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# The Role of Family Interactions in HIV Risk for Gay and Bisexual Male Youth: A Pilot Study

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## Abstract

Despite ongoing prevention efforts, young gay and bisexual males continue to engage in sexual behaviors that place them at disproportionately high risk for HIV infection. Parental monitoring and parent-child communication have been found to be associated with low-risk sexual behavior among heterosexual youth, but the role of family interactions for gay and bisexual male youth remains largely unexplored. To help address this gap, an exploratory study of recorded and coded interactions among 35 gay and bisexual youth and their parents was done to begin to identify which types of family interactions were associated with youth high-risk sexual behavior. Parent-son communication that was mutual and low in conflict was found to be most prevalent among youth with the fewest reported high-risk sexual behaviors. These preliminary findings, along with a case example, demonstrate how social workers can coach families to engage in productive and potentially influential interactions that reduce HIV-related sexual behaviors among young gay and bisexual males.

**Keywords:** gay youth, bisexual youth, families of gay youth, HIV prevention, family therapy

In spite of years of HIV prevention efforts, gay and bisexual men, along with other men who have sex with men (MSM), make up over half of all cases of HIV in the United States, and gay and bisexual youth seem to be particularly at-risk of infection (Centers for Disease Control [CDC], 2015). In 2010, gay and bisexual males accounted for 63% of all new infections; 22% of which were between the ages of 13-25 (CDC, 2014). Young gay and bisexual men (YGBM) of color are disproportionately represented among these statistics. Of the 38% of new infections among Black gay and bisexual men, 45% were among youth aged 13-25, and of the 22% of newly infected Latino YGBM, 39% were in this age range (CDC, 2015). Overall, there is good reason to believe that YGBM continue to engage in unsafe sex all too frequently (CDC, 2013) which no doubt accounts for these high rates of infection.

Individually-focused interventions such as safe-sex education, instruction in stress reduction, and sexual assertiveness, along with peer education have all been shown to reduce the frequency of unsafe sex among these youth (Koblin, 2004; Peterson & Jones, 2009; Wilton, Herbst, & Coury-Doninger, 2009). However, the overrepresentation of YGBM in the HIV statistics, along with the seemingly unstoppable rise of infection among them, indicates the need for additional prevention methods. This paper describes an exploratory study whose findings begin to suggest an additional way social workers and HIV prevention specialists can target family interactions for HIV prevention for this population.

Mental health problems (Beidas, Birkett, Newcomb, & Mustanski, 2012), substance use (Newcomb, Clerkin, & Mustanski, 2011), pressure from partners (Sullivan, Salazar, Buchbinder, & Sanchez, 2009), inadequate peer support (Carlos, et al., 2010), perceived social oppression (Arreola, Ayala, Diaz, & Kral, 2012), and low socioeconomic status (Myers, Javanbakht, Martinez, & Obediah, 2003) have all been found to be related to unsafe sex among gay and

bisexual youth. However, there is also a small, emergent body of knowledge suggesting that strong, supportive family relationships may be associated with being HIV negative (Garofalo, Mustanski, & Donenberg, 2008) and avoidance of unsafe sex (Author, 2007, 2014; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010; Yoshikawa, Wilson, Chae, & Cheng 2004), including among HIV-positive men (Kimberly & Serovich, 1999), while family rejection may be related to high-risk sexual behavior (Ryan, Huebner, Diaz, & Sanchez, 2009). Further, positive and supportive parental relationships may be protective for gay and bisexual youth when it comes to HIV risk factors, such as mental health problems and substance abuse (Needham & Austin, 2010; Ryan, et al., 2010). It is also noteworthy that family support may be important for the well-being of HIV-positive gay men (McDowell & Serovich, 2007; Serovich, Grafsky, & Craft, 2011). In light of this small but promising body of literature suggesting the impact of family relationships on YGBM along with the rising rates of HIV among this population, it is important to more thoroughly examine and specify the various family influences on gay and bisexual youth so that social workers, family therapists, mental health practitioners, and HIV prevention professionals can harness this information to help families keep their sons safe.

Generally, among samples of presumably heterosexual youth, parent-child interactions that include parental monitoring and communication are associated with youth engaging in lower-risk sexual behaviors (DiClemente, et al., 2008). Further, supportive family relationships, parental monitoring, and parent-child communication may be related to lower rates of drug and alcohol use (Rowe, 2012; Tobler & Komro, 2010), which are factors that have been found to be connected to risky sex (Donenberg et al., 2012; Marvel, Rowe, Colon, DiClemente, & Liddle, 2009). Parent-child communication that is mutual or nonhierarchical, open, and receptive has been attributed to lower sexual risk (DiIorio, McCarty, & Denzmore, 2006; Krauss & Miller, 2012; Pequegnat & Bell, 2012), and parental expertise, trustworthiness, and accessibility may be factors associated with lower risk behaviors (Guilamo-Ramos, Jaccard, Dittus, & Boris, 2006). However, these findings may not equivocally apply across populations of youth. For example, among a sample of adolescents receiving mental health treatment, mutual conversation about sex seemed to be related to higher risk sexual behaviors, while parent-child disagreement and more directive parent-led conversations were associated with lower risk, perhaps due to the need for more hierarchal relationships in these families (Nappi, McBride, & Donenberg, 2007; Wilson & Donenberg, 2004). For youth in the juvenile justice system, open communication combined with parental monitoring was found to be related to general sexual activity among girls but not boys (Udell, Donenberg, & Emerson, 2011), which echoes previous findings that suggest less of an impact of parent communication on boys than on girls (Browning, Leventhal, Brooks-Gunn, 2005). In a recent study of a sample of young MSM, parental monitoring and reported general communication about sex seemed to be related to higher incidents of unsafe sex (Thoma & Huebner, 2014). However, this study leaves open the question of whether various types of interactive communication patterns, other than parental monitoring, might be persuasive. Thus, it is important to recognize and continue to explore how different communication styles may be influential for different types of youth.

When investigating parent-child communication as a component of HIV prevention for YGBM, the distinct challenges such families encounter must be taken into consideration. When gay and bisexual youth disclose their sexual orientations to their parents, parent-child relationships can be temporarily and even permanently disrupted (Author, 2010; Ryan et al., 2009). Once families overcome the coming out crisis, relationships can still seem tentative as parents cope with feelings of guilt, mourning, and worry, while their children seek their unconditional love and support (Author, 2010). Considering the potential obstacles these families face, as well as the previous literature on family influences for heterosexual youth, more information is needed to specifically identify parental influences and particularly influential parent-child interaction patterns so that they can be targeted for HIV-prevention interventions. To that aim, the research question for this study was: What are the types of parent-child interactions that may relate to sexual risk behavior among gay and bisexual youth? If social workers, family therapists, and HIV prevention specialists knew which types of family communication were potentially associated with lower sexual risk, they could help facilitate these interaction patterns in their client families.

## Method

Thirty-five gay and bisexual youth and their parents/caretakers participated in a larger qualitative study of family influences on young gay and bisexual men's risky sexual behavior. Parents/caretakers and youth were interviewed individually and separately for the first phase of this study, and parent and youth reports of influences are documented elsewhere (Author, 2014). Following the individual interviews, parents and sons were brought together to discuss assigned topics with each other so that their interactions could be observed. The analysis of these observed discussions is the focus of this paper.

## Participants

*Eligibility.* Participant criteria for this project were as follows: youth needed to be males between 14 and 21 years old, living in New Jersey, the New York City, Washington DC, 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 the required 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. Additional recruitment venues included 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). Interested youth and their parents contacted the principal investigator (PI) who is the first author of this paper, and if they met the participation criteria, appointments for interviews and observed discussions were scheduled. Each individual respondent was paid \$100 for participating in the entire study.

*Respondents.* The 35 youth were between the ages of 14 to 21-years-old with a mean of 18.65 years of age ( $SD = 2.01$ ). Five youth self-identified as bisexual, and the rest identified as gay. One youth respondent was 14 years old, another was 15, and the rest were between 16 and 21 years of age. Forty-two parents and parental figures participated. They consisted of 9 fathers, 28 mothers, 2 custodial grandmothers, 2 custodial aunts, and 1 foster mother. Seven of the families in the sample included both biological parents. Parent/guardian respondents were between the ages of 32 and 60 with a mean age of 45.78 ( $SD = 7.21$ ). Though several youth and parents discussed initial negative reactions to learning that their son was gay or bisexual, parents who were interviewed were largely accepting of their children by the time of the study. Household income ranged from \$0 (two families in which the parents were unemployed) to \$275,000 with a median of \$46,000. Twelve of the youth were White, 13 were Black, and 10 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 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 during a consensual encounter and the other was infected by a man who raped him. Both of these youth reported engaging only in safe sex since becoming infected.

## Data Collection

Following their individual interviews, parents (one or both if available) and youth respondents from the same family were brought together and asked by the interviewer to discuss the following topics with each other: “How openly should parents and youth discuss safe sex? How openly do you discuss safer sex with each other?” “Is it ok for parents to supply their kids with condoms?” “How specific should parents and children be about sex, sexuality, and homosexuality as it relates to HIV/AIDS? How specific do you get?” “What obstacles, if any, are there for families of gay youth to talk about HIV/AIDS risk? What obstacles are there for you?” “What makes it easier or harder for such families to discuss HIV risk? What makes it easier or harder for each of you to talk about this?” “What can parents do to convince their kids to engage in only safer sex? What works in your family? What doesn’t?” “What should society do about the rising rates of HIV among gay youth? What should society do about the rising rates of HIV among African American and Latino gay youth, particularly because those rates are so much higher than those of White gay kids?” “Is there anything else you would like to add about how families talk about HIV?” “Is there anything anyone would like to add about how families can influence gay youth to engage only in safe sex?” “What kinds of HIV prevention services would help families like yours?” These questions were derived from the first author’s previous research and clinical experience working with families of gay youth. The conjoint interviews were facilitated by the interviewer whereby he fed the respondents questions one at a time and prompted them to discuss their answers with each other. Interviews lasted anywhere from 60-90 minutes.

All families were invited to be video recorded but if they declined, they could still participate as long as they agreed to be audio recorded. Nineteen families agreed to be video recorded and 16 were audio recorded only. This study was approved for human subjects by the (Authors’) University Institutional Review Board for the period of January 2013-January 2015.

## Date Analysis

A coding system to rate family discussions of risky sexual behaviors developed by Whalen, Henker, Hollingshead, and Burgess (1996) and utilized in modified form by Wilson and Donenberg (2004) was further modified to analyze the family interactions. The resulting typology used for this study consisted of: 1) Mutuality: interactions in which parent(s) and child relate on an equal basis; opinions and values of each are seen as equally important and worthwhile; 2) Directiveness: the degree to which a parent or son relates in a dictatorial, dominating, or demanding manner, attempting to control the other's behavior through commands; 3) Support: the degree to which parents encourage, validate, compliment, and admire their son and vice versa; 4) Disagreement: the degree to which parents or sons disagree with each other; 5) Withdrawal: the degree to which family members shut down and avoid talking with each other, particularly in the face of disagreement.

*Coding.* A team consisting of the PI along with two MSW-degreed research assistants who are second and third authors of this paper and who both are experienced in qualitative and quantitative data analysis, coded the audio and video recordings. The dialog following each discussion question was considered the unit of analysis for this study. Each of the variables in the typology (e.g., Mutuality, Mom's Disagreement, Son's Withdrawal, etc.) was coded on a scale ranging from 1 (low or very little) to 6 (high or very much). After a segment of dialog was reviewed, the recording was stopped and each member of the research team coded the interaction independently. Afterward, ratings were compared and disagreements discussed. Generally, after these discussions, the team arrived at one score, but occasionally team members disagreed and submitted scores that were different.

All demographic data and rater scores were entered into Excel and reviewed for entry errors. Next, the rater scores were used to construct new variables that represent resulting scores for each of the identified latent constructs (i.e., Mutuality, Directiveness, Disagreement, Support, and Withdrawal) for parents and sons. The resulting scores are the totals from the three raters (see Table 1 for descriptive information for the constructed variables).

Data were cleaned and rechecked to identify and exclude any data entry errors. An analysis of descriptive information and variability of rater scores showed no signs of differences between families who were video versus audio recorded, thereby ruling out potential bias associated with recording methods. Also, no differences were found based on gender of parent, race/ethnicity of the respondents or nature of the parental relationship (biological parent versus guardian). It is worth noting that female caregivers who were not biological mothers of the youth respondents, namely the two aunts, two grandmothers, and one foster mother, were included in the category "Mom" for the subsequent analysis. The One-sample Kolmogorov-Smirnov test (i.e., testing variables for normality) along with data missingness and descriptive information were used to review each variable and the information available for exploring the five parent-child interactions. The review showed no signs of missing bias but signs of non-normality. Therefore, parametric procedures are deemed not appropriate due to the small number of respondents and concerns over meeting statistical assumptions. With this conclusion we elected to use a respondent profiling procedures, not to draw inference on classification of individuals (which is ill-advised with only 29 people) but as an unbiased tool to identify which communication characteristics best help explain sexual behavior differences.

*Latent Class Analysis.* The traditional use of LCA, also called Latent Profile Analysis, is to build a probabilistic model with all variable values to predict group membership (Latent Class Analysis, 2014). LCA can accommodate non-normal variables and missingness (Latent Class Analysis, 2014; Rosato, & Baer, 2012; Sherman, et al., 2008). Other studies have used LCA to focus on grouping respondents (i.e., families in this study) to explore sexual-risk behaviors (Connell, Gilreath, & Hanson, 2009; Smith & Lanza, 2011). However, our use of LCA was not to build a probabilistic model, but to implement an unbiased procedures to identify which set of variables would provide the largest separation of mean values for sexual behavior for groups of youth. A systematic review of the variables was conducted to understand which parent-child interactions were more important than others in an LCA model (see Table 1). Next, correlations among the construct variables and unsafe sexual activity were reviewed to identify other variables that were either redundant or not informative. The correlation values for unsafe sexual behavior were all found to be non-significant at  $\alpha = .05$  and ranged from .01 to .65, indicating that no one construct variable was a replacement for measuring unsafe sexual behavior (see Table 2).

Mplus 7.11 (Muthén, & Muthén, 2011) was used to perform the LCA. Even though we were not interested in identifying group membership, model fit indices (e.g., entropy) were followed to verify that each combination of variables examined did reasonable fit the data. In addition, because of the small dataset, the occurrence of a group



with few respondents is highly possible, but a very small group within a LCA model is not necessarily problematic in that "...if it is a clearly interpretable class, I think it would be a pity to not consider it..." (Muthen, 2014). Respondent demographic data were not modeled because no significant differences within collected demographic data were identified.

Different variable combinations were used to model relationships with levels of Unsafe Sex (the number of incidents of unsafe sex in the year prior to study participation). The goal was to identify which potential set of parent-youth interaction variables were most related to risky sexual behavior. Due to the small number of participating families, the number of modeled groups (explored number of respondent groups) was limited to two and three. Deciding on the optimum combination of variables was accomplished by comparing estimated distribution of Unsafe Sex by group (i.e., mean and variance along the range of Unsafe Sex), group size among the LCA models, and theoretical validity of the selected variables for a model, all while following entropy, Akaike Information Criterion (AIC) and Bayesian Information Criterion (BIC) fit indices.

## Results

After examining many different LCA models with different combinations of construct variables, a final best-fitting model representing the widest difference in groups for unsafe sexual activity was identified. The final model included five variables (Unsafe Sex, Mutuality, Mom's Disagreement, Dad's Disagreement, and Son's Disagreement) with an entropy value of .989, which indicated that 98.9% of the respondents were matched correctly to the model's theoretical grouping of the respondents. The variables that were eventually excluded from the LCA model did not demonstrate a consistent relationship with, or offer recognizable group differences into unsafe sexual behavior. The concepts for both parents and sons associated with the excluded variables were Directiveness, Support, and Withdrawal. Therefore, Mutuality and Disagreement were found to be the relevant concepts when examining unsafe sexual behavior. See Figure 1 for the estimated distributions for Unsafe Sex values for three respondent groups ( $n = 29, 4,$  and  $2$  respectively).

Clearly, the majority of the respondents did not report large amounts of unsafe sexual behavior (Group 1 and 2), which could be a function of social desirability whereby respondents may tend to underreport unsafe sexual behavior (DiClemente, Swartzendruber, & Brown, 2013). However, respondents in Group 3 reported recognizably higher incidents of reported unsafe sex when compared to Group 1 and Group 2. This difference provided the opportunity to explore variances among the groups in the model (see Figure 2 for the mean values by group for the five variables in the model).

Respondents in Group 2 reported the lowest level of unsafe sexual activity while Group 3 represents respondents who reported the most incidents of unsafe sexual behavior (mean values of 0.492 and 2.5, respectively). A closer look at Figure 2 suggests that higher levels of unsafe sexual activity were associated with lower levels of mutuality between parents and sons and higher levels of disagreement. In addition, given the possible tendency to underreport unsafe sexual activity, one conclusion from examining Figure 2 is that respondents within Groups 1 were potentially in more jeopardy than they reported as indicated by the observed levels of mutuality and disagreement in their family interactions.

## Discussion

Although very exploratory in nature, this pilot study, combined with previous empirical investigations of YGBM and their families, contributes to an increased understanding of family influence for this population. Prior studies have acknowledged the importance of parental relationships on the HIV-risk behaviors of YGBM (Author, 2007, 2013; Garofalo, et al., 2008; Ryan, et al., 2009; Ryan et al., 2010; Yoshikawa, et al., 2004). Further, additional research has begun to identify how the content and context of parent-child discussions, such as parent-child closeness as well as warnings about condoms and the dangers of HIV and AIDS, might be related to gay and bisexual youth engaging consistently in safer sex (Author, 2014). This study adds to these findings by specifically identifying potential communication processes that might be influential or related to safer sex practices for this population.

Though conclusions from these findings must be very tentative considering the small sample, the way respondents were classified in the analysis suggests that family interactions typified by high mutuality and low conflict may be related to lower incidents of unsafe sex. These findings are consonant with studies of other samples of youth (DiIorio,

et al., 2006; Guilamo-Ramos, et al., 2006; Kraus & Miller, 2012; Pequegnat & Bell, 2012) and potentially add nuance to the findings of Thoma and Huebner (2014) as to the types of parent-youth communication that might be helpful. However, they contrast with those found among youth in mental health treatment (Nappi, McBride, & Donenberg, 2007; Wilson & Donenberg, 2004). Different types of family boundaries and interactions have different levels influence depending on the population of youth. This study's findings perhaps suggest that among a population that is gay or bisexual, family hierarchies and boundaries need to be less rigid than those in other families (i.e. youth in psychiatric care). This makes sense when one considers these findings in relation to how YGBM experience family relationships (Author, 2010). Youth seeking unconditional love and support can be met, at least initially, with parental disapproval, and these conflicting dynamics could interfere with influential family communication. Conversely, it has been found that open, supportive family relationships can be a protective factor for gay youth (Author, 2007; Ryan et al., 2010). Thus, families that successfully negotiate the coming out crisis to the extent that they can establish mutual, low-conflict dialogues about this potentially awkward topic, albeit with prompting, could indeed be considered supportive. Therefore, it would make sense that these youth would be among the lowest risk in the sample of this study.

As reported elsewhere (Author, 2014), half of the parents in this sample stated that they needed help discussing HIV issues with their sons. Parents in this study were knowledgeable of how HIV was transmitted, but did not know how to broach the topic with their children. Many of these parents reported that they participated in this research because they wanted to learn better ways to do so. Social workers, psychologists, and other mental health professionals, as well as HIV prevention specialists, can use the findings of this study to begin to guide their practice with YGBM as they help families discuss this potentially difficult topic. Enactment is a structural family therapy intervention during which the clinician stimulates interactions in order to help the family resolve conflict and improve communication (Minuchin & Fishman, 1981; Nichols, 2013), and clinicians can use enactment to help YGBM and their parents discuss HIV risk in a manner that is mutual and low in conflict. During enactments, the practitioner prompts family members to talk with each other, first to assess family interaction patterns and second, to help families improve their communication. Coaching parents to communicate with their children in ways that are less lecturing and authoritative but instead acknowledge their fears and their sons' wishes for parental approval and acknowledgement of their growing autonomy could go a long way in establishing the potentially helpful interactions identified in this study.

The following case example of Ricky, a 19-year-old Latino gay youth and his mother Ana, illustrates how a clinical social worker can use enactment to begin to help families establish and maintain conversations typified by the mutual and low conflict interactions identified as helpful communication patterns in this study:

Clinician: So, how do the two of you discuss HIV risk?

Ana: Well, I tell him all of the time, he needs to protect himself. His Aunt Rita died of AIDS 20 years ago. It was awful, so I tell him all of the time, "Don't be stupid," Don't I Ricky?

Ricky: [grunts] Mmm hmmm.

Ana: Damn right.

Ricky: [Looks up in the air, distracted.]

Clinician: I am wondering; is he hearing you? Is he listening?

Ana: He better be if he knows what's good for him.

Clinician: Look at him now. Are you sure you're getting through? Ask him.

Ana: [in a sharp tone] Ricky, are you listening to me when I talk about this? It's very important.

Ricky: [shrugs]

In this very one-sided conversation, Ana is attempting to send the right message about safety, but based on Ricky's verbal response and body language, it is not clear that she is getting it across. In response, the clinician lays the groundwork for an interaction that is more mutual and conversational.

Clinician: Let's try something a bit different today. Let me start with you, Ricky. Tell me how old you are again?

Ricky: 19.

Clinician: Does your Mom know this?

Ricky: What?

Clinician: What I mean is; does she get that you are pretty much an adult?  
Ricky: Ha! No! She treats me like a child...like I don't know anything.  
Clinician: A lot of mothers who worry for their children tend to do this and it looks like your mom is no exception. It can be pretty frustrating, no?  
Ricky: [shrugs]  
Clinician: So, what is Mom not understanding?  
Ricky: That I am not stupid... Jeez, I know how to take care of myself!  
Clinician: I believe you Ricky, and I might be able to help you convince your mom of that.  
Ricky: [pause] How?  
Clinician: Tell her right here, right now, in front of me, what you know about HIV and how you keep yourself safe, or plan to keep yourself safe.  
Ricky: Really? Now?  
Clinician: Yes, right now; and Ana, I want you to first just listen. Go on Ricky.  
Ricky: [tentatively and while glancing at the clinician] Mom, I know all about condoms and stuff; I am not stupid. Besides, I am not with a lot of guys.  
Clinician: Good Ricky, now go a bit further. What does your mom need to understand about you? What isn't she getting? Go ahead...tell her.  
Ricky: I am grown Mom, I know what I am doing.  
Ana: [softly] I know you are almost a man now, and you are smart and mature for your age in many ways....but...I guess I just worry about you, that's all.  
Clinician: Good Ana. Of course you worry a lot—I think that's part of the job description of being a mother, no?  
Ana: Yes [smiling] of course.  
Clinician: Now can you tell your son what it is that you would need to hear that would help you feel better and help convince you that he is being safe?  
Ana: Well, already, just by having this conversation, I feel a little better. But I have a few questions for Ricky.  
Clinician: Good. Go ahead; ask him.  
Ana: Do you need me to buy you condoms? You know you can ask me if you need them.  
Ricky: [softly] No Mom. Like I said, I don't go off with a lot of people, but when I need condoms I can get them for free at the community center.

McGoldrick, Carter, and Garcia Preto (2011) describe a family development perspective that articulates a young adult's growing *independence* in the context of family *interdependence*. Conversations about HIV prevention that are mutual and low in disagreement could be considered evidence of this developmentally appropriate autonomy-in-connection balance. In this brief hypothetical case example, the clinician, informed by the research findings of this study, is helping to shift the interactions from an authoritative, hierarchal style to one that is more mutual; validating the mother's concerns while at the same time acknowledging the son's emerging autonomy. Enactment, as introduced in this brief segment, is one way to help families communicate to each other in ways that recognize these roles. Several interventions have been designed and tested to enhance parental efficacy in discussing HIV (DiIorio, et al., 2006; Weekes, Haas, & Gosselin, 2013), and enactment could be an additional method worthy of empirical investigation.

### **Limitations and Conclusions**

This small, exploratory study has several limitations. First, caution must be taken in attempting to generalize these results to the overall population of families of YGBM. In this pilot research, LCA was used to begin to identify group differences within a small sample, and studies of larger samples are needed to enable sufficient statistical power to help confirm if the differences found herein are indeed valid. Secondly, the respondents were recruited from the northeastern United States, a relatively tolerant part of the country. Thirdly, only a small number of youth in this sample reported high frequencies of unsafe sex. Finally, this sample consisted largely of parents and guardians who were accepting and supportive of their sons. These factors could be indicative of a somewhat biased sample of safe



youth in positive family relationships likely typified by interactions that are relatively high in mutuality and low in disagreement. In addition, no differences were found regarding respondent race or ethnicity, gender of parent, or whether the interviewee was a birth parent or a guardian. This could also have been a function of the small sample, and further studies with larger samples that are more diverse in terms of geography, race and ethnicity, gender of the parent, nature of the parental relationship, parental acceptance, and sexual risk are needed.

It is important to acknowledge the artificial, somewhat contrived setting of the interactions that were the basis of these findings. It is reasonable to assume that parents and children were on their best behavior when they participated in the observed discussions. As stated earlier, many of these parents believed they did not do a good enough job discussing HIV with their sons (Author, 2014). Therefore, these observed interactions might have been the first time families discussed this issue in any length, and thus may have inadvertently served as an intervention. It is interesting to note that in spite of these factors, there was sufficient variability among the responses to conduct the analysis. Perhaps, in a more naturalist setting, there might be more variability in interactions, thus resulting in findings about mutual interactions that are more robust.

Additionally, it should be noted that in this sample, parents were generally unaware of their son's specific unsafe sexual behaviors. For sure, knowledge of a son's unsafe sexual practices could influence parent-child interactions, perhaps making them more likely to seek to monitor their children, and future studies of parent-child communication among families of YGBM who engage in unsafe sex could help further identify parent-child influences.

Previously identified factors that relate to HIV risk for this population should be taken into consideration and combined with family influence variables in future research. How the influences of family communication patterns interact with overall quality of parent-child relationships, youth drug and alcohol use, peer influence, partner pressure, experiences of oppression, and social support could be areas of further study leading to a multi-pronged approach to HIV prevention for these youth.

Social workers, family therapists, and HIV prevention specialists need additional information as to how to identify and make use of the potential resources of families of gay and bisexual youth (Author, 2013; Hartwell, Serovich, Grafsky, & Kerr, 2012; Henke, Carlson, & McGeorge, 2009). Limitations notwithstanding, this pilot study adds to extant literature that articulates family influences on gay and bisexual youth's safer sex behaviors by beginning to identify possible family interactions that have the potential to persuade gay youth to stay safe, and that also could be targeted as interventions. As seen with other populations of youth, the family is an important prevention resource for YGBM, and it is of vital importance that social workers, family clinicians, HIV prevention specialists, and other mental health and health professionals understand and access the power and influence of the family in the battle against HIV/AIDS.

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Table 1. Descriptive information for construct variables

Variables	N	Min	Max	Mean	SD
Mutuality	35	5	17.1	10.79	3.09088
Mom's directiveness	33	10.73	17.78	14.3492	1.86986
Dad's directiveness	9	4	14.92	10.5042	3.74215
Son's directiveness	35	5.89	17.27	11.9761	2.95202
Mom's support	33	3.36	15.4	8.3405	3.57746
Dad's support	9	3.09	10.58	5.8653	2.37996
Son's support	35	3.31	15.6	7.4831	3.13656
Mom's disagreement	33	3	14.36	4.6852	2.12984
Dad's disagreement	9	3	5.33	4.0985	0.91101
Son's disagreement	35	3	14.55	4.9122	2.52444
Mom's withdrawal	33	3	4.09	3.1868	0.36319
Dad's withdrawal	9	3	12.55	5.2247	3.54983
Son's withdrawal	35	3	10.45	4.1431	1.74338

Table 2 – Bivariate Correlation Values

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13
1- Unsafe_S	1												
2 - Mutuality	0.01	1											
3 - Mom's Directiveness	-0.32	-0.22	1										
4 - Dad's Directiveness	-0.32	0.17	0.7	1									
5 - Son's Directiveness	0.16	.871**	-.486**	0.09	1								
6 - Mom's Support	-0.24	.518**	0.04	-0.41	.392*	1							
7 - Dad's Support	0.65	0.65	0.01	0.2	0.61	0.72	1						
8 - Son's Support	-0.17	.573**	-0.02	-0.24	.414*	.816**	0.65	1					
9 - Mom's Disagreement	0.27	0.24	-0.13	0.11	0.33	-0.03	0.19	-0.21	1				
10 - Dad's Disagreement	-0.33	0.08	0.52	0.29	0.11	-0.4	-0.21	-0.61	.781*	1			
11 - Son's Disagreement	0.23	0.25	-0.09	0.03	.375*	0.06	0.15	-0.1	.911**	0.66	1		
12 - Dad's Withdrawal	-0.11	-0.09	-0.67	-.861**	-0.01	0.17	-0.49	0.05	0.1	-0.03	0.2	1	
13 - Son's Withdrawal	-0.18	-.569**	.436*	0.14	-.644**	-0.3	-0.66	-.411*	0.04	0.15	-0.01	-0.08	1

Figure 1. Distribution of unsafe sex by LCA classes

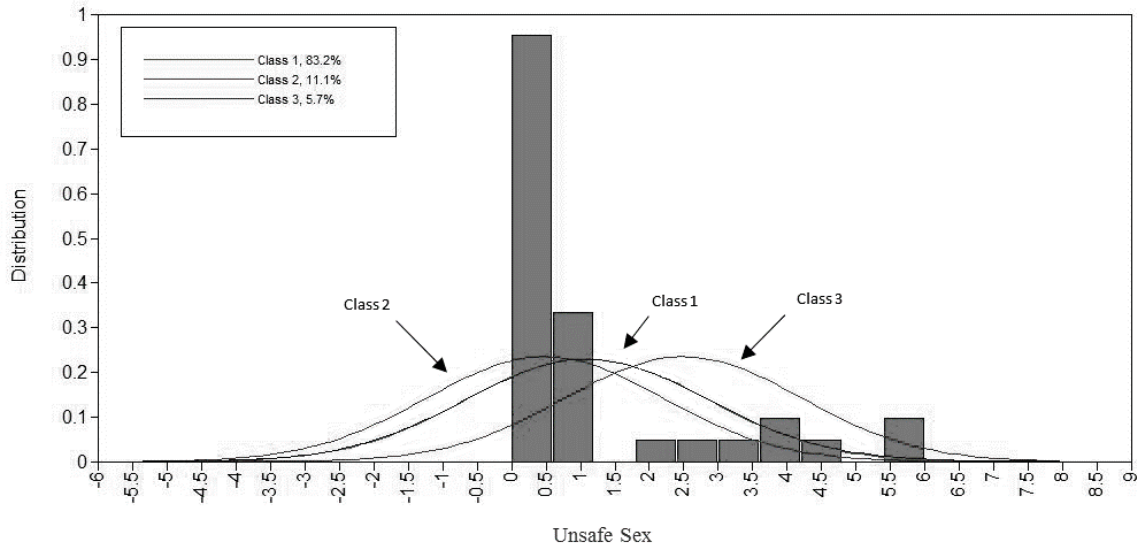


Figure 2. Line graph of mean values by LCA class

