but her training as a psychologist is mentioned first. In his analysis of gay relationship manuals, Klesse (2007: 574) argues that 'The fact that manual authors stress their psychological professionalism to bolster the authority of their voices can be interpreted as an attempt to base their educational project on a strategy of "pastoral power"', recalling its Foucauldian depiction as a technique of government.

However, professional experts' definitional power does not only emerge from how authorship is presented. The definitional issue appears to be a main concern of the book: with the goal of offering correct information to parents, it provides a very articulated taxonomy of the dimensions of gender and sexual identities, based on what is presented as objective knowledge. An assumption that seems to lay under this effort is that good parents are supposed to be able to recognize and accept a clear, uncontroversial, ahistorical and ethnocentric system of classification of their children, validated by experts.

In providing these definitions and in giving account of the changes in psychiatric and psychological approaches to homosexuality and same sex parenting, the conflictual dimension of the struggle on definitions, and political actors like the LGBT movement, are erased. The process of

depathologization is interpreted as scientific progress due to new research results:

> The process of de-pathologization of homosexuality in the scientific field has been very long and complicated. In the landscape of the development of psychological and psychiatric sciences, in 1952 the American Psychiatric Association (APA) published the DSM1 [where] homosexuality appeared among the 'sociopathic personality disturbances.
>
> In 1957 Evely Hooker carried out an important experiment [...] The analysis of the result of these tests clearly showed that there were no differences between homosexual and heterosexual persons: there was no sign that could hit to the possibility of homosexuality being an disease.
>
> After 35 years of studies, in the DSM III-R of 1987, homosexuality was declassified and the possible difficulties of a homosexual persons are scribed to the interiorization of social hostility by that person, and not to homosexuality per se (Broggi, Ragaglia, 2016: 14).

Through the intertwining of scientific knowledge and some exemplary stories, accounts of experiences providing narrative schemata against which readers can judge their own experiences and behaviour (Klesse, 2007), a normative model of healthy parenting is conveyed, more outspokenly emerging in the section on practical advice. Grounded upon an imperative to 'talk about it' (Brownlie, 2014) as a basis for the building of authentic relationships in the family, the section goes in much detail in advising parents and educators about what to do and not to do with their children (or pupils), what are the wrong and the correct answers to give.

Finally, another dimension that has been highlighted in the processes of medicalization is the construction of vulnerability, upholding the hierarchy between experts and their patients, and between heterosexuality and homosexuality (Moon, 2005). The construction of expert discourse positions straight parents as vulnerable subjects needing guidelines and help, and their children as being at constant risk and suffering from minority stress and homophobia.

The position of the victim has the advantage of releasing from responsibility and guilt, and making one's involvement in the reproduction of social hierarchies invisible (Giglioli, 2014). In fact, the normative model of good, accepting parents is built against a countertype: the refusing parents, trapped into prejudices by their ignorance (or by their religious fundamentalism), unable to have an authentic dialogue with their children. In Italy, typically, we have media depictions of the peasant or underclass Sicilian father stabbing his gay son – or of the Arab one beating his lesbian daughter. Represented as falling out of the modernization project, their otherness is

plaid out in terms of class, race and ethnicity, and bears the risk of pathologization in the move from the metaphor of homophobia as a social disease, to its diagnosis as an individual disease.[1] But, as Giglioli (2014) argues, the victim is an in-fant (a non-speaking): it is not possible to speak as a victim, or on behalf of a victim, since speaking is the first form of agency, while the victim is only defined by what s/he is/has been subjected to: 'Reduced to what has been done to them, they have tears, but they don't have reasons. Their voice (...) is only useful to express pleasure and especially pain, not to deliberate in common on the right and the wrong. Their truth is in the other's gaze' (Giglioli, 2014: 19/20).

The changes we have detected here in advice books promoted by Agedo are emblematic of the strategic dilemmas of LGBT organizations about what drawing on clinical discourses, and on experts' authority, can do to their political subjectivity and public voice.

5. Rainbow parents

Medicalization has been a crucial and conflictual dimension in the construction of same sex parenting, starting with lesbian mothers being labelled as a category of perverts, potentially raising unhealthy children.

In her history of the construction of lesbian parenting in psychological literature, Clarke (2008) shows how the move from the construction of the masculine lesbian as an outsider to motherhood in sexology and phychoanalytic psychiatry to notions of the fit lesbian mother has been the result of collective struggles, with alliances between lesbian feminist activists and psychologists engaging in research on lesbian mothers. These alliances developed around the very practical aim of providing evidence to courts in support of lesbian mothers not to be denied custody of their children after divorce.

The process of social and legal recognition of same-sex parenting, Clarke and others argue (Hicks, 2005), should not be read in terms of objective scientific progress, the gathering of more accurate data (which is however the case), but as a social, collective process of depathologization led by alliances

[1] A group researchers, including important Italian sexologists, has recently published a study that has been presented in the media as proving that homophobia is a mental disease (Ciocca, Tuziak, Limoncin, Mollaioli, Capuano, Martini, Carosa, Fisher, Maggi, Niolu, Siracusano, Lenzi, Jannini, 2015). See e.g. http://espresso.repubblica.it/attualita/2015/09/22/news/l-omofobia-e-una-malattia-da-curare-1.230804, retreived 14/05/2017. For this study, they have won the 2015 prize for research by Cild, the Italian coalition for civil liberty and rights (https://cild.eu/blog/2016/10/18/premio-cild-la-ricerca-fa-la-differenza-omofobia-jannini/, retreived 14/05/2017).

between activism and research, a process that implied certain constructions of lesbian and gay parenting. Clarke (2008: 123) points to 'the regulatory power of psychology' in supporting constructions of the dichotomy between the good lesbian mothers, those hiding their sexuality and subordinating it to their mothering role, and the bad ones, the militant, visible dykes, openly challenging heterosexuality, a distinction upon which the judges drew in custody cases in the 1980s and 1990s. Despite important changes, towards presentation of lesbian families not only as 'just-as-good-as' heterosexual families, but as 'better than' them (Stacey, Biblarz, 2001), Clarke (2008: 125) points to the normative underpinnning of the very question on which psychological research on lesbian parenting is based, bearing the risk of reproducing essentialist understandings of gender and sexuality, and heteronormative (but also class and race specific) norms of adequate child development: 'The question "are lesbians 'fit to parent'?" renders "no" lesbians are not fit to parent a plausible and intelligible answer: if their sons do not play with trucks and their daughters do not wear dresses, or if they lack self-esteem'.

The critical argument made by Clarke points to the fact that the process of construction of the fit lesbian and gay parent has involved more an overturning of its construction as a category of perverts into its positive appropriation, rather than its deconstruction, and a challenge to the definitional power of clinical knowledge. In their endeavour to put themselves on the healthy side of parenting, to prove their fitness by getting high scores in psychological measures of children's well-adjustment, same-sex families contribute to upholding a clinical frame for the definition of good parenting. We can ask, then, who remains on the unhealthy side: queer critiques of homonormativity and homonationalism have pointed to the exclusionary dimensions of a liberal, assimilationist framing of LGBT rights constructing the dangerous, exotic pervert as a countertype of the well-integrated homosexual.

Devoid of its challenging potential to broader understandings of parenting, the construction of same-sex parents as a specific category, a new kind of family, which is measured against the assumed heterosexual norm, with specific needs to be acknowledged, also provides a reassuring positioning that fits into the clinical frames often informing public and private services devoted to helping families (Bertone, 2015; Scarscelli, 2015).

Moreover, by grounding the legitimacy of their claims for recognition upon scientific knowledge assessing their parenting capacities, same-sex families and their organisations lend definitional power to professional experts, and provide a recognition of objectivity to their assertions, supporting the idea that experts can measure the outcomes of good and bad parenting,

despite the fact that the idea that there is a causal relationship between parenting and outcomes for children actually remains controversial (Dermott, 2012). In Clarke's words, they risk reinforcing the role of psychologists as 'the arbiters of lesbian mother's fitness to parent' (Clarke, 2008: 121).

Finally, by seeking recognition through an individualised and depoliticised clinical/therapeutic frame for the definition of good parenting, erasing class and other social inequalities, in other words, by erasing issues of redistribution from their self-representations, organisations of LGBTIQ parents contribute to undermining the very conditions for emancipation of most of the constituency they are speaking on behalf of. Indeed, they contribute to undermining the possibilities for most parents not to be afflicted by the struggle of finding time to care. In fact, as Fraser (2013; 2016: 104) has outlined, neoliberalism has enforced at the same time welfare retrenchment and women's paid work, and thereby 'Externalizing carework onto families and communities, it has simultaneously diminished their capacity to perform it'. As a consequence, by not questioning their contribution to 'progressive neoliberalism', rainbow families as well get caught in the resulting 'dualized organization of social reproduction, commodified for those who can pay for it and privatized for those who cannot' (Fraser, 2016: 112).

In the Italian context, the body of international psychological research showing the lack of negative effects of sexual orientation on parenting, and the related statements of professional organizations abroad and in Italy acknowledging its results (including the Ordine Nazionale degli Psicologi Italiani), are fundamental resources upon which Italian LGBT families' organizations draw, crucial tools for the construction of their social legitimacy and the articulation of their claims for legal recognition[2]. They are also important tools of the litigation strategies that have been developed to obtain the recognition of parenthood that laws still fail to provide.[3]

At the same time, however, competing frames (Brownlie, 2014) are mobilized, with the public self-representation of the main LGBTQI parents' organisations (Famiglie Arcobaleno and Genitori Rainbow) revolving around visibility and the displaying of the families' everyday practices (with little thematization of class, ethnic or race diversities), and their claimsmaking being also framed in terms of fighting discrimination (La Delfa, 2016).

Advice material does not have the relevance we have seen in the case of Agedo. A translation of a US manual has been circulating, with the preface of

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[2] See, for instance, the dedicated section in Famiglie Arcobaleno's website: http://www.famigliearcobaleno.org/it/informazioni/studi-e-ricerche, and the relevance given to articles such as Giartosio 2015.

[3] See in particular the judgements recognizing the stepchild adoption, as the pioneering one issued by the Juvenile Court of Rome in 2014.

the former president of Famiglie Arcobaleno (Johnson, O'Connor, 2015); in the Italian title, *Famiglie arcobaleno: Consigli e testimonianze di mamme lesbiche e single per crescere figli felici e orgogliosi di sé*, the reference to 'health' in the original title (*For Lesbian Parents. Your Guide to Helping Your Family Grow Up Happy, Healthy, and Proud*) has been removed. The book is also characterised by a mixture in which the voice of experts and clinical framings are compensated by attention to the diversity of family structures and experiences.

More research, however, would be needed to analyse the role of a clinical framing of good/healthy versus bad/dysfunctional parenting in LGBT parents' organisations' discourses in Italy, and the degree of definitional power lent to medical or psychological experts.

6. Conclusions

Alliances with professional experts, the use of scientific knowledge and the adoption of medical frames have been, and are, important strategic resources for the actors of the LGBT movement, in their struggles for social and legal recognition of parent-child relationships beyond heterosexuality. Without dismissing this, I have proposed some 'cautionary notes' about the possible implications of these strategies (Epstein, 2003), based on the analytical tools provided by critical perspectives on medicalization. I have explored in particular the implications in terms of reproduction, and construction, of normative and exclusionary models of good parenting, and in terms of power relations between collective actors and professional experts. But we can also look in the opposite direction, at strategies to counter medicalization tendencies and their implications.

There seems to be a tension between classificatory approaches legitimizing parents' experiences by measuring them against standards of good and healthy parenting, confining experiences in some sets of stories that can be told, and heard, and accounts of the messiness of everyday life, the diversity of parenting experiences and of their everyday challenges (Gabb, 2013). Taking up Brownlie's (2014) suggestion, there are disjunctures between discursive shifts on family relations in policies and public discourses, and the meanings people attach to their everyday family practices. Detecting the competing frames people draw upon in making sense of their family life, she argues, can help challenging the cultural pervasiveness of therapeutic frames.

In terms of collective strategies, in looking at the connection between the conceptual level of medicalization and the institutional one (Conrad, 1992), that is the implementation of a medicalized approach into organisational practices, Epstein (2003) warns against the risks of de-politicization and

shifting entitlements in defining the meanings of health from grassroots to experts related to professionalisation. In this respect, in the Italian context, the long experience of feminist anti-violence centres and their resistance to professionalization can provide conceptual and strategic tools to oppose these processes (Creazzo, 2008).

Finally, resisting de-politicization and individualization, and considering issues of parenting as social problems, can allow for greater attention to how parenting experiences and access to rights are shaped by social inequalities: challenging hierarchies of parenting is not only a question of acknowledging the different forms it can take, but needs an emancipatory project aimed at securing to all the possibility to care.

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