

CONDOMS AND CONNECTION: PARENTS, GAY AND BISEXUAL YOUTH, AND HIV RISK

Michael C. LaSala

Rutgers, the State University of New Jersey

The family has long been considered a powerful influence on youth's high-risk behaviors. However, little is known about preventive family influences for gay and bisexual youth, a group at high risk for HIV infection. For this study, qualitative interviews from a sample of 38 gay and bisexual youth and their parents/guardians underwent a thematic analysis. Youth described parent-child closeness, parental warnings, and urgings to use condoms as influences. Youth denying family influence came from families in which parent-child relationships were disrupted or HIV-related discussion was lacking. Most families reported discomfort discussing HIV risk. These findings, along with a case example, suggest how family therapists can enhance parental influence by helping these families strengthen their relationships and discuss this important topic.

Men who have sex with men (MSM), including men who identify as gay or bisexual, are estimated to be 2% of the population, but make up over 56% of all existing cases of HIV in the United States (Centers for Disease Control [CDC], 2013a). Despite considerable efforts by HIV-prevention specialists, young gay and bisexual men engage in unprotected anal sex all too frequently (CDC, 2013b), which explains why HIV infection among young MSM rose 22% from 2008 to 2010, and accounted for 78% of all newly diagnosed cases in 2011 (CDC, 2012). HIV-prevention programs targeting young gay and bisexual men emphasize education, stress reduction, communication, sexual assertiveness training, and peer education, and such individually focused interventions have been shown to reduce the frequency of unsafe sex among these youth (Koblin, 2004; Peterson & Jones, 2009; Wilton et al., 2009). However, the overrepresentation of gay and bisexual men in the HIV statistics, along with the relentless rise of infection among them, suggests that prevention efforts targeting this group warrant further attention. The findings from this study underscore the potentially influential role of the family, and thus family therapy, as a tool for HIV prevention for this vulnerable population.

Family support, open family discussion of sexuality, close parent-child relationships, communication, and parental monitoring have all been found to be associated with consistent, low-risk sexual behavior among samples of presumably heterosexual youth (Aronowitz, Todd, Agbeshie, & Rennells, 2007; Guilamo-Ramos, Jaccard, Dittus, & Bouris, 2006; Pequegnat & Bell, 2012). In addition to reducing unsafe sex, parental support has also been shown to be related to lower rates of drug and alcohol use (Rowe, 2012; Tobler & Komro, 2010), which are factors related to risky sexual behaviors (Donenberg et al., 2012; Marvel, Rowe, Colon, DiClemente, & Liddle, 2009). Furthermore, several effective HIV-prevention programs targeting heterosexual youth engage families in their efforts (Pequegnat & Bell, 2012).

Investigators have identified important variables and risk factors associated with incidents of unsafe sex among gay and bisexual youth, including drug and alcohol use (Newcomb, Clerkin, & Mustanski, 2011), mental health problems (Beidas, Birkett, Newcomb, & Mustanski, 2012), perceived social oppression (Arreola, Ayala, Díaz, & Kral, 2013), low peer support (Carlos et al.,

Michael C. LaSala, PhD, LCSW, School of Social Work, Rutgers, the State University.

The research described in this article was funded by the New York Community Trust, Lois and Samuel Silberman Fund Faculty Grant Program. The author wishes to acknowledge James Fedor, LCSW, and Christopher Familietti, BA for their assistance with data collection and analysis, and Elyse J. Revere, MA, LSW for her transcribing and editorial assistance.

Address correspondence to Michael C. LaSala, PhD, LCSW, School of Social Work, Rutgers, the State University of New Jersey, 536 George Street New Brunswick, New Jersey 08901; E-mail: mlasala@ssw.rutgers.edu

2010), pressure from partners (Sullivan, Salazar, Buchbinder, & Sanchez, 2009), and low socioeconomic status (Myers, Javanbakht, Martinez, & Obediah, 2003). However, there is also a small but growing body of knowledge suggesting the importance of the role of family in preventing HIV infection among young gay and bisexual men (Garofalo, Mustanski, & Donenberg, 2008; LaSala, 2007; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010; Yoshikawa, Wilson, Chae, & Cheng, 2004). For gay and bisexual youth, family rejection has been shown to be related to high-risk sexual behavior (Ryan, Huebner, Diaz, & Sanchez, 2009), while family connectedness and support may be associated with being HIV negative (Garofalo et al., 2008) and avoidance of unsafe sex (LaSala, 2007; Ryan et al., 2010; Yoshikawa et al., 2004), even among men who are already HIV positive (Kimberly & Serovich, 1999). Strong parental relationships may be protective for gay and bisexual youth when it comes to factors related to HIV risk, such as mental health problems and substance abuse (Needham & Austin, 2010; Ryan et al., 2010). It is worth noting that family support, when available, may be important for the well-being of HIV positive gay men (McDowell & Serovich, 2007; Serovich, Graftsky, & Craft, 2011). Thus, this small but promising extant literature on family relationships, along with the rising rates of HIV among this population, underscores the need to more thoroughly examine the role of family influence in HIV prevention for gay and bisexual youth so that family therapists can use this knowledge to help families keep their sons safe.

When exploring the potential of the family as a resource for HIV prevention for gay and bisexual males, the special challenges such families encounter must be taken into consideration (LaSala, 2010). Young gay and bisexual males may face parental disapproval or even rejection upon coming out (Ryan et al., 2009). Parents who do not reject their children may go through an adjustment period as they find ways to cope with guilt, mourning, and worry, while youth are seeking unconditional acceptance (LaSala, 2010). Thus, there is a need for information about how families influence these youth, or fail to do so, in light of their unique circumstances.

The specific question guiding this research was, "What do gay and bisexual youth and their parents believe is effective in persuading young gay and bisexual males to avoid high-risk sexual behavior?" The foci of this study were young gay and bisexual men and their families because of the elevated HIV transmission risk of male-male sexual behavior (CDC, 2013a), their propensity to engage in high-risk sexual behaviors (CDC, 2013b), and the insufficient in-depth knowledge available about family influence for this population (Garofalo et al., 2008). It was anticipated that the answer to this question might begin to inform family-based HIV-prevention interventions for young gay and bisexual men.

METHOD

Participants

Eligibility. Sampling criteria for this project were as follows: youth needed to be between 14 and 21 years old, living in New Jersey, the New York City or Philadelphia metropolitan areas, identify as gay or bisexual, and be "out" or known as gay or bisexual by their parents or caretakers. At least one of the youth's parents or caretakers needed to be willing to participate. Youth whose ages fell outside of this range, did not identify as gay or bisexual males, or who did not have a parent or caretaker willing to participate were excluded from the study.

Recruitment. Two thirds of the youth and their parents/caretakers were recruited through advertisements on Craigslist. A local, nonprofit human service agency serving gay youth, two HIV-prevention programs targeting young MSM, support group meetings of Parents, Families, and Friends of Lesbians and Gays (PFLAG), as well as informal social networks (word-of-mouth to friends and families) were other recruitment venues. Interested youth and their parents contacted the principal investigator (PI) and, if they met the sampling criteria, appointments for interviews were scheduled. Each individual respondent was paid \$100 for participating.

Respondents. The 38 youth were between the ages of 14–21 years with a mean of 18.8 years of age ($SD = 2.04$). Five youth identified as bisexual, and the rest identified as gay. It is worth noting that only one youth respondent was 14 years old, another was 15, and the rest were between 16 and 21 years of age. Forty-five parents and parental figures participated. They consisted of nine fathers, 31 mothers, two custodial grandmothers, two custodial aunts, and one foster mother. Seven of the families in the sample included both biological parents. Parent/guardian respondents

were between the ages of 32 and 58 with a mean age of 45.57 ($SD = 7.17$). Household income ranged from \$0 (two families in which the parents were unemployed) to \$275,000 with a median of \$47,500. Twelve of the youth were White, 14 were Black, and 12 were Latino. Two youth reported that they were HIV positive. Ten respondents reported never having been tested for HIV; twelve had been tested within the past year prior to their interview, and the rest had been tested over a year ago. Seventeen respondents reported engaging in unsafe sex within the past year, defined as anal intercourse without a condom; thirteen of them had two or more incidents of unsafe sex; and the other four respondents each reported one incident of unsafe sex. None of the youth reported engaging in unsafe vaginal intercourse. As for the two HIV-positive youth, one reported being infected by a man who raped him, and the other was infected during a consensual encounter. Both reported engaging only in safe sex since infection.

Data Collection

A semi-structured interview guide was developed for parents and youth (Patton, 2002). All interviews were audio recorded and took place in the family's home, the PI's office, or his conference room. Participants were interviewed by either the PI or a supervised, graduate research assistant specifically trained in the practice of using probes. Both the PI and the research assistant are openly gay men who are experienced therapists specializing in working with gay men and their families. Each interview lasted 60–120 min.

Sons' interviews. Sons were asked about their current and historic family relationships including how their parents reacted after discovering their sexual orientation and how, if at all, they adjusted. Sons were asked what they knew about HIV infection, and about their safe and unsafe sexual behaviors. Questions related to influence included, "What, if anything, influences you to avoid unsafe sex?" "What, if anything, about your relationship with your parents helps you avoid unsafe sex?" "Are your parents worried? How do you know?" "Have they ever talked to you about HIV? If so, what did they say? How did you respond?" "Do you ever try to reassure your parents that you are protecting yourself from HIV? If so, how?" "What do you think would reassure your parents that you are protecting yourself from getting HIV?" "What did your parents do or say that you think was helpful in persuading you to avoid unsafe sex?" "What did they do or say that was perhaps not so helpful?" "What, if anything, would help you or make it easier for you to discuss this issue with your parents?"

Parents' interviews. Parents were asked about current and historic parent–child relationships, including how they reacted and adjusted to the news of their sons' sexual orientation. Parents were also asked questions intended to assess what they knew about HIV infection, as well as their son's risk behaviors, testing behaviors, and history of sexually transmitted diseases (STD's). The following questions and probes were some of those utilized to capture parental attempts at influence: "How concerned are you about your son getting HIV?" "Have you ever talked to him about HIV or using condoms? If so, what did you say? How did he respond?" "What, if anything, do you say or do that you think is helpful in persuading your son to avoid unsafe sex?" "What did you do or say that was perhaps not so helpful?" "How comfortable are you talking about condoms and/HIV risk to your son? How good (effective) are you at it?" "What would make it easier for you to discuss?"

Youth and parent respondents were assured that their responses would be kept confidential, and under no circumstances would youth responses be shared with their parents, nor vice versa. All parent and child interviews were transcribed verbatim for analysis.

Data Analysis

The data were analyzed by the author using the six phases or steps of thematic analysis (Braun & Clarke, 2006): (1) audio recordings were transcribed verbatim and were read thoroughly so the researcher could become familiar with the data; (2) during this initial read though, 20 initial broad codes were established. Using word processing software, a file was established for each initial code, and the coded material was copied and pasted into the appropriate file; (3) the material in each file was reviewed to determine potential themes; (4) the entire data set was reviewed for information that added to, clarified, or contradicted the initial theme; (5) borrowing from grounded theory (Corbin & Strauss, 2008), memos were formulated that captured the relationships between codes

and themes, including causal and contextually linked concepts, to determine the relationship between themes, and to develop a coherent story; (6) the report was developed. It should be noted that phases 4–6 were not undertaken in a linear fashion, but were done recursively. Comparative analyses were done to look for differences related to sexual orientation of the youth (gay or bisexual), race, recruitment source, age of the child, and age of parent/caretaker regarding safe sex, influence, and family discussion. None were found.

Interrater reliability. In an attempt to minimize researcher bias, a second research assistant, who was a young gay man and a master's student in social work, independently coded respondent quotes from the following overarching key categories: closeness, scaring, warning to use condoms, and no influence. The assistant's coding results were compared to those of the PI, and in cases of disagreement, the coding discrepancies were discussed and transcripts were reviewed to determine: (a) if the respondent's statement was incorrectly coded by either the PI or the research assistant, or; (b) if the disputed coding category needed to be altered. As a result of the code check, it was discovered that the code entitled: "no influence," needed to be broken down into "no influence, family disruption," "no influence, lack of discussion," and "possibly negative influence." No other codes were altered.

RESULTS

As a result of the analysis, a main theme that emerged was youth-reported parental influence. Subthemes included: closeness; family discussions; and family influence, yet unsafe sex. No parental influence was the second main theme and included the subthemes of family disruption and lack of discussion. Barriers to discussion emerged as another important theme, as family members in both the influence and no influence categories reported barriers. Respondent quotes are provided to explicate the findings.

Family Influence

Twenty of the 38 youth described some form of family influence on their sexual behaviors. The families of these youth, for the most part, enjoyed good relationships with parents who, after an initial short period of adjustment (1–6 months following disclosure), were accepting of their sons' sexual orientation.

Closeness and connection. Overall, reported parent–child closeness emerged as the most effective influence that sons and parents agreed helped youth to avoid high-risk sexual behaviors. As stated by Raffi.¹

My mom's love is what really, you know, keeps me grounded 'cause I know I don't ever want to hurt her, and I know if I did, if I were to come home with a positive result or, you know, diagnosis . . . she would be hurt. All the males from my Dad's side, like, his father, his two brothers, have had heart conditions. I myself was born with a heart condition, so I always ask her, "What would you do if like you had to bury me?" and she'd be like, "Well, they better make room in that coffin for two." (21 years old, Latino)

Parents in these families tended to agree that a strong family connection was a protective factor. Raffi's mother, Gina, described,

He knows that if something happens to him, how much I am going to suffer. Our family loves him and we encourage him to take care of himself. I always tell him, "Remember you are not alone. I do not want anything to happen to you; I would go crazy." We demonstrated him love because if a person does not have someone who cares, and if this person feels rejected, he will assume that he does not have anybody. My son knows that he has a person behind his back. He knows that he is important and that if he doesn't do things right, he will suffer and his life will be transformed. He needs to remember that we love him so much. So, if he feels this love and loves himself, he will be more responsible and careful, and that's important. (45 years old, Latina)

This closeness could be manifested through open communication. As described by this college student when asked what, if anything, about his relationship with his mother

influenced him to avoid unsafe sex, “We have an open relationship, like, we are best friends and we can talk about anything.” (Micky, 21 years old, Black) Ricardo, a 21-year-old Latino youth, identified the influence of his relationship with his mother, although they do not directly discuss HIV:

Ricardo: I value my health and my body. I’m also pretty sure the fear tactics of my childhood from sex education have a lot to do with it, um, and I also wouldn’t want to disappoint my mother.

Interviewer: Disappoint? Tell me more about that.

Ricardo: Maybe disappoint isn’t the right word; maybe burden is the right word. I just feel like she has so much going on right now, and she does so much that adding something like that would just hurt her or give her unnecessary stress.

Ricardo was one of the few youth reporting influence in the absence of discussion. Eighteen of the 20 youth who reported family influence described that their parents directly talked to them about HIV risk in some way.

Family discussions: Cautions and condoms. According to the youth, HIV-related discussions frequently took the form of either warnings or scare tactics. Although these “discussions” were mostly parent-directed and somewhat one-sided, the youth described them as influential. As stated by Jamel,

My mother always warned me and told me you can’t look at somebody and tell if they have it . . . I would have never in a million years guessed that my aunt had it. She looks perfectly healthy, perfectly normal and everything. (17 years old, Black)

When Jamel’s mother was asked how she attempted to influence her son, she responded: “By letting him know what happens if you become HIV positive or end up with full-blown AIDS.” (Letitia, 40 years old, Black)

According to the youth, another influential action on the part of parents was their urging them to use condoms. As stated by this young man when asked what his parents did to influence him to consistently engage in safer sex,

Um, I guess it was the same typical kind of stuff: “Always use a condom and it’s not worth the risk not to use a condom, and you know if you’re gonna’ be doing these things, you definitely need to make sure you are having safe sex and using a condom.” (Mike, 18 years old, White)

Again, according to the youth, these discussions were influential, albeit somewhat unidirectional. However, in contrast, their parents emphasized the importance of general communication rather than explicit parental urgings or warnings. For example, this young man described, “They’ve been pretty helpful in terms of constantly telling me and warning me about the dangers, and how it could kill you.” (Ralphie, 16 years old, White) However, his mother, like some of the other parents in this sample, reported that her efforts to influence him were more holistic, grounded in open discussion that went beyond simple admonitions to use a condom:

I think open communication, being honest and up front. He’s come home from school and told me different sexual things that are absolutely untrue, and my husband and I both set him straight. “[We tell him] if there’s anything that you hear at school and it doesn’t sound right to you, come and talk to us because we’re the ones who know. We’re the ones who are gonna’ tell you honestly whether it’s right or wrong,” and it’s not even just sexual things, it’s all kinds of things that have to do with the gay community and whatnot. (Jennifer, 50 years old, White)

Kevin (17 years old, White), whose mother Pam is quoted below, said that his parents’ main influence is that they tell him to use condoms. Pam mentions condoms when asked about her attempts to influence her son, and hopes he is hearing her:

Um, I hope that everything I say he listens to and really thinks about and not just yeses me . . . If you really think about it seriously, something so simple as using a condom can save your life, so I hope that he realizes that. (47 years old, White)

Kevin did realize this. When asked what role his relationship with his mother played in his avoidance of unsafe sex, he replied, “I guess my mom telling me that if I ever needed something, she would help me with it, like if I did need condoms she would get them for me.” However, without back and forth dialogue, Pam is left wondering if her message is getting through.

Family influence, yet unsafe sex. Some of the youth reported positive family influences to stay safe, yet had engaged in at least one incident of unsafe sex. Five of these youth reported succumbing to pressure from partners: “He pushed me. I was like, ok.” (Brian, 21 years old, White). Thus, the influence of partners seemed to outweigh that of parents in these instances. Two additional respondents reported not liking condoms, and one of these youth, Alan (18 years old, White), had a father with whom he sometimes lived, but who was very rejecting, calling him a “dirty gay.” The other respondent was very much closeted, out only to his parents, and suffered from depression. Mental illness (Beidas et al., 2012), partner pressure (Sullivan et al., 2009), and parental rejection (Ryan et al., 2009), have all been found to relate to unsafe sexual behavior in this population, which might explain these findings.

No Influence

Eighteen of the 38 youth interviewed for this study denied that there was any parental influence on their decisions to engage in safe or unsafe sex. It is noteworthy that nine of these youth reported engaging in unprotected anal intercourse in the past year.

Disrupted parent–child relationships. Almost all of the families in which youth claimed no family influence experienced some type of parent–child relationship disruption, either due to a parent’s death, abuse, drug or health problems, or ongoing disapproval or rejection because of the child’s sexual orientation. For example, Mitchell’s mother died when he was 11 years old. From a young age, Mitchell lived with his grandmother and had an ongoing relationship with his father until he came out, at which time his father cut off ties. At the time of the interview, he reported that he had engaged in two incidents of unprotected anal intercourse in the past year. When asked about parental influence, he stated, “My dad would say go right ahead; I don’t care what you do. Do that and see what happens to you.” (19 years old, Black) In another family, the son described being sexually abused by his stepfather for several years during his childhood, then brutally bullied by his brothers for being gay during his adolescence, and then was raped by a man he met online who infected him with HIV. He reported that his mother knew of his abuse, but failed to protect him. When asked about parental influences on his sexual behaviors, he stated that he and his mother are “more like friends . . . I was never able to respect her as a mother.” (Jimmy, 21 years old, Latino) Both he and his mother reported that HIV was never discussed in his family. His mother attributed her failure to do so to her own history of trauma and discomfort discussing sex.

In four other families, the youth had been moved from relative to relative, or placed in foster homes due to parental death or incapacity, until finally landing with a caretaker who could offer stability. Le Roy was born to parents who struggled with drug addiction. Though he maintains a relationship with both parents, including his mother who uses gay slurs when she is angry at him, he has never lived with them. Instead, he was cared for by his grandmother up until 5 years ago, and he now lives with his aunt. He denies any influence from his past or current caretakers on his sexual behaviors, saying that he stays safe due to the education he has received at a local HIV services agency and also his awareness of how widespread the illness is. However, he did report one incidence of unsafe sex in the past year. When asked if he thought there were any family influences that dissuaded him from unsafe sex, he replied,

No, I don’t, ‘cause they aren’t really open with me about it . . . I’m such a smart kid, you know, I think, like, I learned to [protect myself], ‘cause I’m so used to fending for myself, and I’m so used to like, doing everything for myself, and so it’s just like I learned on my own . . . My family is just ridiculous. (18 years old, Black)

This quote typifies the perspective of the youth who claimed no influence, whereby their responses emphasized personal autonomy rather than family influence. It seemed that within this sample, if the youth had experienced disrupted parental relationships through abandonment or rejection, there lacked a foundation from which family members could effectively influence them because they did not see them as reliable resources.

Young men who reported maintaining historically good parental relationships that were disrupted by the coming out process were also among those who claimed no parental influence. For example, this 21-year-old Latino man had come out to his parents at age 15. His family belonged to a Pentecostal church where he was stigmatized after coming out:

Yeah, that's when they found out about my orientation and they [the Church] put me on discipline, and, um, when you are on discipline you can't participate in any of the activities, and I used to sing; I used to preach. I used to read the Bible, and they didn't let me do nothing in church, so that's why I stopped going. (Miguel, Latino)

The pressure on him was so great that he left his family for a while to live in a group home. He now lives back with his parents and does HIV-prevention work in an urban neighborhood. He claimed that what he had learned in his job training was what kept him safe, not parental influence. Miguel reported that he has used condoms in the past, but not with his current partner.

Nathaniel came out to his parents at age 16, and he became HIV positive shortly thereafter. He described enjoying a close relationship with his mother before he came out, but afterward the relationship became conflicted. He described his mother's initial and ongoing disapproval:

Of course, like I said, she was extremely homophobic. Like I mean, she would say some of the harshest things . . . some mean stuff like just like, "Oh you're not going outside with me looking like that," or "I'm not buying you this." If I bought something, she would tell me to take it back if it's too tight, or if we had our family events, she wouldn't go with me because she didn't want to be embarrassed. Like, she was telling me I was an embarrassment. Things like that used to really hurt me. (20 years old, Black)

Even though, at the time of the interview, his mother Freda had known about her son's sexual orientation for 4 years, she still struggled with it: "I grew up in a homophobic family, to be honest, and that's why I told you I wanted a son, and I wanted a football player, and this is the total opposite." (44 years old, Black) It is worth noting that after Nathaniel came out, and while facing his mother's strongest disapproval, he engaged in a relationship with an older man from whom he contracted HIV.

Lack of discussion. Half of the youth who claimed no family influence reported that there was very little or no family discussion of the topic. However, parents were much more likely than their sons to report that they discussed HIV-related issues with their children. All but three parents of youth who reported no parental influence described discussing this topic with their sons. For example, as described by Joan, the mother of Jules, a White, 20-year-old college student,

Interviewer: How comfortable are you in talking about condoms and/HIV risk to your son?

Joan: Totally comfortable.

Interviewer: You are?

Joan: Absolutely.

Interviewer: What do you do? How do you do it?

Joan: Um, well Jules actually got condoms in his stocking for Christmas when he was 16. So, he opened up his stocking and he was like, "Ma really?" I'm like, "Hey look, I know you're not going to buy them on your own." (52 years old, White)

However, Jules denied that there was a parental influence on his sexual behaviors, and he also reported that he had engaged in unprotected anal intercourse in the past year. Further, Jules

claimed never to have discussed this issue with his mother. One possible explanation for this difference is the effect of social desirability; parents who would agree to be in a study about parent-child communication about HIV might be reluctant to admit that they do not discuss this important issue with their children. However, another possible explanation might relate to the nature of the family discussions that did take place. A close read of parental reports suggest that these discussions, when they occurred, were often sporadic, sometimes vague, and as in the examples previously described, rather one-sided. In the last example, when Joan was asked how she discussed this topic with her son, she talked about giving him condoms, but it was unclear whether there was much discussion, and if there was, it did not register with her son. Renee, a mother of a 16-year-old young man who denied parental influence, or that his parents ever discussed HIV, reported, "I talk to him not so much about HIV but condoms . . . But Rashonn is really good. He has condoms all over his room." (45 years old, Black)

This Latina mother could not give an example when asked about discussing this issue with her son: "I can't remember right now, but I think I always talk about it with him . . . yeah all the time." (Eva, 42 years old, Latina) Her son claimed that his mother had not discussed HIV with him at all, had no influence on his sexual behavior, and he also reported that he engaged in unprotected sex repeatedly in the past year. (Roberto, 21 years old, Latino)

Barriers to Discussion

Parents in 18 of the families reported that they could have done a better job talking to their sons about HIV, but it is worth noting that all but two of them were parents of youth who claimed parental influence. A frequently mentioned obstacle to HIV-related discussions was communication difficulties due to discomfort on the part of the parents. As described by Renata, the mother of a 16-year-old Black youth who claimed no family influence and denied that his parents discussed HIV risk with him,

Renata: It's so uncomfortable because I'm not used to talking about sex. I'm not an expert. I guess me and my husband, we have brought it up to him. We did tell him to protect himself. I know that he's learned about it in school. He's mentioned it, so E for effort, but I am not beating him over the head.

Interviewer: Have you ever talked to him about HIV or using condoms?

Renata: I have never used the actual word condoms . . . but he's 16 and his favorite line is "I know." (37 years old, Black)

When Renata's son was asked what would make it easier to discuss HIV risk issues with his parents, he replied, "I don't know what would make it easier. I just don't talk to them about it or want to talk to them about it." (Ray, 16 years old, Black) This response seems to be in agreement with the parents' experiences. As stated by Ricardo's mother, Aggie:

Interviewer: What would make this easier to discuss this issue with your son?

Aggie: His being more receptive . . . actually talking to me in an adult manner and not being more on the defensive side. He might say, "She never brings it up." I don't, and I haven't in a really, really long time. . .

Interviewer: But it also seems like you've tried.

Aggie: I haven't tried in a really long time. If I tried now to ask him, "What did you do this weekend out at school?" "Went out with friends." He just never talks about his private life, ever. So I just can't say, "Well, are you practicing safe sex? I don't know what you're doing, but I hope you're using condoms." I don't think he would really respond positively. I think he would get defensive: "It's nothing you need to hear about Mom." (Aggie, 52 years old, White)

Many of these parents wished that their sons would bring up this topic, but the youths' reticence made this unlikely: "I just don't like having conversations like that with my parents." (Leon, 19 years old, Black) "I mean sex is sex; it's just kind of awkward." (Lorenzo, 19 years old, Latino)

When Aggie's son, Ricardo, was asked what would help make this topic easier to discuss, like a third of the youth in the sample, he simply replied: "Nothing." However, others said it would be easier if parents brought up the topic:

I feel like if they brought it up first, it would be easier 'cause I'm not, I'm probably not gonna' bring that up like just, "Hey Mom let's talk about [this]." Like, I feel like they have to bring it up. (Pierre, 15 years old, Black)

Fathers. It is worth noting that only seven of the youth reported experiencing good relationships with their fathers, and this could explain why only eight fathers participated in this research. Further, fathers who did participate expressed a particular lack of confidence in speaking with their children about HIV: "I am not as good as I should be, probably." (Vicente, 42 years old, Latino) Even in families where sons reported influence, fathers reported that the youth were more likely to talk to the children's mothers: "He talks more to my wife, I guess, on that kind of level, than me." (Joe, 49 years old, White)

Lack of monitoring. Considering the lack of discussion reported, it is perhaps not surprising that less than a third of the parents in the overall sample knew for certain that their child had been tested for HIV. The other parents either did not know that their child had been tested, or assumed their child was HIV negative without indications for certain. For example, when asked if his son had been tested, this father replied, "I hope so. He had blood tests; I'm sure of that. I don't know if he was ever checked for it." (Bill, 49 years old, White)

Although many parents told their children to use condoms, whether they were actually using them was another area that lacked direct discussion. As stated by this PFLAG member and mother of a 16-year-old when asked what, if anything, her son was doing to stay safe, "Well, I hope he has condoms; I mean I found four in my basement." (Barbara, 53 years old, White)

Some parents who were successful in influencing their children to avoid unsafe sex seemed to find a way to push through the awkwardness and discomfort without overstepping boundaries that separate parent and child sexuality. As stated by this mother of a 21-year-old,

[I talk with him] always with respect because there is a line that cannot be crossed because I'm his mom, and we don't get into details. But I always tell him that he has to protect himself. I told him that he needs to take into account his feelings because not everything is about sex. (Lola, 43 years old, Latina)

It is noteworthy that several families reported that they sought participation in this study to learn how to communicate more effectively with their sons about this difficult topic. The experiences of families like Lola's may provide some insight into how family therapists may be able to coach parents and youth to discuss this topic in a way that is respectful and productive.

DISCUSSION

Previous research has found an association between family relationships and safer sex among gay and bisexual youth (Garofalo et al., 2008; Ryan et al., 2010), and this study adds to this literature by identifying and describing the parental influences on the safer sexual behaviors among a sample of young gay and bisexual males. These influences: family closeness, communication about condom use, and avoidance of unsafe sex, could each be intended outcomes of family therapy interventions. McGoldrick, Carter, and Garcia Preto (2011) offer a family development perspective that describes a young adult's growing autonomy in the context of family interdependence. From this perspective, it could be tentatively asserted that in families where there was influence, parent-child relationships enabled the child to be autonomous enough to explore sexual and romantic relationships outside of the heterosexual norm while sustaining family connections sufficient to maintain influence. Thus, the "ties that bind" could be a powerful motivator to stay safe, and family therapists can play a role in strengthening these connections to enhance parental influence.

Alternatively, for youth in families with disrupted histories due to either parental incapacity or strong parental disapproval, parent-child relationships lacked the foundation upon which to build these protective bonds. Thus, therapists working with gay and bisexual youth whose parents

were unavailable to them growing up, or who are from very disapproving families, would be advised to consider that helping families unite and adjust to a child's sexual orientation is, in and of itself, an HIV-prevention intervention, even if this is not the initial treatment focus.

Particularly relevant to family therapists is the finding of discrepancies between parent's and children's reports about whether family HIV-related discussions took place, and if so, the nature of these discussions. Many youth reported that the discussions, when they occurred, were vague and superficial, or were one-sided parental warnings, perhaps due to the discomfort both parents and youth felt about discussing this topic. Furthermore, a significant proportion of parents wanted to learn how to better discuss HIV issues with their sons, and that real or anticipated awkwardness was a barrier. For heterosexual youth, discussion and monitoring has been found to play a strong role in their avoidance of unsafe sex (Hadley et al., 2009). Thus, direct discussion of the child's efforts to protect himself could prove useful, and it behooves therapists working with these families to encourage these conversations.

Therapists working with families that are at least moderately accepting should consider raising the issue of HIV risk and assessing how the family discusses it as a matter of course, even if the family does not present with these concerns initially. As the findings of this research suggest, families may not be discussing this awkward topic because they do not know how. The following description of a segment of a therapy session with Tyrone, an 18-year-old gay youth, and his parents illustrates how to introduce this subject and begin to help the family discuss it.

Therapist: Before we begin today, I would like to raise an important issue with you all. In light of the elevated risk for young gay men to be infected with HIV, I was wondering how, or even if, this ever comes up as a topic of discussion for this family?

Mom: Well, we worry about that all the time.

Therapist: Ok, so have you discussed this as a family at all?

Mom: Not really, but it is something I have discussed with my husband.

Therapist (to father): Really? (He nods). But not with your son?

Dad: No.

Tyrone (agitated): Ugh! I don't want to talk to them about their sex lives! Why should they be so nosy about mine?

Mom (looking at therapist): He is still so young. I know how in the heat of passion, young people can lose their heads and do stupid things.

Based on the findings of this study, it would be important to find ways to directly encourage the father's participation, when available.

Therapist: Dad, can you help out here? What do you think?

Dad: Son, you know you are never supposed to have sex without a condom, right?

Tyrone: Dad! Gross!—I can't believe we are talking about this!

Like the youth of this study, Tyrone is reluctant to discuss this uncomfortable topic. However, the therapist can help his family approach this issue in a manner that could overcome his reluctance. Enactment is a well-known, structural family therapy intervention during which the therapist stimulates family interactions to help the family improve communication and correct boundary issues (Minuchin & Fishman, 1981; Nichols, 2013). Through the use of enactments, the therapist can help parents and children cut through the awkwardness and communicate about this topic in a way that conveys the caring found among some of the families in this study in which youth claimed influence. Tyrone's parents' clumsy attempts to discuss this issue belies their anxiety about this topic, and also fails to acknowledge their son's competence and autonomy, thus resulting in his defensive response. Through the sensitive use of enactments, the therapist can begin to help the family overcome these hurdles.

Therapist: Wow! Hold on everyone! Clearly, you are worried about your son's health and well-being. That's why you are urging him to use condoms, which of course is good advice, but for you (to son), this is a pretty uncomfortable topic to discuss with your folks. However, I want to see if you guys can go a bit deeper with this without necessarily getting into the nitty-gritty of Tyrone's sex life.

Mom: How?

Therapist: Well, instead of talking about what he should be doing, I'd like to see you try telling him how you are feeling. What are you most concerned about? I thought I heard some fear in what you said before. Can you talk about that with your son? Dad, why don't you start? Look at your son right now and tell him how you feel.

Dad: I'm scared, Ty, that you might make a mistake and something would happen to you.

Mom: Yes, that you would be all caught up in the moment and lose your head.

Tyrone: Jeez, you guys really don't trust me do you?

Therapist: Ok. Hold on a second. It is important that your parents trust you and see you as someone who can handle things, and I can see that they are having trouble with that. In most families, kids grow up as parents catch up. Parents worry a lot about their kids, even if they are older and responsible, and your parents are no exception. However, I am wondering if there is something you can tell them that would reassure them? Is there something you could tell them right now that might ease their minds?

Tyrone (softly): Mom, Dad, I learned all that stuff in health class; I am not stupid.

Dad: We know you are not stupid, but we are your parents, and it is our job to worry. You know, they take our parenting license away if we don't nag our kids.

Tyrone (shows a small smile): Well, I got tested last week at the Pride Center, so I know I am negative. Really, you guys, I am ok; I am always careful. I have condoms all the time with me, and I really don't mess around with many people.

Family therapy can be effective in resolving the discrepancies in perceptions between youth and their families (Guo & Slesnick, 2013). Initiating and supporting dialogue during enactments could diminish the differing perceptions around family discussions found in this sample, and also ensure that they are productive. This brief case example begins to demonstrate how to introduce and get families to dialogue about this topic in a way that acknowledges parental fear, respects the child's privacy and growing autonomy, and builds upon family connections. Because youth as young as 13 years old can get tested for HIV without parental permission or even knowledge in many states (The Center for HIV Law & Policy, 2011), it is vital that parents learn how to discuss this issue with their children to ensure they are being safe and also, if their sons are HIV positive, to be available for support and help with securing medical treatment.

Limitations and Conclusions

This study has several limitations. This is a small sample from the northeastern United States. It could be argued that families in this region might be more accepting of gay youth and therefore, more open to discussing this topic with not only their sons, but also an investigator. Thus, it is important to be cautious in generalizing these findings to the broad population of families of gay youth. Secondly, only a small number of youth identified as bisexual. Further studies targeting this population as well as other high-risk groups of MSM not included in this sample (i.e., families of other ethnicities and transgender youth) are needed.

To participate, at least one parent or parent figure needed to be willing to be interviewed. To be willing to do so, they probably had to be at least somewhat supportive of their sons. This likely

skewed the sample in that it is reasonable to assume that youth without at least one supportive parent or caretaker would claim no parental influence. Parents who are unaware of their child's sexual orientation might also be unavailable to assist in targeted HIV prevention for this population. For such youth, there are a host of individually focused prevention programs that should be considered (Peterson & Jones, 2009; Wilton et al., 2009).

This study examined reported family influences at one point in time. It is reasonable to assume that, like family acceptance, parental influence might increase from the time of a child's coming out, and future longitudinal studies could capture how these influences change over time.

Further, other factors that relate to HIV risk for this population should be taken into consideration in future research. How family dynamics interact with youth drug and alcohol use, peer influence, experiences of oppression, and social support, could be areas of further study leading to a multifaceted approach to HIV prevention for these youth.

Family therapists need additional information about the resources of gay families, as well as how to access them (Hartwell, Serovich, Grafsky, & Kerr, 2012; Henke, Carlson, & McGeorge, 2009; LaSala, 2013). Despite its limitations, this study sheds light on one potential resource, namely the power of the family, to help prevent HIV transmission among gay and bisexual sons. Based on the findings of this and the few existing studies examining the role of family in HIV risk, family therapists, armed with the skills to harness the protective power of close family relationships, have much to offer in the fight against HIV for this at-risk population.

REFERENCES

- Aronowitz, T., Todd, E., Agbeshie, E., & Rennells, R. E. (2007). Attitudes that affect the ability of African American preadolescent girls and their mothers to talk openly about sex. *Issues in Mental Health Nursing, 28*, 7–20.
- Arreola, S. G., Ayala, G., Díaz, R. M., & Kral, A. H. (2013). Structure, agency, and sexual development of Latino gay men. *Journal of Sex Research, 50*, 392–400.
- Beidas, R. S., Birkett, M., Newcomb, M. E., & Mustanski, B. (2012). Do psychiatric disorders moderate the relationship between psychological distress and sexual risk-taking behaviors in young men who have sex with men? A longitudinal perspective. *AIDS Patient Care and STDs, 26*, 366–374.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77–101.
- Carlos, J. A., Bingham, T. A., Stueve, A., Lauby, J., Ayala, G., Millett, G. A., et al. (2010). The role of peer support on condom use among Black and Latino MSM in three urban areas. *AIDS Education and Prevention, 22*, 430–444.
- Centers for Disease Control (CDC) (2012). CDC fact sheet: New infections in the United States. Retrieved from <http://www.cdc.gov/nchstp/newsroom/docs/2012/HIV-Infections-2007-2010.pdf>
- Centers for Disease Control (CDC) (2013a). HIV among gay, bisexual, and other men who have sex with men. Retrieved from <http://www.cdc.gov/hiv/risk/gender/msm/facts/index.html>
- Centers for Disease Control (CDC) (2013b). HIV testing and risk behaviors among gay, bisexual, and other men who have sex with men—United States. *Morbidity and Mortality Weekly, 62*, 958–962. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6247a4.htm?s_cid=mm6247a4_w
- Corbin, J., & Strauss, A. (Eds.). (2008). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Thousand Oaks, CA: Sage.
- Donenberg, R. R., Brown, L., Hadley, W., Kapungu, C., Lescano, C., & DiClementi, R. (2012). Family-based HIV prevention for adolescents with psychiatric disorders. In W. Pequegnat & C. C. Bell, (Eds.), *Family and HIV/AIDS: Cultural and contextual issues in prevention and treatment* (pp. 261–278). New York: Springer.
- Garofalo, R., Mustanski, R., & Donenberg, G. (2008). Parents know and parents matter; is it time to develop family-based HIV prevention programs for young men who have sex with men? *Journal of Adolescent Health, 43*, 201–204.
- Guilamo-Ramos, V., Jaccard, J., Dittus, P., & Bouris, A. M. (2006). Parental expertise, trustworthiness, and accessibility: Parent-adolescent communication and adolescent risk behavior. *Journal of Marriage and Family, 68*, 1229–1246.
- Guo, X., & Slesnick, N. (2013). Family versus individual therapy: Impact on discrepancies between parents' and adolescents' perceptions over time. *Journal of Marital and Family Therapy, 39*, 182–194.

- Hadley, W., Brown, L. K., Lescano, C. M., Jekkm, H., Spalding, K., DeClemente, R., et al. (2009). Parent-adolescent sexual communication: Associations of condom use with condom discussions. *Journal AIDS and Behavior, 13*, 997-1004.
- Hartwell, E. E., Serovich, J. M., Graftsky, E. L., & Kerr, Z. Y. (2012). Coming out of the dark: Content analysis of articles pertaining to gay, lesbian, and bisexual issues in couple and family therapy journals. *Journal of Marital and Family Therapy, 38*, 227-243.
- Henke, T., Carlson, T. S., & McGeorge, C. R. (2009). Homophobia and clinical competency: An exploration of couple and family therapists' beliefs. *Journal of Couple & Relationship Therapy, 8*, 325-342.
- Kimberly, J. A., & Serovich, J. M. (1999). The role of family and friend social support in reducing risk behaviors among HIV-positive gay men. *AIDS education and prevention, 11*, 465-475.
- Koblin, B. A. (2004). Effects of a behavioral intervention to reduce acquisition of HIV infection among men who have sex with men: The EXPLORE randomized controlled study. *Lancet, 363*, 41-50.
- LaSala, M. C. (2007). Parental influence, gay youth, and safer sex. *Health and Social Work, 32*, 49-55.
- LaSala, M. C. (2010). *Coming out, coming home: Helping families adjust to a gay or lesbian child*. New York: Columbia University Press.
- LaSala, M. C. (2013). Out of the darkness: Three waves of family research and the emergence of family therapy for lesbian and gay people. *Clinical Social Work Journal, 41*, 267-276.
- Marvel, F. A., Rowe, C. L., Colon, L., DiClemente, R., & Liddle, H. A. (2009). Multidimensional family therapy HIV/STD risk-reduction intervention: An integrative family-based model for drug-involved juvenile offenders. *Family Process, 48*, 69-83.
- McDowell, T. L., & Serovich, J. M. (2007). The effect of perceived and actual social support on the mental health of HIV-positive persons. *AIDS Care, 19*, 1223-1229.
- McGoldrick, M., Carter, B., & Garcia Preto, N. (2011). Self in context: Human development and the individual life cycle in systemic perspective. In M. McGoldrick, B. Carter & N. Garcia Preto (Eds.), *The expanded family life cycle: Individual, family, and social perspectives* (4th ed., pp. 20-42). New York, NY: Allyn & Bacon.
- Minuchin, S., & Fishman, H. C. (1981). *Family therapy techniques*. Cambridge, MA: Harvard.
- Myers, H. F., Javanbakht, M., Martinez, M., & Obediah, S. (2003). Psychosocial predictors of risky sexual behaviors in Black Men: Implications for prevention. *AIDS Education and Prevention, 15*, 66-79.
- Needham, B. L., & Austin, E. L. (2010). Sexual orientation, parental support, and health during the transition to young adulthood. *Journal of Youth and Adolescence, 39*, 1189-1198.
- Newcomb, M. E., Clerkin, E. M., & Mustanski, B. (2011). Sensation seeking moderates the effects of alcohol and drug use prior to sex on sexual risk in young men who have sex with men. *AIDS and Behavior, 15*, 565-575.
- Nichols, M. P. (2013). *Family therapy: Concepts and methods* (10th ed.). New York, NY: Pearson.
- Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.
- Pequegnat, W., & Bell, C. C. (Eds.) (2012). *Family and HIV/AIDS: Cultural and contextual issues in prevention and treatment*. New York, NY: Springer.
- Peterson, K. L., & Jones, K. T. (2009). HIV prevention for black men who have sex in the U.S. *American Journal of Public Health, 99*, 976-980.
- Rowe, C. L. (2012). Family therapy for drug abuse: Review and updates 2003-2010. *Journal of Marital and Family Therapy, 38*, 59-81.
- Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. *Pediatrics, 123*, 346-362.
- Ryan, C., Russell, S. T., Huebner, D., Diaz, R., & Sanchez, J. (2010). Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing, 23*, 205-213.
- Serovich, J. M., Graftsky, E. L., & Craft, S. M. (2011). Does family matter to HIV-positive men who have sex with men? *Journal of Marital and Family Therapy, 37*, 290-298.
- Sullivan, P. S., Salazar, L., Buchbinder, S., & Sanchez, T. H. (2009). Estimating the proportion of HIV transmissions from main sex partners among men who have sex with men in five US cities. *AIDS, 23*, 1153-1162.
- The Center for HIV Law and Policy (2011). Compendium of state HIV testing laws: Quick reference guide for clinicians. National HIV/AIDS Clinicians' Consultation Center, University of California at San Francisco. Retrieved from <http://www.hivlawandpolicy.org/resources/compendium-state-hiv-testing-laws-quick-reference-guide-clinicians-national-hivaids>
- Tobler, A. L., & Komro, K. A. (2010). Trajectories or parental monitoring and communication and effects on drug use among urban young adolescents. *Journal of Adolescent Health, 46*, 560-568.
- Wilton, L., Herbst, J. H., Coury-Doniger, P., Painter, T. M., English, G., Alvarez, M. E., et al. (2009). Efficacy of an HIV/STI prevention intervention for Black men who have sex with men: Findings from the Many Men, Many Voices (3MV) project. *AIDS and Behavior, 13*, 532-544.

Yoshikawa, H., Wilson, P. A.-D., Chae, D. H., & Cheng, J.-F. (2004). Do family and friendship networks protect against the influence of discrimination on mental health and HIV risk among Asian and Pacific Islander gay men? *AIDS Education and Prevention, 16*, 84–100.

NOTE

¹Only pseudonyms are used to protect respondent confidentiality.