

# Families Of Homosexual Men: Their Knowledge And Support Regarding Sexual Orientation And HIV Disease

Lawrence Fisher, PhD, Ronald H. Goldschmidt, MD, Robert B. Hays, PhD,  
and Joseph A. Catania, PhD

**Abstract: Background:** The number of homosexual men (gay) with the human immunodeficiency virus (HIV) who will become ill in the next few years is expected to rise dramatically. Many will need and desire support from their families of origin. Understanding the history of family relationships can be crucial for the optimal care of these patients and their families. Little is known, however, about the relationship between gay men and their families of origin.

**Methods:** A convenience sample of gay men (n = 265) from three northern California cities was surveyed to determine family member knowledge of their sexual orientation and HIV status and perceived family supportiveness regarding issues of HIV disease and acquired immunodeficiency syndrome (AIDS). Fifty-five percent of the sample were HIV negative, 14 percent were HIV positive, 8 percent had received a diagnosis of AIDS, and 23 percent had not been tested.

**Results:** Approximately 70 percent of family members knew a son's or brother's sexual orientation. Fewer family members (50.9 percent) knew a son's or brother's HIV status than knew his sexual orientation. Untested gay men reported the least family knowledge of both sexual orientation and HIV status. There was, however, considerable variation in knowledge among members of the same family, with mothers and sisters knowing HIV status more frequently than fathers and brothers. The amount of supportiveness regarding issues of HIV disease within the family also varied considerably.

**Conclusions:** It is important for the family physician caring for the gay male patient, his family, or both to understand that the pattern of knowledge and supportiveness among family members concerning sexual orientation and HIV status is selective, even within the same family. The physician needs to assess family members' knowledge and attitudes to plan an overall care strategy. (J Am Board Fam Pract 1993; 6:25-32.)

The human immunodeficiency virus (HIV) epidemic has focused considerable attention on the primary medical care of HIV disease<sup>1-5</sup> and physicians' attitudes and responsibilities in the care of homosexual men (gay)<sup>6-8</sup> and persons with acquired immunodeficiency syndrome (AIDS).<sup>9-11</sup>

Relatively less attention, however, has been given to an understanding of relationships between gay men and their families of origin. An appreciation of family issues is important for the delivery of emotional and physical support for all family members affected by chronic or terminal disease.<sup>12,13</sup> Such issues become critical when a stigmatized disease such as AIDS occurs. For the family physician, understanding the history of family relationships and current family functioning in families of gay men can be helpful, and in many instances essential, to assure optimal care of the gay male patient and all family members.

Results of only one survey of gay men regarding their families of origin have been reported.<sup>14</sup> This 1982 market survey of urban gay men suggested that as few as 20 percent of the sample had told family members they were gay. Clinical findings have suggested that many family members do not

Submitted, revised, 15 June 1992.

From the Center for the Study of Family and Health, the Family Practice Residency Program, San Francisco General Hospital, the Department of Family and Community Medicine, University of California, San Francisco (LF, RHG), and the Center for AIDS Prevention Studies, University of California, San Francisco (RBH, JAC). Address reprint requests to Lawrence Fisher, PhD, Department of Family and Community Medicine, University of California, San Francisco, Box 0900, San Francisco, CA 94143.

This study was supported in part by the Center for AIDS Prevention Studies through Center Grant MH42459 from the National Institute of Mental Health and the National Institute on Drug Abuse.

Presented at the Society of Teachers of Family Medicine Annual Spring Conference, St. Louis, MO, 20 April 1992.

learn a son or brother is gay until learning that he is HIV positive or has AIDS.<sup>15</sup> This news can result in a double trauma to family members, who simultaneously learn about his sexual orientation and his life-threatening disease. For many family members, the health consequences can be considerable. The psychiatric morbidity of family members and the negative effects of ongoing stress and emotional turmoil on the health of parents and siblings have been well described.<sup>16-18</sup> Similarly, stressful family relationships can affect the ability of a gay male patient to manage his personal health care.<sup>19</sup>

Family support for persons with HIV disease is an important component of care. The variability in support even among members of the same family, however, is considerable. Several clinical reports have suggested that fathers have the most difficulty accepting a son's homosexuality, followed by brothers, sisters, and mothers.<sup>20-22</sup> Indeed, fathers are the most reluctant to engage in treatment or support programs for family members of HIV patients. Fathers are also less likely to involve themselves in a son's care.

Family members can maintain close ties with a gay son or brother, can have variable relationships, or even can avoid all contact. Gay men can live in the same city or town or they can live many miles away, often in an urban area within a large gay community. Nevertheless, an increasing number of gay men reunite with their families of origin and return to the family household at some point during their illness.<sup>23,24</sup>

Considering the paucity of recent systematic research on the relationships between gay men and their families of origin and the expected increase in persons with HIV disease and AIDS in the next few years, we undertook a community-based study of gay men in California. Our goals were to learn more about a gay man's perceptions of (1) family members' knowledge of his sexual orientation, (2) family members' knowledge of his HIV status; and (3) family support and concern regarding AIDS and HIV disease. This information has important implications for clinical strategies in primary family care.

## Methods

### *Recruitment*

We surveyed gay men through gay community centers in three California cities not included

among the national epicenters of the gay community: Sacramento, San Jose, and Fresno. All three centers operated educational, athletic, social, and support programs and served as a meeting place for various gay and lesbian groups in their respective communities. The cities were selected to reflect a diversity of personal lifestyles and economic and social characteristics. Sacramento has a population of approximately 400,000 and is located about 90 miles east of San Francisco. It is a center for government and related business. San Jose is a rapidly expanding urban city of approximately 785,000 inhabitants. It lies at the southern rim of San Francisco Bay but has a cultural and economic life separate from San Francisco. It is adjacent to the Silicon Valley, and the surrounding communities include a variety of high-technology firms and other businesses. Fresno is a semirural community (approximate population 310,000) located in the center of the state, close to the Sierras. It is a major hub of the state's agribusiness.

Questionnaires were placed at the entrance of each of the three community centers for 2-week periods in November 1989 and March 1990. A letter was attached to each questionnaire explaining the purpose of the research and assuring anonymity. Users of the community centers were encouraged to complete the 2-page questionnaire and to place the completed questionnaire in a container that was sealed to assure confidentiality. Because no research staff were present, it was not possible to ascertain the percentage of potential respondents who completed the questionnaire.

### *Subjects*

Two hundred sixty-five men who described themselves as gay completed the questionnaire. Of the total sample, 4 percent were Asian, 4 percent African-American, 7 percent Hispanic, and 85 percent white. Eight percent completed high school, 39 percent had some college education, 34 percent completed college, and 18 percent had some postgraduate education. Fresno subjects were the least educated, and San Jose subjects were the most educated.

The mean age of the sample was 33.1 years (SD = 8.1). HIV-positive men (mean age 35.4 years) and AIDS patients (mean age 35.0 years) combined were significantly older than HIV-negative men (mean age 32.6 years) ( $t = 2.633$ ,

$P < 0.01$ ). Men from Fresno (mean age 36 years) were significantly older than men from Sacramento (mean age 32 years) ( $t = 2.162, P < 0.05$ ).

Of the 265 respondents 146 (55 percent) reported being HIV negative based on their last test results, 37 (14 percent) said they were HIV positive, and 60 (23 percent) reported that they had not been tested. Twenty-two (8 percent) had received a diagnosis of AIDS by their health-care provider (Table 1). All but 1 of the AIDS patients were receiving medication (predominantly zidovudine). HIV status varied as a function of recruitment site, with the San Jose sample having the highest percentage of subjects with AIDS (23 percent) and the Sacramento sample having the highest percentage of HIV-negative subjects (62 percent).

### Assessment and Analysis

The questionnaire contained 19 items. Fifteen questions assessed demographic characteristics and HIV status, and four questions elicited information about each member of the subject's family of origin (mother, father, sisters, and brothers): (1) Does this family member know you are gay or bisexual? (2) Does this family member know your HIV status? (3) How helpful or supportive has this family member been to you regarding issues of HIV disease and AIDS? (4) In general, has HIV disease or AIDS changed your relationship with this person? Responses about deceased family members were excluded from all analyses.

The first two questions, regarding family members' knowledge of sexual orientation and HIV status, were scored yes or no. These data were analyzed separately by chi-square (between-subjects analysis) for all mothers, all fathers, all brothers, and all sisters. Additional analyses were per-

formed to assess the variability of perceived knowledge within each subject's family (within-subjects analysis).

Responses to the third question, regarding perceived family member support, were scored on a five-point scale, with values ranging from very unhelpful to very helpful. The last question, regarding perceived change in the relationship, was scored on a five-point scale, with values ranging from much worse to much better. Because the third and fourth questions were scored on a continuous rather than a yes-or-no format, a two-way analysis of variance (ANOVA) was used in the analysis of each. To account for potential statistical bias in these analyses (violation of cell independence caused by multiple ratings by the same subject both within and across cells), we selected a subsample of 68 subjects who had rated both parents, at least one brother, and at least one sister. Mean ratings for multiple brothers and for multiple sisters were calculated. A within-subjects ANOVA was run for these subjects.

Only subjects who reported that their families knew they were gay were included in the analyses of the third and fourth questions. Differences in response to the family knowledge and support questions based on city of residence (Sacramento, San Jose, Fresno) were not due to residence as such, but to differences in HIV status among the three cities. Consequently, site of data collection was not included in the analyses reported below. Also, because responses to the 19 questions were not meaningfully correlated with the subject's level of education, a statistical control for social class was not included in the analyses.

## Results

### Family Knowledge of Sexual Orientation

Overall, subjects reported that 71.2 percent of all family members knew their sexual orientation (Table 2). More mothers (74.5 percent) than fathers (65.8 percent) knew their sons were gay, although this difference was not statistically significant ( $\chi^2 = 3.287, P < 0.06$ ). Similar differences between mothers and fathers, however, occurred in all four HIV status groups. No statistically significant differences in knowledge of sexual orientation were found between all brothers (71.0 percent) and all sisters (72.4 percent), and among all family members when taken as a group (mothers, fathers, brothers, and sisters). The order of percentage of

**Table 1. Human Immunodeficiency Virus (HIV) Status of Subjects by Recruitment Site.**

Status	Sacramento No. (%)	San Jose No. (%)	Fresno No. (%)	Total No. (%)
HIV negative	102 (62)	32 (47)	12 (38)	146 (55)
HIV positive	16 (9)	14 (20)	7 (22)	37 (14)
AIDS	5 (3)	16 (23)	1 (4)	22 (8)
Untested	42 (26)	7 (10)	11 (36)	60 (23)
Total	165 (100)	69 (100)	31 (100)	265 (100)

HIV = human immunodeficiency virus, AIDS = acquired immunodeficiency syndrome.

**Table 2. Family Members Who Knew Respondent's Sexual Orientation.**

	HIV Negative No. (%)	HIV Positive No. (%)	AIDS No. (%)	Untested No. (%)	Total No. (%)
Mothers	127 (75.6)	34 (79.4)	19 (78.9)	47 (65.9)	227 (74.5)
Fathers	105 (66.7)	28 (71.4)	13 (61.5)	38 (60.5)	184 (65.8)
Brothers	163 (68.7)	46 (82.6)	38 (76.3)	56 (64.3)	303 (70.9)
Sisters	139 (74.8)	43 (81.4)	16 (68.7)	51 (59.6)	250 (72.4)
Total	534 (71.5)	151 (79.5)	86 (73.2)	193 (62.7)	964 (71.2)

HIV = human immunodeficiency virus, AIDS = acquired immunodeficiency syndrome.

family members who knew the subjects' sexual orientation, however, was the same as reported earlier: mothers (74.5 percent), sisters (72.4 percent), brothers (71.0 percent), and fathers (65.8 percent).

Knowledge of the subjects' sexual orientation for all family members combined was different among the four HIV groups ( $\chi^2 = 12.042$ ,  $P < 0.06$ ; Table 2). The percentages were as follows: 79.5 percent of the family members of HIV-positive subjects knew their sexual orientation, 73.2 percent of family members of subjects with AIDS, 71.5 percent of family members of HIV-negative subjects, and 62.7 percent of family members of untested subjects. Family members of untested subjects were the least likely to know his orientation.

Variation in knowledge of sexual orientation within each respondent's family was computed by calculating the percentage of family members who were reported by him to know his sexual orientation. Because percentage scores often are extreme in small family units (0 percent versus 100 percent), we excluded 45 families with only the respondent and one other family member. The results for the remainder of families ( $n = 220$ ) are presented in Table 3. The variability in knowledge of sexual orientation among family members (standard deviation) within the families of each of the four groups of subjects was extremely large, often approaching 40 percent of the mean. This finding suggests that the number of family members within each family who knew the respondent's sexual orientation varied considerably from family to family, even for families of HIV-positive subjects and those with AIDS.

**Knowledge of HIV Status**

With the exception of subjects with AIDS, fewer family members knew their sons' or brothers' HIV

status than knew that they were gay (Tables 3 and 4). Whereas the percentage among mothers, fathers, brothers, and sisters who knew the respondents' sexual orientation ranged from 65.8 percent to 74.5 percent (Table 2), the range of knowledge of HIV status was from 45.6 percent to 56.8 percent (Table 4), indicating nonoverlapping distributions.

More mothers and sisters knew the subjects' HIV status than fathers and brothers ( $\chi^2 = 8.445$ ,  $P < 0.037$ ) (Table 4) for the total sample, for HIV-negative subjects, and for HIV-positive subjects. No differences occurred in families of subjects with AIDS, for whom knowledge of HIV status was relatively high for all family members. In addition, more sisters than brothers knew the subjects' HIV status ( $\chi^2 = 4.885$ ,  $P < 0.027$ ) for the total sample and for both HIV-negative and HIV-positive subjects. No similar differences were found between mothers and fathers. Family members of subjects with AIDS had the highest rate of knowledge concerning HIV status of all four HIV

**Table 3. Number and Mean Percentage of Members within Each Family Who Knew Subject's Sexual Orientation and HIV Status.**

	Number	Mean Percent Per Family	SD
<b>Knowledge of sexual orientation</b>			
HIV negative	133	71.7	36.8
HIV positive	25	71.2	35.5
AIDS	17	74.8	35.3
Untested	45	61.7	25.5
<b>Knowledge of HIV status</b>			
HIV negative	129	46.8	41.0
HIV positive	35	50.2	28.2
AIDS	20	81.3	10.0

HIV = human immunodeficiency virus, AIDS = acquired immunodeficiency syndrome, SD = standard deviation.

**Table 4. Number and Percentage of Family Members Who Knew the Subject's HIV Status.**

	HIV Negative No. (%)	HIV Positive No. (%)	AIDS No. (%)	Total No. (%)
Mothers	123 (54.5)	34 (50.0)	19 (73.7)	176 (55.7)
Fathers	100 (43.0)	28 (46.4)	14 (64.3)	142 (45.8)
Brothers	152 (34.9)	45 (48.9)	40 (82.5)	237 (45.6)
Sisters	132 (49.2)	43 (72.1)	17 (76.5)	192 (56.8)
Total	507 (44.9)	150 (55.3)	90 (76.7)	747 (50.9)

HIV = human immunodeficiency virus, AIDS = acquired immunodeficiency syndrome.

groups. Nevertheless, one-quarter to one-third of family members did not know that the subjects had AIDS.

As expected, the percentage of brothers and sisters with knowledge of HIV status increased when the groups were ordered from HIV negative to HIV positive to subjects with AIDS (brothers:  $\chi^2 = 29.212$ ,  $P < 0.001$ ; sisters:  $\chi^2 = 9.850$ ,  $P < 0.007$ ). A similar, although nonsignificant, trend occurred for fathers but not for mothers (Table 4).

To assess the variability in knowledge of HIV status within each subject's family, the average number of family members who knew the subject's HIV status was calculated separately for those who were HIV negative, HIV positive, and who had AIDS (Table 3). Families with only two members were eliminated to reduce the likelihood of extreme scores. There was considerable variation in the average percentage of family members within the same family with knowledge of HIV status. For HIV-negative subjects, the standard deviation approached 88 percent of the mean (mean = 46.8, SD = 41.1), and for HIV-positive subjects, the standard deviation was more than 50 percent (mean = 50.2, SD = 28.2). Much less variation in knowledge among family members of AIDS patients occurred (mean = 81.3, SD = 10). About one-fifth of members within each family of subjects with AIDS, however, were reported by the subject to be unaware of his disease.

#### Family Supportiveness

Subjects with AIDS rated their families as most supportive, and untested subjects rated their families as least supportive of the four HIV status groups ( $F = 5.830$ ,  $P < 0.006$ ) (Table 5). Mothers and sisters were rated more supportive than fathers and brothers ( $F = 4.770$ ,  $P < 0.002$ ). All

the ratings of mothers' and sisters' supportiveness were significantly higher than the ratings of brothers' and fathers' supportiveness (all  $t$ -tests  $P \leq 0.01$ ; Table 5). The within-subjects ANOVA yielded the same results.

#### Change in Family Relationships

HIV-positive subjects, HIV-negative subjects, and subjects with AIDS reported greater positive change in family relationships as a result of HIV disease and AIDS than did subjects from the untested group ( $F = 3.380$ ,  $P < 0.018$ ). No significant differences in change in relationship were noted in ratings of mothers, fathers, sisters, or brothers. The (within subjects) ANOVA aimed at correcting potential statistical bias was not significant, although subjects who were HIV-positive, HIV-negative, and who had AIDS again reported greater positive change in family relationships than did untested subjects.

#### Discussion

This study addressed family member knowledge of a gay son's or brother's sexual orientation and HIV status and perceived family member support regarding issues of HIV disease and AIDS.

**Table 5. Ratings of Family Member Supportiveness.\***

	HIV Negative	HIV Positive	AIDS	Untested	Total
Mothers					
Mean	3.5	3.5	3.9	3.1	3.5
SD	1.0	1.0	0.9	1.0	1.0
No.	103	28	18	30	179
Fathers					
Mean	3.2	3.0	3.5	2.8	3.1
SD	0.9	1.0	0.7	1.1	0.9
No.	84	23	13	25	145
Brothers					
Mean	3.2	3.1	3.5	3.1	3.2
SD	0.9	0.7	1.1	0.8	0.9
No.	131	40	40	37	248
Sisters					
Mean	3.5	3.7	3.5	3.3	3.5
SD	0.9	1.1	1.2	1.2	1.1
No.	111	37	17	32	197
Total					
Mean	3.4	3.4	3.6	3.1	
SD	0.9	0.9	1.0	0.9	
No.	429	128	88	124	

\*Supportiveness was rated from 1 to 5, from very unsupportive (1) to very supportive (5). SD = standard deviation, HIV = human immunodeficiency virus, AIDS = acquired immunodeficiency syndrome.

### ***Knowledge of Sexual Orientation***

As expected, the results suggest a substantial increase in the number of family members who knew a son's or brother's sexual orientation compared with findings from a market survey taken in 1982. Coppola and Zabarsky<sup>14</sup> found that 20 percent of the family members of gay men in their sample knew the men's sexual orientation, whereas our data, collected from community center members in 1989 and 1990, showed a family member knowledge rate of 71.2 percent. Although the samples upon which these two studies are based are not identical, the HIV epidemic and the greater visibility of gay lifestyle in most communities have contributed to an atmosphere that can foster greater family awareness than previously. Similarly, the social atmosphere could have made it more acceptable for gay men to be more forthright in responding to the research questionnaire.

There was, however, considerable variation in knowledge among members of the same family. In addition, fewer family members from the untested group than from the other respondent groups were aware of a son's or brother's sexual orientation. Although more mothers (74.5 percent) than fathers (65.8 percent) knew their sons were gay, this difference was not significant in our sample ( $P < 0.06$ ). Also, no difference in knowledge between brothers and sisters was found.

### ***Knowledge of HIV Status***

Fewer family members were reported to know the respondent's HIV status than his sexual orientation (50.9 percent versus 71.2 percent). This finding suggests that although there is a growing public awareness and acceptance of gay lifestyle, including a more open attitude among family members, issues of HIV disease and AIDS remain relatively private. Disclosing one's sexual orientation to family members occurs more frequently than in previous years, but there appears to be less willingness among gay men to disclose HIV status to family members. This finding could, in part, reflect the personal difficulties and fears inherent in accepting a diagnosis of any chronic or terminal illness. The stigma of HIV disease and AIDS, however, can make disclosure and family member acceptance even more difficult. For example, Robinson, et al.<sup>18</sup> reported that disclosure of AIDS to family members tended to reopen old wounds in 90 percent of patients and family mem-

bers interviewed, and Greif and Porembski<sup>25,26</sup> reported the recurrence of previous family splits and alliances. Learning of a son's or brother's positive HIV status forces family members to come to terms with this health crisis. This knowledge can prompt a shift from a relatively passive stance regarding sexual orientation to an active stance regarding the family members' potential roles as caregivers and to broader, social implications.

More mothers and sisters were reported to know the respondent's HIV status than fathers and brothers. Furthermore, sibling knowledge of HIV status increased from HIV-negative to HIV-positive to AIDS subjects. Considerable variability in knowledge among the members within the same family also was reported. These results are consistent with previous clinical reports.

Thus, it is likely that most but not all members of a gay man's immediate family know his sexual orientation, but far fewer know his HIV status. In both instances, however, mothers and sisters are more likely to have this knowledge than fathers and brothers.

### ***Family Supportiveness and Change***

As expected, the data show that gay men share sensitive information with family members whom they perceive to be supportive. Once again, mothers and sisters were reported to be more supportive than fathers and brothers. It is not clear, however, whether gay men are more open to female than male family members because family caretaking roles are traditionally assumed by women,<sup>27</sup> because a son's homosexuality is more troublesome for fathers than mothers, or because of both or other factors. Fathers of gay men are less frequently involved in and more resistant to treatment and support groups for HIV disease than mothers.<sup>28,29</sup> Conflicted or threatened fathers often are protected from this information by other family members. Those who know conclude to keep others in the family from knowing, making the process of gaining accurate information and becoming involved in care truly a family phenomenon. These forces can combine to make gay men reluctant to approach fathers, and fathers reluctant to respond openly to gay sons.

### ***Untested Respondents***

We were surprised to learn that of all respondent groups, untested gay men reported the fewest

number of family members who knew they were gay and the fewest who knew their HIV status. In addition, untested respondents gave their family members the lowest ratings of supportiveness among the four HIV status groups.

Our findings suggest that reluctance to be tested for HIV disease may be rooted, in part, in previous or current family relationships. Although peer support, counseling, and education have been shown to be critical ways to increase motivation for testing, issues regarding a gay man's family of origin might need to be addressed as well. A gay man's disclosure of HIV seropositivity has the potential to exacerbate troublesome family issues when family members learn that he is both gay and HIV positive. Consequently, family history and lack of family acceptance could undermine motivation for testing. In this sense, HIV testing could also involve far-ranging family and historical concerns, which should be addressed directly in future research.

#### **Limitations**

Two qualifications need to be addressed in reviewing these data. First, the use of a community-based convenience sample of gay men who attended community centers in small urban cities raises issues concerning the generalizability of findings, because such samples are not based on a cross-section of a defined population. Researchers studying men who have sex with men consistently have been unable to obtain random or well-stratified population samples for two reasons: not all men who have sex with men will identify themselves as gay or reveal their behavior in a survey, and gay population samples are very site dependent.<sup>30</sup> Most research and market surveys of gay men in the era of AIDS are based on convenience samples of men who are patrons or clients of specific settings (gay bars, bath houses, clinic samples, community centers). The resulting data are, therefore, of unknown generalizability to the broader community of gay men. The problems inherent in gathering representative samples of gay men make it difficult to conceive of a standard gay demographic profile for any given community or to determine variations in profiles across communities. Our data are based on a convenience sample of gay men who volunteered from the sites selected. The findings, therefore, need to be replicated in other settings and in different cities for

generalizability to be established. The similarity of findings among the three cities selected in our study contributes to this process. Data from studies such as ours and from market surveys such as that of Coppola and Zabarsky<sup>14</sup> probably represent overestimates of openness with family members, because respondents are sufficiently public about their sexual orientation to attend a gay community center and are willing to declare their sexual orientation by completing a questionnaire or interview.

Second, family members' knowledge of sexual orientation and HIV status was based on our subjects' appraisals and not on direct contact with family members. Subject appraisals, however, are likely to be an underestimate of actual member knowledge.

#### **Conclusions**

Our findings emphasize the family aspects of sexual orientation and HIV disease. The processes by which multigeneration families come to grips with these issues, the patterns of caregiving that are received, and the need for family members to redirect their energies and resources are issues of concern to the family physician.

It is important for the physician caring for the gay male patient, his family, or both to understand that the pattern of knowledge among family members concerning sexual orientation and HIV status is selective, even within the same family. Being aware of who in the family knows, who does not know, who openly acknowledges knowing, who denies knowing, who is supportive, and who is distant or angry can assist the family physician in planning a strategy of care based on shared knowledge among family members. In addition, exploring the family's relationship with the gay son's or brother's partner and social network can identify other sources of support or areas of conflict. Careful interviewing of some or all family members at the outset can avoid unintentionally disclosing very sensitive information and can provide a foundation for proper care of gay men and their families.

This study represents some initial steps in describing the complexity of relationships between gay men and their families of origin. Further studies to describe these relationships more fully and to link them to practical interventions are needed.

Appreciation is expressed to Kevin Grumbach, MD, and Shotsy C. Faust, FNP, for their helpful comments on an earlier draft of this paper.

## References

1. Sadovsky R. HIV-infected patients: a primary care challenge. *Am Fam Physician* 1989; 40:121-8.
2. Goldschmidt RH, Dong BJ, Johnson MA, Cello JP, Simon RP. Evaluation and treatment of AIDS-associated illnesses: an approach for the primary physician. *J Am Board Fam Pract* 1988; 1:112-30.
3. Goldschmidt RH, Dong BJ. Treatment of AIDS and HIV-related conditions. *J Am Board Fam Pract* 1991; 4:178-91.
4. Paauw DS, O'Neill JF. Human immunodeficiency virus and the primary care physician. *J Fam Pract* 1990; 31:646-50.
5. Dozor RB, Meece KS. Relationships with AIDS patients: clinical metaphors and preventive bioethics. *Fam Med* 1990; 22:474-7.
6. Owen WF. The clinical approach to the homosexual patient. *Ann Intern Med* 1980; 93:90-2.
7. Remafedi G. Fundamental issues in the care of homosexual youth. *Med Clin North Am* 1990; 74:1169-79.
8. Dardick L, Grady KE. Openness between gay persons and health professionals. *Ann Intern Med* 1980; 93:115-9.
9. Kelly JA, St Lawrence JS, Smith S Jr, Hood HV, Cook DJ. Stigmatization of AIDS patients by physicians. *Am J Public Health* 1987; 77:789-91.
10. Richardson JL, Lochner T, McGuigan K, Levine AM. Physician attitudes and experience regarding the care of patients with acquired immunodeficiency syndrome (AIDS) and related disorders (ARC). *Med Care* 1987; 25:675-85.
11. Gerbert B, Maguire BT, Coates TJ. Are patients talking to their physicians about AIDS? *Am J Public Health* 1990; 80:467-8.
12. Campbell TL. Family's impact on health: a critical review. *Fam Syst Med* 1986; 4(2 & 3):135-328.
13. Rolland JS. Chronic illness and the life cycle: a conceptual framework. *Fam Process* 1987; 26:203-21.
14. Coppola V, Zabarsky M. Coming out of the closet. *Newsweek*, 1983, Aug 8, p 34.
15. Quirk J. The effects on parents of hospitalization of AIDS patients. Presented at the Fifth International Conference on AIDS. Montreal, Canada, June 4-9, 1989. Abstract.
16. Bor R, Miller R, Goldman E, Johnson M, Lee C. AIDS and the family. Presented at the Fifth International Conference on AIDS. Montreal, Canada, June 4-9, 1989. Abstract.
17. Colburn KA, Malena D. Bereavement issues for survivors of persons with AIDS: coping with society's pressures. *Am J Hosp Care* 1988; 5:20-5.
18. Robinson BE, Walters LH, Skeen P. Response of parents to learning that their child is homosexual and concern over AIDS: a national study. *J Homosex* 1989; 18:59-80.
19. Walker G. In the midst of winter: systemic therapy with families, couples, and individuals with AIDS infection. New York: Norton, 1991.
20. Tiblier KB, Walker G, Rolland JS. Therapeutic issues when working with families of persons with AIDS. In: Macklin ED, editor. AIDS and families: report of the AIDS Task Force, Groves Conference on Marriage and the Family. New York: Haworth Press, 1988:81-127.
21. Frierson RL, Lippmann SB, Johnson J. AIDS: psychological stresses on the family. *Psychosomatics* 1987; 28:65-8.
22. Myers MF. Counseling the parents of young homosexual male patients. *J Homosex* 1981; 7:131-43.
23. Allers CT. AIDS and the older adult. *Gerontologist* 1990; 30:405-7.
24. Verghese A, Berk SL, Sarubbi F. *Urbs in rure*: human immunodeficiency virus infection in rural Tennessee. *J Infect Dis* 1989; 160:1051-5.
25. Greif GL, Porembski E. AIDS and significant others: findings from a preliminary exploration of needs. *Health Soc Work* 1988; 13:259-65.
26. Greif GL, Porembski E. Significant others of IV drug abusers with AIDS: new challenges for drug treatment programs. *J Subst Abuse Treat* 1987; 4:151-5.
27. Anashensel CS, Pearlin LJ. Structural contexts of sex differences in stress. In: Barnett RC, Biener L, Baruch GK, editors. Gender and stress. New York: Free Press, 1987:75-95.
28. Macklin ED. AIDS: implications for families. *Fam Relat* 1988; 37:141-9.
29. McKinlay JB, Skinner K, Riley JW Jr, Zablotsky D. On the relevance of social science concepts and perspectives. In: Riley MW, Ory MG, Zablotsky D, editors. AIDS in an aging society: what we need to know. New York: Springer, 1989: 127-46.
30. Harry J. Sampling gay men. *J Sex Res* 1986; 22:21-34.