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Communicating in Complex Situations: A Normative Approach to HIV-Related Talk Among Parents Who Are HIV+

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Abstract

Parents with HIV/AIDS are confronted with unique challenges when discussing HIV-related information with their children. Strategies for navigating these challenges effectively have not been systematically examined. In this study, we conducted in-depth interviews with 76 parents with HIV/AIDS who had children ages 10-18. Guided by O'Keefe and Delia's definition of a complex communication situation and Goldsmith's normative approach to interpersonal communication, we examined parents' goals for discussing HIV-related information, factors that made conversations challenging, and instances where these conversational purposes conflicted with one another. Our data reveal the following parent-adolescent communication predicaments: relaying safety information about HIV while minimizing child anxiety, modeling open family communication without damaging one's parental identity, and balancing parent-child relational needs amidst living with an unpredictable health condition. Parents also described a variety of strategies for mitigating challenges when discussing HIV-related topics. Strategies parents perceived as effective included: reframing HIV as a chronic, manageable illness; keeping talk educational; and embedding HIV-related topics within more general conversations. The theoretical and practical applications of these findings are discussed with regards to their relevance to health communication scholars and HIV care professionals.

Keywords: parent-adolescent communication; HIV prevention; HIV disclosure

Introduction

Chronic health conditions can create complex communication situations within families with regards to talking about lifestyle issues. These situations arise when a family member has multiple goals in mind for carrying out health-related conversations, but significant challenges to communicating those goals exist (Goldsmith, Lindholm, & Bute, 2006; Wilson, 2002). Parents with HIV/AIDS, for example, are likely grappling with several conflicting goals or objectives when discussing HIV and HIV prevention with their children. These parents typically have a keen appreciation for educating their children about the risks of HIV, and thus an implicit goal of keeping their children safe from HIV infection (Murphy, Roberts, & Herbeck, 2012). Many have not disclosed their HIV status to their children, however, and might also be reticent to discuss broader aspects of HIV and HIV prevention (Green & Smith, 2004; Letteny & Laporte, 2004). Studies that have examined parental concerns about discussing HIV with children report that parents with HIV wish to avoid upsetting or scaring their children (Murphy, 2008; Obermeyer, Bajjal, & Pegurri, 2011), are worried about disclosing their past "mistakes" in conversation, and sometimes feel

“inexperienced” when discussing behavioral risk (Brackis-Cott, Block, & Mellins, 2003, p.64). Thus, striking a balance between providing safety information about HIV, while at the same time attending to personal communication goals (e.g. not disclosing damaging information about one’s past) has the potential to create significant conversational predicaments.

Understanding the complex situations parents with HIV/AIDS face when communicating about HIV with their children is important for a number of reasons. First, youth who have a parent with HIV are considered among the highest risk for contracting HIV themselves (Chabon, Futterman, & Hoffman, 2001; O’Sullivan, Dolezal, Brackis-Cott, Traeger, & Mellins, 2005). Second, parent-child relationship factors (e.g., lack of parental monitoring, supervision, and communication) have been identified as a key mechanism by which adolescents in these families might be at risk for unsafe sex or drug use (Mellins et al., 2007). Third, thanks to advances in HIV treatment, individuals with HIV are living longer and having children; it is estimated that 75% of women with HIV are mothers, with an average of 2.6 children per woman (Bhaskaran et al., 2008; Forsyth, 1995; Mofenson, 2003). Along with the increase in lifespan and parenthood has come a need for up-to-date and contextually-relevant communication interventions, including those that focus on parent-child communication about HIV prevention (Tinsley, Lees, & Sumartojo, 2004).

The broader parent-adolescent communication literature (examining parents who are *not* HIV+) provides ample evidence that parent-child discussions about sexual health can have a significant impact on adolescent attitudes and HIV risk behavior (DiIorio, Kelley, & Hockenberry-Eaton, 1999; DiIorio, McCarty, & Pluhar, 2008; Hutchinson & Cooney, 1998; Pick & Palos, 1995). Adolescents of parents who broach the topic of sexual health are less likely to initiate early sexual activity (Baumeister, Flores, & Martin, 1995), more likely to use personal protection when they are sexually active (Miller, Kotchick, Dorsey, Forehand, & Ham, 1998; Whitaker & Miller, 2000), and have a decreased risk of HIV transmission (Leland & Barth, 1993; Perrino, González-Soldevilla, Pantin, & Szapocznick, 2000). Most current evidence also suggests that effective parent-adolescent conversations about HIV prevention are frequent, timely (e.g., occur before the onset of sexual activity), open and comprehensive, interactive, and occur within supportive parent-child relationships (Dittus & Jaccard, 2000; Dittus, Miller, Kotchick, & Forehand, 2004; Dutra, Miller, & Forehand, 1999; Miller et al., 1998; Miller, Levin, Whitaker, & Xu, 1998; Pluhar, 2001). Although a number of studies have examined disclosure of parental HIV status to children (Greene, Derlega, Yep, & Petronio, 2003; Kennedy et al., 2010; Murphy, 2008; Qiao, Li, & Stanton, 2011; Shaffer, Jones, Kotchick, & Forehand, 2001), less is known about how families who have actually been affected by HIV/AIDS communicate about HIV prevention. The few studies examining parent-adolescent conversations about HIV prevention estimate that 48-95% of parents with HIV have broached preventive topics (Cederbaum, 2009; Corona et al., 2009; Marhefka, Mellins, Brackis-Cott, Dolezal, & Ehrhardt, 2009; Murphy et al., 2012, O’Sullivan et al., 2005).

To date, there have been no analyses of the conversational goals, communication predicaments encountered, or conversational strategies attempted by parents who are HIV+ when communicating with their children about personal protection and sexual issues. As recent health communication scholarship has demonstrated the utility of studying sensitive conversations through a goals lens (Brashers et al., 2003; Caughlin et al., 2009; Goldsmith et al., 2006; Kosenko, 2010), we propose that HIV-related conversations between parents with HIV and their children can be usefully examined within the framework of Goldsmith’s (2001; 2004) normative theory. According to normative theory, it is important to examine the personal motivations, situational demands, and multiple interpretations of talk that influence how conversations unfold with greater or lesser success. At the heart of this theoretical framework are the premises that individuals pursue multiple goals during communication and that these goals might conflict, giving rise to various conversational predicaments.

The notion that communication is goal-oriented, and motivated by far more than a simple desire to transmit information, is a fundamental postulate of interpersonal communication theory and research (Clark & Delia, 1979; Dillard, Segrin, & Harden, 1989; O’Keefe, 1988). Clark and Delia (1979) first identified three types of goals that are relevant to communication: instrumental goals, which define the purpose of an interaction (e.g., persuading an adolescent to abstain from sexual contact); identity goals, which focus on the mutual presentation and reinforcement of interlocutors’ selves (e.g., trying to be a responsible parent, and respecting adolescents’ growing autonomy); and relational goals, which address the development and negotiation of relationships (e.g., dealing with concerns about how conversations about sexual behavior and HIV might change the nature of a parent-child bond).

Scholars have theorized that communication becomes particularly complex when multiple goals are significant and relevant to a conversation (O'Keefe, 1988; O'Keefe & Delia, 1982). According to Wilson (2002), a situation is complex when (a) its constituent features create multiple situationally-relevant objectives, (b) significant obstacles to achieving those objectives are present, and/or (c) actions that accomplish one objective conflict with those that accomplish other relevant objectives (p. 161). To appreciate how HIV-related conversations between parents and children meet the complexity criteria outlined by Wilson (2002), consider the objectives and goal conflicts in the following example:

A father wishes to share with his teenage son the story of how he contracted HIV. His primary purpose is to caution his son about unprotected sexual encounters. The father also wishes to impart first-hand knowledge of what it is like to be diagnosed and subsequently live with HIV, and how his circumstances might have been avoided. Given conventional parent-child relationship norms about discussing sexuality, this conversation has the potential to make both men uncomfortable (Kirkman, Rosenthal, & Feldman, 2005), and thus create a significant obstacle to conversation.

Consequently, actions to accomplish one objective (e.g., navigating the conversation in a way that helps both father and son maintain appropriate levels of privacy about their respective sexual relationships) might conflict with actions to accomplish another objective (e.g., the goal of being honest about past errors in judgment when it comes to sexual behavior). An additional impression management concern for the father might involve his desire not to be viewed by his son as irresponsible, which could also conflict with his goal of being truthful about the past.

In essence, one helpful means of conceptualizing why parent-child communication about sex and HIV is challenging is to consider that multiple goals are relevant, that they can conflict with one another, and that relational partners may grapple with how to overcome conversational obstacles in satisfying ways. Thus, with regard to parents who are HIV+, we asked:

RQ1: Do parents' descriptions of communication with their children demonstrate challenges that exist as a result of multiple, competing goals? If so, how?

A subsequent principle of normative theory is that not only do multiple goals exist during complex conversations, but their presence and pursuit have implications for the relative success of interactions (Goldsmith, 2004). This is because some conversational strategies more effectively satisfy the demands of the conversation than others (Goldsmith, 2001). Consequently, Goldsmith's framework is an ideal fit for examining parent-child talk about HIV because it both helps us to identify problematic competing goals and enables us to examine how parents resolve or minimize goal conflicts. In this study, we were interested in how parents would describe their attempts to manage the complex communication situations that arose when talking about HIV-related topics with adolescents, and we sought to identify the strategies that were described as relatively effective. Therefore, we asked:

RQ2: What strategies do parents who are HIV+ use to mitigate communication challenges created by multiple relevant goals?

Method

Sample

Following Institutional Review Board approval, 76 parents with HIV or AIDS were interviewed as part of a larger study on parent-child communication about HIV and HIV prevention. Recruitment took place via fliers mailed to over 180 HIV/AIDS service organizations in the Midwest. Fliers instructed interested parents to call a toll-free number where they could be assessed for inclusion in the study. Parents or guardians who self-reported an HIV or AIDS diagnosis, had one child aged 10-18 who was *not* infected with HIV, and either lived with or had frequent (at least monthly) contact with their adolescent over the past year were eligible to participate. Each participant received \$30 for his or her participation.

Altogether, 63% of participants were mothers; 37% fathers. The majority of the sample identified as African American (72%) and reported a high school education or less (89%). Average parental age was 47 years ($SD = 7.5$); average adolescent age was 15 years ($SD = 2.5$). Approximately two-thirds of parents had disclosed their HIV status to their children. The average time since HIV diagnosis was 12 years ($SD = 5.7$); 11% reported an AIDS diagnosis.

Procedures

Each parent participated in a 60-90 minute semi-structured interview. The interview script was constructed after a thorough review of the relevant health communication literature and pretested during pilot interviews. Questions were open-ended to allow for sufficient depth and originality of participant responses. Guided by Goldsmith's normative theory, questions focused on the two main domains of interest: (1) communication challenges parents encountered when discussing HIV prevention with their children and (2) strategies they believed were effective for discussing HIV-related topics with adolescents. For example, parents were asked if it was difficult to bring up information about HIV prevention, what challenges they faced, if certain ways of bringing up HIV with adolescents worked "better" than others, and what ways of talking about HIV and prevention had "worked well" within their family. They were also asked for examples of conversations that had not worked well, and to provide advice on how to broach HIV-related topics. At the conclusion of the interview, parents filled out a questionnaire assessing relevant demographic and health-related characteristics.

Although this study was originally designed to examine parental discussions about HIV prevention with adolescents, during the interviews it became apparent that parents viewed the distinction between HIV prevention and HIV disclosure conversations as somewhat artificial. Disclosure conversations often included some form of preventive information and HIV prevention communication sometimes involved self-disclosure. To capture the complex and sometimes fluid nature with which parents spoke of disclosure and prevention, we have chosen the broader term "talk about HIV-related topics" to describe these conversations.

Data Analysis

Interviews were audio-recorded and transcribed verbatim. To protect confidentiality, identifying information was removed from the transcripts and each participant was assigned a pseudonym. Coding proceeded via a grounded theory approach, using participant data to generate inductive themes and the constant comparative technique to systematically assess those themes (Charmaz, 2006; Strauss & Corbin, 1990). Data analysis was an iterative process, with theoretical memos kept throughout the interview, transcribing, and coding process. The research team met multiple times over a period of several months to discuss ideas and findings. Prior to analysis, two members read through a random sample of 15 transcripts and developed independent lists of common themes focused on the two major study objectives (e.g., communication challenges and effective parental management strategies). All members then agreed upon a central list of themes for analysis. Memos were used to make analytic connections between and within transcripts and to flesh out dimensions of themes (Charmaz, 2006).

Coding was separated into two rounds. During the first round, two coders independently coded the same half of transcripts (looking for themes related to the complex communication situations faced by parents when discussing HIV-related information with adolescents). Because the coders were largely consistent in their coding, the primary coder completed the remaining transcripts. Any coding problems or questions were discussed and decided upon by at least two coders. During the second round, coders returned to the transcripts to analyze the conversational strategies parents used to effectively navigate their complex communication situations, using the same methods outlined above. The credibility of the data and findings were assessed by peer debriefing sessions and by systematically comparing observations within and across study participants (Charmaz, 2006; Thomas & Magilvy, 2011). Recruitment continued until no new themes emerged and theoretical saturation of each theme had been reached (Charmaz, 2006).

Results

Communication Challenges Associated with Multiple Goals

For our first research objective, we examined whether or not parents faced communication challenges as a result of multiple, competing goals (and if they did, what specific goals conflicted and presented a challenge). Parental goals for communicating about HIV-related topics included instrumental goals (e.g., promoting child safety and minimizing child anxiety), identity goals (e.g., being open and maintaining a positive role identity and self-image), and relational goals (e.g., communicating in ways that fostered a close, balanced, and emotionally supportive parent-

child relationship). Some parents reported that their goals conflicted with one another, which presented them with the challenge of how best to accomplish their multiple objectives. Examples of three prominent parental goal conflicts are provided next.

Promoting safety while minimizing child anxiety. Parents expressed a great desire to protect their children from the physical, social, and emotional harms of contracting a sexually transmitted infection like HIV. Parents' goal of promoting adolescent safety was sometimes in conflict, however, with another instrumental goal, that of minimizing adolescent anxiety about HIV and HIV infection. One mother summarized her predicament as follows: "So for me it's like a draw off. It's still a sticky situation...because I don't want to scare him, but I don't want what happened to me to happen to him." Thus, although parents wanted their children to be safe and informed about HIV, they did not want adolescents to be overly scared of HIV, constantly worried about their (the parent's) health status, or to burden them with information that might cause them to "grow up too fast." Camille summarized her conflicting goals for talking to her 15 year old son as follows:

I'm just really confused. I think I should tell my son everything about HIV and AIDS...because they [kids] have to be really smart with what they're doing, like use protection...But I don't want him to feel afraid...and I don't want him to feel more sad.

As Camille alludes, discussing key information about HIV had the potential to help her son make smart behavioral decisions, but also had the potential to frighten or upset him. Another mother had similar sentiments: "I can say chlamydia, I can say syphilis, I can say HIV/AIDS, so that they're getting a clear understanding, but it's scary. The first time I ever heard the word AIDS...I got to trembling...all you think about is death." As this mother points out, the terms "HIV" and "AIDS" remained so embedded in cultural and societal perceptions marking the early epidemic (e.g., AIDS as a "death sentence") that some parents feared any HIV-related discussion might evoke these images in adolescents' minds. For this mother, referring to the disease in a straightforward manner satisfied the goal of being clear in order to promote child safety, but also had the potential to be frightening and thus interfered with the goal of minimizing children's unease.

In addition, parents emphasized that their goal of keeping their children safe from HIV infection included keeping them safe at home. On the one hand, parents wanted to discuss any potential danger of HIV transmission in the household, while on the other, they wished to avoid making their children anxious or scared of their own living environment. Nonetheless, many parents chose to talk with their children about the importance of household safety measures and of being extra cautious with one's personal belongings. This included teaching children not to use their toothbrushes, razors, nail clippers, and not to touch dirty laundry, medical equipment (e.g., diabetic finger prickers), or anything else that might have remnants of blood or body fluids on it. One mother recounted an episode where her daughter had scared her by shaving with her razor:

She [my daughter] is getting to that age where they've got to be curious. She was in the bathroom a long time and I said "Theresa, what are you doing?" She says, "Oh, I'm shaving my legs." The first thing that went through my mind was "She's using my shaver!" When she got out I said "Let me tell you something sweetheart. NEVER do that...Don't get me wrong, it does give you a little bit of a scare. Because when I told her about HIV and AIDS and how it was transmitted, I never told her other precautions... And I don't want to be mean or scare her, but there are things you can't do when [your mother has] HIV.

This mother had since re-arranged many of their household items to make them less available to her daughter. Although she was glad she had encouraged her daughter to be cautious in the above scenario, she also wanted to avoid making her daughter fear common household items. Stories such as this one revealed that parents sometimes struggled with how to prioritize and integrate the goals of emphasizing the dangers of HIV transmission while also making sure their child wasn't overly anxious about becoming infected at home.

Being open without damaging parental identity. Most parents had a goal of being "open" or "real" with adolescents, and felt that adolescents deserved to be informed of family issues and health concerns in a timely manner. The goal of openness, however, was sometimes at odds with two other identity goals: parents' desires for their children to view them as caring, responsible adults and parents' wishes to maintain a positive self-image. Jerry emphasized this obstacle as follows:

We talk about prevention. I advocate that, until we're able to discuss this at the dinner table, at the barbershop, in church, at the pool, then the disease is killing us... So I'm a proponent of discussing things as openly as possible...But it's tough...because I felt like if we didn't deal with my addiction we couldn't deal with HIV.

As Jerry alludes, one potential challenge with being open and honest was discerning *how* to disclose information about one's past in a way that was productive for the child, yet did not cause the parent undue guilt, anxiety, or shame about their past. Parents struggled with identifying what information was appropriate and/or necessary to share with a younger audience versus what information they should keep private. For example, Samuel explained the difficulties of trying to be truthful yet maintain his self-worth as follows:

I don't lie to people, I try to tell the honest truth as much as I can...[But] I really was more ashamed to tell them. I was [ashamed] because I also am a drug addict. ...So to tell them after my episodes of not being there that I was not only a drug addict but I was HIV+ – I think they were more angry at me than anything. Because my youngest, his reaction was “Well, you can't eat out of our plates.” I took that as evidence he didn't know about the disease.

Comments such as this reveal the multiple, contextually-embedded meanings that parents associated with HIV-related talk. For Samuel, talking openly with his children could simultaneously paint him in an honorable and a shameful light (e.g., an honest parent, but one who had been addicted to drugs). Some parents feared that talking about HIV prevention openly would lead to questions about whether or not the parent was HIV+ and how the parent contracted HIV, and that this information could conflict with their goals of maintaining a positive self-image and their identity as a caring, responsible adult.

Balancing parent-child relational needs. The final goals parents expressed were of a relational nature: communicating in a way that fostered a balanced and emotionally supportive parent-child relationship. Parents *wanted* to be able to talk about HIV-related topics, for example, in order to attend to their own mental health and well-being. The more open parents could be with their children about HIV-related information, the less they had to worry about keeping track of secrets, keeping multiple versions of a secret with different family members, or hiding their emotions about HIV in the presence of their children. As one father summarized: “My secrets kept me sick...And I want to be well; I want all of my family [to be] well.” Parents were also cognizant, however, that *too* much talk about HIV could interfere with their goals of having a close, normative, and emotionally supportive parent-child relationship, by either straying too far from what is considered normative parent-child talk or by detracting from discussions of their child's most imminent interests and needs. Mabel, for example, explained that sharing information about her own HIV status, safe sex, and condoms with her daughters often reminded her of how close they were, however she also worried that she might overload her children with information about HIV, which could actually detract from a normative parent-child relationship. As she relayed:

My daughters and me, we are like this [crosses her fingers]. I tell them everything about sex and HIV. Everything. Sometimes people will be like “You don't need to be telling that girl this and that [about HIV].” And I wonder that sometimes too. Maybe I should just let them be and talk about normal teenage stuff.

Another mother, Eyana, recounted an incident where she felt her goals of remaining emotionally supportive for her daughter conflicted with her goals of trying to keep her daughter safe from HIV infection. As this mother shared:

She [my 17 year old] just had a situation where she was a victim in a rape case...I was trying to be there for her. One of my friends had gone to the hospital with me and we told her that she can get on preventive medicines, so just in case he had HIV she wouldn't get it. And she had to stay on the meds for 28 days. And everyday it was like pulling teeth trying to get her to take those pills. She was like “Well, can't they just wait until I test positive and then give me the medicine to get rid of it?” I was like “NO! Because once you test positive you've got to take the medicine for the rest of your life.”

Eyana struggled with how to most effectively meet her goals of “being there” for her daughter (e.g., demonstrate that she valued their relationship, not upset her daughter or strain the parent-child bond, and respect her daughter’s autonomy), while at the same time trying to convince her daughter to do something she knew she didn’t want to do: take post-exposure HIV prophylaxis. She worried that her attempts to keep her daughter safe might actually detract from their close relationship, by repeatedly bringing up an HIV-related conversation she knew her daughter would resist.

Effective Conversational Management Strategies

In answer to our second research question, parents reported strategies they believed to be effective for managing the challenges presented by competing goals. The following efforts helped them both prevent and resolve the problems that occurred when conflicting objectives were present.

Reframing HIV as a “normal” chronic illness. Parents felt they could both promote adolescent safety and prevent undue child anxiety by reframing HIV as a “normal” (e.g., manageable, unstigmatized) chronic illness in their households. Many believed that if HIV was made a relatively common topic of conversation, adolescents would feel less anxious discussing HIV and related safety information. Parents took several steps to reframe conversations about HIV for their children, including focusing on HIV as a chronic versus an acute illness and fostering messages of acceptance of people living with HIV (e.g., people with HIV are “normal” or “no different than other people”). As one mother conveyed:

As the years went by and we kept going to [HIV] camp...by like eight or nine years old she started asking me questions, like “Mom what is HIV? Are you going to die?”... That’s when I said “Look, we all have to die one day, but you’ve got to understand that this is something people are living with. I mean nowadays people are living!...But with this epidemic, if you guys are going to have sex, you’re going to have to use a condom, because if you don’t you could get infected and if you get infected that’s it... you’re going to have to take medications for the rest of your life.”

This mother used her child’s interactions with both sick and healthy individuals at camp to discuss what HIV was, how it was transmitted, and some possible consequences of living with the disease. Reframing HIV as a normal chronic illness helped her to lessen her daughter’s anxiety about the disease, but still invoke an appreciation for the seriousness of the disease (e.g., the possibility of death, taking daily medications for life) and the need for personal protection.

Keeping talk educational. One strategy parents used to balance being open with adolescents while maintaining a desirable self-image was to set explicit boundaries between personal and professional and/or educational information. Parents who used this method tended to be strategic about what information they shared. For example, they separated purely educational information (e.g., how HIV is transmitted in general) from deeply personal information (e.g., I contracted HIV when I cheated on my partner and we were both using drugs). Learning to separate personal from educational information allowed parents to be “open” with adolescents to the extent they felt comfortable doing so, while still maintaining self-dignity and respect. Robert, for example, had initially struggled to discuss HIV-related topics because he was embarrassed about both his HIV status and his sexual orientation. He had since learned to set explicit boundaries for his children regarding questions about sex and HIV:

One of my kids actually asked me.... “Well if you’re with HIM, how could you have been with HER?” I’m like, “I’m not getting into that, because that goes back to parents and what happens in the bedroom between Mommy and Daddy. You don’t need to know about that. Now, what happens between Dick and Jane, yeah we can talk about that...” That’s more or less [why it’s hard], I think most parents are afraid of “let me tell you what happens in our bedroom” rather than what’s happening in Dick and Jane’s.

As this father emphasized, he was not making these topics unapproachable for his sons (i.e., his children could still ask him about homosexuality in general or about hypothetical situations); he was merely drawing a line when it came to details about his *personal* sexual history and relationships. This strategy allowed him to view himself as an open, caring, and responsible parent (e.g., one who provided important educational information to his children about HIV), but also helped preserve his self-image by avoiding topics that he felt could portray him in a damaging light.

Framing or embedding HIV-related talk. The predicament of balancing parent-child relational needs and preserving the parent-child bond was often addressed by framing or embedding HIV-related talk within more general topics. This strategy allowed parents to craft messages that expressed the information they wanted to convey to their child *and* to make sure they were meeting their child's needs (e.g., a nurturing, stable, and respectful parent-child relationship). For example, one father preferred to “ease in” talk about HIV while he asked his children how their day went at school. As he advised:

Have fun and laugh with them. First, find out things that are going on in their lives, at school, and question them. Take time. That way, if you feel like the tension in the air is kind of thickening when you get to HIV, you can say “You want an apple?...Here, taste that.” Then you can initiate more with them. Now they're like “Oh, ok. Well there was a question I was wondering about.” And they ask it or come back [and ask later]. Mine have all done that. They have said “Well, what is HIV? Will I get it?” I said “Not if you keep doing what you are supposed to be doing.”

For this father, embedding HIV-related information within more general and expected conversations enabled him to pursue his conversational objectives (e.g., feel close to his children, create a safe space to discuss HIV) while also attending to his children's relational needs during the communication encounter (e.g., stability and closeness from following their regular after school routine).

Discussion

Talking about HIV-related topics with adolescents gave many parents an opportunity to promote adolescent safety, model open family communication dynamics, and strengthen their relationships with their children. Nonetheless, negotiating these conversations took considerable self-confidence and skill. Whereas parents generally felt they had high quality knowledge about HIV to share with their children, they were sometimes faced with communication predicaments when relaying this knowledge. Effective conversations were often viewed as situations where parents could carefully manage their competing communicative goals. The following section discusses the theoretical and practical implications of these findings.

Complex Communication Situations: Theoretical and Practical Implications

Promoting safety while minimizing child anxiety. Parents viewed communicating about the risks of contracting HIV as a vital means of keeping their children safe: they wanted to ensure that their children knew about HIV/AIDS and understood that the consequences of acquiring the disease were real. Yet parents also recognized that talking about HIV could be frightening to their children, and many purposefully avoided or sought to minimize methods that invoked adolescent anxiety or perpetuated fear. Thus, parents were caught between wanting to arm their children with knowledge and not going overboard with scare tactics, either inadvertent or intentional ones. They weighed the tradeoffs between educating adolescents and scaring them, and ultimately ended up reframing or “normalizing” HIV to try to effectively manage this challenge.

These findings suggests that parents with HIV might be apprehensive about using strategies that focus on fear-arousing messages—a common, yet contested health persuasion strategy. Despite decades of debate on whether or not fear-based messages are effective, more recent scholarship on fear appeals (e.g., Peters, Ruiter, & Kok, 2012; Witte, Meyer, & Martell, 1994) indicates that fear-based messages can be relatively successful if (a) substantial perceptions of threat severity and susceptibility are aroused, and (b) these perceptions are accompanied by beliefs that one can effectively respond to the threat or danger (Witte & Allen, 2000). Applied to our sample, this theory predicts that parents could effectively influence their children to engage in protective behaviors if they (a) established that HIV is a substantial threat to their child's well-being, and (b) enhanced their child's self-efficacy for avoiding HIV infection (e.g., told them what household objects to avoid, explained the necessity of using condoms). However, many parents in our sample indicated that they were hesitant to use fear-arousing messages about HIV with their children (and instead preferred to invoke an appreciation of the seriousness of HIV while using a more normal tone). As more and more literature amasses indicating the circumstances under which fear-based messages are effective, our findings remind scholars that it will be important to test these messages on various subpopulations (e.g., parents with HIV) and tailor interventions accordingly. Communication frameworks such as the one we've

chosen for this study (e.g., Goldsmith's normative theory; 2001) provide a particularly useful lens for examining the multiple, often nuanced meanings associated with various types of conversations, and could be of great value for designing specific HIV prevention messages for families affected by HIV/AIDS.

Being open without damaging parental identity. A second parental communication challenge that emerged involved parents' desires for managing their identities when communicating about HIV-related topics. On the one hand, the parents we interviewed had unique life experiences that helped them to establish themselves as credible sources—they had contracted HIV through various behaviors for which their children might someday be at risk, and they had first-hand knowledge about living with the virus. On the other hand, parents struggled with the ramifications of disclosing to their children both their HIV serostatus and how they had contracted the virus. They were concerned that their children would view them negatively, which could interfere with their relationship in general and might detract from their roles as trustworthy experts on sexually transmitted infections.

Concerns about being viewed negatively after self-disclosure are common among individuals living with HIV (Caughlin et al., 2009; Derlega, Winstead, & Folk-Barron, 2000; Greene & Faulkner, 2002). Although the primary intent of our study was not to focus on HIV disclosure conversations per se, our data indicate that talk about prevention and HIV disclosure have distinct overlap (more than is currently attended to in the HIV disclosure and HIV prevention literature). Some parents incorporated information about HIV prevention into HIV disclosure conversations, others used prevention topics to set the groundwork for future disclosure conversations, and still others ended up disclosing aspects of their illness during prevention talks that were not part of their original disclosure conversation. Thus, some of our findings speak to and build upon contemporary models of HIV disclosure.

Two current models of health disclosure information will be briefly considered here: the Disclosure Decision-Making Model (DD-MM; Greene, 2009) and the Disclosure Process Model (DPM; Chaudoir, Fisher, & Simoni, 2011). Whereas past disclosure models focused on the effect of disease progression on HIV disclosure (e.g., parents would disclose when they became symptomatic; Serovich, 2001), more recent theorizing emphasizes the importance of the anticipated after-effects of disclosure (e.g., parents disclose after they weigh various anticipated risks and benefits of disclosure; Derlega et al., 2000). According to both the DD-MM and the DPM, parents who anticipate many positive consequences (and few negative consequences) will have a higher likelihood of disclosing their HIV status. The DD-MM also gives special attention to the "assessment" phase of disclosure, namely that the discloser considers various overlapping factors in his/her decision to disclose (e.g., the stigma and symptoms associated with the disease, the disease prognosis, how prepared the discloser was for receiving his/her diagnosis, and the relevance of the diagnosis to others).

Our findings, though they cannot speak to a quantitative assessment of factors parents' weighed in their decisions, do indicate that parents considered both the positive and negative after-effects of engaging in self-disclosure. Similar to the emphasis of the DD-MM, parents who believed that information about their HIV diagnosis was directly relevant to their children (e.g., could help keep them safe from HIV infection) appeared more motivated to disclose information about HIV and HIV prevention. Thus, parents often assessed the safety measures and protective behaviors that might come out of discussing HIV with their children. This orientation toward sharing information relevant to helping or protecting others is echoed in other research. For example, Serovich, Lim, & Mason (2008) analyzed the disclosure rate of women with HIV and found that women tended to prioritize rewards for disclosure that were beneficial to other people (e.g., protecting close others and respecting their right to know).

According to the DPM, an individual's goals for self-disclosure influence both *whether and how* they disclose, as well as the subsequent long-term outcomes of disclosure. Common goals for disclosure include the desire to maintain a close relationship, emotional catharsis, a desire to educate others, and wishes to avoid rejection and self-blame (Afifi & Steuber, 2009; Derlega & Winstead, 2001; Derlega et al., 2000; Derlega, Winstead, Greene, Serovich, & Elwood, 2004). The findings from our study echo these goals, as well as highlight specific ways in which these goals compete with one another and how parents might choose to manage these competing goals when relaying HIV-related information.

Finally, parents' indication that prevention behaviors are an important anticipated product of HIV-related talk supports the DD-MM's distinction between the receiver's (in our case, the child's) immediate *response* to the news and the longer-term or ultimate *outcomes* of the conversation (Greene et al., 2012). Parents might suspect, for example, that children's responses to conversations about HIV will be awkward or even unpleasant; yet some can foresee future outcomes that are worth the trouble of challenging communication. Whereas the DD-MM has tended to emphasize relational outcomes (e.g., terminating the bond), our study also attends to self-care (e.g., staying away from household items with blood on them) and sexual behavior outcomes (e.g., using condoms to protect against HIV transmission).

Balancing parent-child relational needs. Finally, the predicament of fostering intimacy and trust in the relationship without overstepping or tilting the balance of normative parent-child roles emerged as an important theme. Parents in the present study acknowledged that they wanted to be open with their children about HIV-related topics, and generally believed that open family communication surrounding HIV strengthened parent-child relationships. At the same time, they indicated that discussing HIV-related information *too* much with children (or in a frightening way) could offset normal parent-child relational dynamics, and even create barriers to relational intimacy. Consistent with prior research (Afifi & Steuber, 2009; Cederbaum, 2009), parents in the present investigation found it especially difficult to delve into topics that were personal and potentially embarrassing, as they felt these topics could damage their self-image and/or their relationship with their children.

Health communication scholarship demonstrates that most families subscribe to the ideal of open communication, expecting that they should be honest with one another, and that honesty is a component of close relationships; yet there is clear evidence that even families who describe themselves as "open" avoid discussing a number of sensitive topics, including those related to sex and sexuality (Caughlin, 2003; Kirkman et al., 2005). Scholars have conceptualized this potential discrepancy as "being open while avoiding" (Caughlin, Mikucki-Enyart, Middleton, Stone, & Brown, 2011), "telling but not telling" (Black & Miles, 2002), and "being open with your mouth shut" (Goldsmith & Domann-Scholz, in press). As a whole, these studies emphasize that families can (and often do) vary in their meanings of openness and how they believe openness affects relational bonds. A father who is open regarding hypothetical information about sexual relationships, for example, might not be willing to discuss his personal sexual history, yet still feel that he is open with his son and that their relationship is closer because of his approach to being candid. Whereas parents in our sample emphasized that being open about HIV-related topics had the potential to strengthen parent-child relationships, some also expressed concerns that bringing up HIV-related topics too often or too extensively could worry adolescents, detract from a normative parent-child relationship, or neglect their adolescent's more imminent needs or concerns. These data indicate that parents with HIV would likely appreciate communication interventions that focus on how to maintain normative parent-child roles and open family communication dynamics in the midst of coping with an unpredictable chronic health condition. They also indicate, however, that programs should encourage parents to think through a personal definition of openness and how they might choose to be open strategically (e.g., in a way that preserves their overall relational goals for any given HIV-related conversation).

Effective Conversational Management Strategies: Theoretical and Practical Applications

Although some parents responded to complex communication situations by avoiding conversation altogether, other parents employed strategies they believed allowed them to effectively address these predicaments. Parents who managed conversations effectively did so by reframing talk about HIV, keeping conversations educational, and by embedding HIV-related talk within more general conversations.

Reframing HIV as a "normal" chronic illness. Parents emphasized the importance of making HIV-related conversations approachable or relatively "normal" in their households, as well as relaying to their children that HIV was a manageable chronic illness. They discussed how doing so allowed them to provide safety information to adolescents without eliciting excessive fear. From an intervention standpoint, this finding suggests that parents would welcome HIV-related programs allowing them to interact with their children in settings where educational and therapeutic sessions about HIV are available, but that also include and encourage typical parent-child activities (e.g., playing games, sports, swimming). Creating such environments and/or reminding parents to take advantage of already existing programs (e.g., AIDS walks, family camps, peer mentoring groups) could provide multiple opportunities for parent-adolescent conversations about HIV-related topics. Parents in our study who participated in

such activities emphasized the effectiveness of allowing children to learn about HIV in a family-friendly, open, and non-stigmatizing atmosphere, where children could interact with individuals who had been living with HIV for a number of years.

In addition to talk of sexual health and safety, parents wanted information from health care practitioners about HIV-related household precautions. Discussing the non-sexual modes of transmission of HIV and what a child can do to remain safe at home when their parent is HIV+ (e.g., not touching others' blood or used sharp objects with blood, using gloves if cleaning up blood) seemed to lessen HIV-related stigma and make HIV-related conversations more approachable. Our data suggest that those involved in HIV prevention and care should go beyond the "standard" information about HIV transmission and provide specific examples of if/when household objects could pose a risk of HIV infection, as well as the options that are available if a parent fears their child has been exposed to HIV (e.g., post-exposure prophylaxis).

Keeping talk educational. Being able to filter conversations and discern what information should be kept private versus shared with adolescents was another major parental concern. Parents who learned to set conversational boundaries strategically (e.g., focused on relaying educational messages) felt they were able to manage their competing goals effectively when approaching HIV-related talk. HIV care providers and applied researchers can help parents navigate these complex conversations by explicitly attending to their conversational goals. Following from normative theory and our study's findings, for example, health care providers could: (1) encourage parents who wish to discuss HIV-related topics to outline and prioritize the multiple goals they have for discussing HIV and prevention with their children (e.g., keeping their adolescent safe), and (2) brainstorm strategies that could be used to reach those particular objectives while perhaps sharing strategies that other parents with HIV have found effective for their families. With specific goals and a range of appropriate communication strategies in mind, parents can then practice responding to common adolescent questions about HIV in a safe and professional environment. Our data indicate that parents would find such role-playing exercises useful, and that such interactions could help them enter conversations with a greater sense of preparedness.

Framing or embedding HIV-related talk. Finally, parents emphasized the importance of embedding HIV-related talk within more general conversational topics. Once these general and expected communication topics were established, specific conversations about sex, drug use, and HIV became less difficult to broach. Prior research has indicated that parent-adolescent communication about drug and alcohol use is more effective if everyday parent-child conversations are of relatively high quality (Caughlin & Malis, 2004). Parents in our sample strategically switched between everyday topics and HIV-related topics in order to attend to their relational goals (e.g., fostering intimacy and maintaining a close and stable parent-child relationship). From an intervention standpoint, this belies the importance of practicing general and benign communication topics alongside discussing more sensitive topics like HIV/AIDS. Our data reiterate that, even mundane conversations, if approached with sensitivity and caring, can lay the groundwork for HIV-related talks.

Utility of the Normative Approach

Altogether, this study supports the utility of the normative perspective for examining complex communication situations between parents with HIV and their children. One advantage of using this approach was the ability to explore the multiple meanings and interpretations that parents ascribed to HIV-related conversations. Whereas much of the HIV prevention literature has focused on communication about drug use and safe sexual behavior, parents in our sample broadened this definition to include topics such as household safety precautions, post-exposure prophylaxis, and messages about acceptance of individuals who are HIV+. These findings indicate a need to work with an expansive and multi-faceted definition of HIV prevention when designing programs for families affected by HIV/AIDS.

In their use of the normative perspective, Goldsmith, Bute, & Lindholm (2012) emphasize that "dynamic relationships" exist among communication, how it is interpreted, and the home routines and social resources available in one's network (p.79). Thus, a strategy employed by one individual with certain resources might not be effective for the same individual under a different set of social circumstances. Along these lines, although parents in our study detailed communication strategies that helped them deal with conversational predicaments, they also emphasized that it was important to be *flexible* in the strategies they used, and that strategies beyond interpersonal communication helped mitigate these conversational challenges (e.g., keeping a positive mindset, spending quality

time with one's child). Future studies could explore how these cognitive and relationship-building efforts fit within the normative perspective—for example, how parents' ongoing relational maintenance behaviors might interact with the meanings of talk that are relevant in particular families. Goldsmith et al. (2012) provide some first steps in this direction.

Study Limitations

Though our methods were well-suited for a study examining perceived effectiveness of parent-adolescent communication strategies, one main limitation of this study is reliance on self-reported data. We did not observe parents during their communicative interactions with their children, nor did we interview adolescents (who may have had differing reports of parent-adolescent communication). In addition, our sample reported living with HIV for many years, was predominantly African American, and was limited to the Midwest. These parents may not be representative of newly diagnosed parents or of the broader population of parents with HIV. Future longitudinal work is needed to capture parents' descriptions of their HIV-related communication challenges over time, including how communication dynamics might differ in families where a parent is newly diagnosed. Finally, due to the cross-sectional nature of this research, we cannot establish cause and effect relationships from study findings. Despite these limitations, these data provide a more complete understanding of parent-adolescent communication dynamics in families affected by HIV/AIDS, and detail some practical strategies for managing HIV-related communication challenges.

Conclusion

Parents reported multiple conversational objectives and corresponding challenges when discussing HIV-related topics. To some degree, the challenges parents who were HIV+ experienced when communicating with their children were evocative of the normative obligations that characterize the lives of parents (e.g., protecting one's child from harm). However, these individuals also had to balance the specialized pressures of being a parent with HIV. This study alerts health communication scholars and health care professionals to the specific concerns of parents with HIV. Furthermore, these data encourage professionals to address these challenges by facilitating environments where parents can reframe HIV as a chronic, manageable illness, focus on sharing personal information in an educational context, and frame or embed HIV-related talk within more general parent-adolescent talks.

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