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### Clinicians Experience Using the Family as a Unit of Treatment for Black HIV-Positive Men Who Have Sex with Men

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CLINICIANS EXPERIENCE USING THE FAMILY AS A UNIT OF TREATMENT FOR  
BLACK HIV-POSITIVE MEN WHO HAVE SEX WITH MEN

A Dissertation

Presented to the Faculty of  
Antioch University New England

In partial fulfillment for the degree of

DOCTOR OF PHILOSOPHY

by

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August, 2022

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BLACK HIV-POSTIVE MEN WHO HAVE WITH MEN**

This dissertation, by Steffen Gillom, has  
been approved by the committee members signed below  
who recommend that it be accepted by the faculty of  
Antioch University New England  
in partial fulfillment of requirements for the degree of

DOCTOR OF PHILOSOPHY

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## **ABSTRACT**

### **CLINICANS EXPERIENCE USING THE FAMILY AS A UNIT OF TREATMENT FOR BLACK HIV-POSTIVE MEN WHO HAVE WITH MEN**

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Keene, NH

The present study examines the experiences of five licensed clinicians as they attempted to integrate the family as a unit of treatment into the treatment of Black HIV-positive men who have sex with men (BHPMSM). A single 90-minute focus group study using an interpretive phenomenological approach (IPA) was conducted with five clinicians from diverse backgrounds. The results of the study show that clinicians attempting to integrate the family into the treatment of BHPMSM shared common experiences in the areas of building community through encouraging client self-determination, navigating religion, navigating HIV stigma, feelings of incompetence, and feelings of gratification after successful integration of the family into treatment. These five main themes were further nuanced by the Black and queer identities of BHPMSM and the gender of their family members. Overall, the results show that the family does play an essential role in the treatment of BHPMSM. Further results are discussed in association with existing research, as well as family systems theory and implications for future research are offered. This dissertation is available in open access at AURA (<https://aura.antioch.edu>) and OhioLINK ETD Center (<https://etd.ohiolink.edu>).

*Keywords:* Stigma, Bias, Religion, HIV, Self-determination

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## Chapter 1: Introduction

Clinicians' conceptualization of the treatment of same-sex partnering and gender identity has changed over time, with the field of mental health becoming more comfortable discussing nuanced, often difficult, topics within the queer community (Pepping et al., 2018). More specifically, clinicians are tasked with unique treatment responsibilities to working with HIV-positive men who have sex with men (MSM). MSM in the United States experience a higher risk of adverse health outcomes (e.g., depression (O'Cleirigh et al., 2013; Laurencin et al., 2018) and may create a network that consists of their families of origin or chosen-family as a protective factor against adversity (Ryan et al., 2010; Serovich et al., 2011). More specific to the Black HIV-positive MSM (BHPMSM) population are the unique external (i.e., homophobia and racism) stressors that come with being Black and gay at the same-time (Bird & Voisin, 2013). The family, especially the parents, of HIV-positive MSM are generally accepting, or at least tolerant, of their sexuality and more ready than one might assume to engage in the therapeutic process (Serovich et al., 2011). However, most studies examining HIV and the family focus on the relationship between the family and gay youth, exclusively focusing on HIV prevention (Serovich et al., 2011) and not the adult MSM (Serovich et al., 2011) population. The BHPMSM is focused on even less in the literature (Young & McLeod, 2013). Literature exploring the clinician's role in the disclosure process (Serovich, 2000) and the family's role as a protective factor (Hailey et al., 2020) focuses on the experience of emerging adults or adolescents regarding the family's role in treatment. Although implications for practice are discussed for clinicians to consider, current research offers little to no pathway that explicitly examines clinicians' experiences as they attempt to introduce the family as a unit of therapeutic intervention for BHPMSM. This is despite the fact that much literature exists that shows that HIV impacts the

Black MSM community at much higher rates compared to the white MSM community (Young & McLeod, 2013). Additionally, negative outcomes experienced by BHPMSM are associated with pathological stress (e.g., ostracization, stigmatization, internalized homophobia, sadness, suicidal isolation [SI], and feelings of extreme isolation within the hetero-cis and LBGTQIA communities (Durham et al., 2020)). Exploration of the role of Black families in the life of the BHPMSM may offer essential insights on the treatment of this community due to members of the Black community's tendencies to take a more collective approach when attempting to cope with life challenges, which might result in unique types of support seeking behavior, such as seeking out aid from members of their church community, a spiritual leader, or a family elder not commonly found in other communities' (Balaji et al., 2012; Gafford, 2013).

The purpose of this study is to add to the body of knowledge of family therapy with BHPMSM by gaining a basic understanding of the experiences of expert clinicians who treat BHPMSM and utilize a family approach to expand the unit of treatment. This study will not only add much needed context to the field of psychotherapy around the treatment of Black MSM and HIV, it will also provide a direct pathway and recommendations for better practice. This study will also be beneficial for clinicians tasked with providing clinical care to members of the Black MSM population with the experiences of their colleagues as they strive for best practice and the nuance that is associated with their experiences. Additionally, a study of this nature opens the door for additional research and translational scholarship to take place.

## Chapter 2: Literature Review

The relevant literature concerning individuals with HIV dates back several decades (Allers et al., 1997; Chenneville & Gabbidon, 2020; Ferrando & Freyberg, 2008; Knettel et al., 2020, LaSala, 2015; Moosa & Jeenah, 2012). However, this specific review primarily focuses on peer-reviewed publications created within the last ten to twenty years; this is not to say that there is not some attention paid to older literature, if necessary, to build context. Nevertheless, much of the past research regarding the HIV-positive population has become less relevant or outdated as medical treatment has improved. While a plentiful amount of research concerning the treatment of people living with HIV/AIDS (PLWHA) exists, outside of the clinicians' role in the disclosure process (Chenneville & Gabbidon, 2020; LaSala, 2010; LaSala, 2015), little to no quantitative or qualitative peer-reviewed research examines the personal experience of the clinician as they treat the HIV-positive population.

A majority of the most current peer-reviewed text that focuses on HIV treatment via psychotherapy-centers identifies the treatment of depression (Moosa & Jeenah, 2012; Knettel et al., 2020; Moosa & Jeenah, 2012) and dissociation (Allers et al., 1997) as the entry point to the clinical treatment. This is because many people diagnosed with HIV experience immediate feelings of *depression*, *anxiety*, and *stigmatization*, leading to destructive behaviors, such as self-isolation and bad decision-making (Ferrando & Freyberg, 2008). Past and current literature makes it clear that people who contract the virus suffer from depression more than any other type of mood disorder (Hussen et al., 2018). Additionally, the literature does not explicitly state specific behavioral symptoms associated with the contraction of HIV in the same way that there are clear medical implications (e.g., the lessening of cellular regenerative abilities [Knettel et al., 2020]).

While recognizing depression as an entry point provides a pathway for clinicians to access and treat this population, the use of medication still stands in the way of researchers and clinicians who believe in therapy as a primary method of intervention, if not a replacement for prescription medication. To help normalize the use of psychotherapy as a viable treatment option for members of this community, researchers such as Moosa and Jeenah (2012) compared the application of antidepressants and psychotherapy to treat depression with a group of people living with HIV. Findings suggest that psychotherapy is as effective, or more effective in some cases, as medication in the reduction of depression. This attempt at making the case for the use of therapy as a preferred treatment modality to drugs was also highlighted in a complex case study by Pinkston et al. (2020) that discussed the phenomenon of being *diagnosed with HIV* as something that creates a *stigma-sickness* that requires immediate and ongoing attention. Pinkston et al. (2020) discussed the case of a Latinx trans woman diagnosed with HIV and how the intersection of her racial, trans, and HIV-positive identities created a multi-layered situation that seemed too complex to treat via the application of medical drugs. Thus, instead of over-medicating, they discussed clinical treatment interventions that focused on crisis stabilization and the building up of self-compassion, self-resilience, and community to increase her ability to cope (and eventually transcend) what it means to live with HIV. While this may have seemed like a big step to some, other scholars like Ennis and Cartagena (2020) and Starks (2020) appear to be less preoccupied with making a case for therapy as a legitimate modality for the treatment. Instead, they focus more on figuring out which therapeutic delivery methods (e.g., supportive psychotherapy, therapeutic writing, or interpersonal therapy) are most helpful in treating feelings of anxiety and depression that those living with HIV face. Given these important distinctions,

there appears to be several entry points that researchers have taken to conceptualize and develop treatment techniques for those living with HIV.

It is also important to note that some literature focuses on the treatment of serodiscordant couples (i.e., a partnership in which one member of the relationship is HIV-positive and the other is HIV-negative [Muessig & Cohen, 2014]. This research is geared toward helping clinicians discuss particular issues, such as the risks of sex without a condom, with couples, as well as tips on guiding clients towards the creation of healthy relationships and less towards feeling pressured to "come out" or reveal of their status to loved ones (Jia, 2013). This "self-guided" approach of therapy appears to focus on creating hemostasis in a way that might appear bold or unconcerned with the fact that one partner is HIV positive. However, upon more observation, it can also be interpreted as a significant ideological change in how mixed-status couples are conceptualized and treated in therapy. This change becomes even more evident in literature focused on helping people wrestle with the fact they have "contracted the death sentence" that is HIV (Allers et al., 1997). While many facets likely contribute to this shift, one could assume that significant changes in medication coupled with a reduction of stigmatization of folks with HIV in the queer community have led to growth away from such "doom and gloom" clinical outlooks and analysis by clinicians.

### **General Systems Theory**

Clinicians have long explored treating people living with HIV, and in many cases, clinicians' treatment attempts have tasked them with becoming heavily interwoven into their clients' inter- and intra-personal systems; even if just for a while. Thus, there is a process in which the clinician's systemic experiences interacts with their clients' systemic experiences. Systems theory is a structuralist approach that focuses on complex networks of patterned

interaction between definable units and their environmental context (Bertalanffy, 1968), and systems analysis considers how information from the environment is processed; eventually becoming a definable, adaptive entity (Bertalanffy, 1968; Broderick & Smith, 1979).

This theory originated in the field of mental health and is credited to Bertalanffy (1968), who was a biologist who became dissatisfied with the linear style of cause-and-effect theories and the manner in which they explained growth and change in living organisms. Thus, Bertalanffy (1968) opted to focus more on the interactions between the parts of an organism. This point of view dramatically changed the paradigm from that of reduction to that of one geared towards growth, understanding the whole by the sum of its parts. Thus, a Systems Theory framework puts clinicians in the position to more holistically approach the treatment of PLWHA as they consider: (a) behavior and problems in context, (b) issues of reciprocity, (c) how relationships are influenced by beliefs and behaviors, (d) the developmental stage in which the problem occurred, and (e) the complexity of HIV as a medical issue (Bor et al., 1993). Bor et al. (1993) also posited that the primary focus should be the interaction between the client (e.g., the individual, family, or other biosocial systems) and "the disease" (i.e., HIV) to make sure that the contemplated resolutions to emotional problems consider all of the proper contexts.

### **Family Systems Theory**

Family systems theory is a sub-theory of systems theory that goes one step further by seeing the family as a system where the *environment* is the family's society and individual members are the component units (Wedemeyer & Grotevant, 1982). Individual family members are complex systems, but they are treated simply as enactors of family systems without concern for their unique internal structure (Wedemeyer & Grotevant, 1982). McBride et al. (2007) discussed the use of family systems theory as the best way to reach minority populations such as

Black youth; a population that is considered high-risk for contraction of HIV due to a combination of external stressors present in some urban neighborhoods and peer-pressure to engage in sex at an early age (McKay et al., 2014; Murry et al., 2012). McBride et al. (2007) and Bhana et al. (2010) utilized a family systems framework to create the Collaborative HIV/AIDS Adolescent Mental Health Project (CHAMP) as a tool to use the power of the family structure to ensure that youth receive support, education, and value messages that increase their capacity to negotiate peer-situations involving sex and other risky behavior. Utilizing a systemic approach that includes not only BHPMSM and their family as a unit of treatment, but also introduces clinicians into the family system via the clinical treatment processes, is key in exploring how the Black family system works as a potential protective and factor for BHPMSM. This would provide needed insight into family interactions in effective clinical treatment.

### **MSM, HIV, and the Family**

A search of the terms "HIV," "HIV+MSM," and "HIV+Family" in journals such as the *Journal of Marriage and Family Therapy*, *the Family Journal*, *The Journal of Family Issues*, *Family Relations*, and *The Journal of Family Violence* was conducted to scan for peer-reviewed literature that discussed the intersection of family therapy, MSM, and HIV. The search produced nine articles with all but two (i.e., Delaney et al., 2009; Palmer & Bor, 2001) related to HIV and the family. These two studies focused on the disclosure process of mothers who have HIV (Delaney & Serovich, 2009) and challenges of intimacy for serodiscordant same-sex male couples (Palmer & Bor, 2001), which fall too far outside of the scope of this work to be considered. Other peer-reviewed works covered topics such as reduction of risky sexual behavior (Lasala, 2015), the impact of the family relationship on behavior (Serovich et al., 2011),

disclosure and acceptance (Schlossberger & Hecker, 1996; Serovich, 2000), and planning and preparation for treating MSM who are living with HIV (Serovich, 2000).

In terms of risk, LaSala (2015) suggested a small but growing body of literature focused on the importance of the family in preventing HIV among MSM and that family rejection is related to an increase in sexually risky behavior. Their study borrowed from the tenants of grounded theory by breaking data into six phases that selected, compared, and then created memos from themes based on answers to the question “what do gay and bisexual youth and their parents believe is effective in persuading young gay and bisexual males to avoid high-risk sexual behavior?” (Lasala, 2015, p. 2). This question was asked to thirty-eight youth (ages 14 – 21 years old, with 18 years old being the median age) living in Northeastern United States and their parents to assess relationships. Findings suggest that something as simple feelings of connectedness with their parents (especially their mothers) positively affected teen mental health and resulted in a 30% reduction in contraction of HIV. Additionally, Serovich et al. (2011) conducted a study with MSM from the Midwest between the ages of 18 and 78 years old that found that family relationships were essential to HIV-positive MSM. This study also used a grounded theory approach to conduct a focused analysis that deployed inductive and deductive approaches and comparative themes methods. Both studies implied that the family (or engagement with family) is important and can act as a protective factor for HIV-positive (or at risk) MSM and encouraged clinicians to engage in conversation around this issue. Findings by Serovich et al. (2011) also suggested that family is multidimensional and includes the family of origin and familial relationships forged through solid bonds with those not related by blood. Serovich et al. (2011) also promoted the family resilience approach (e.g., the family’s ability to maintain effective functioning in the face of traumatic events), as a potentially appropriate

mechanism for examining the role and importance of the family for MSM. The mention of *chosen* family and other eco-systemic familiar relationships shows the importance of conceptualizing populations such as BHPMSM through a systemic lens and family systems lens that allows for the encapsulation of the complex-system that may create what a consists of family.

Pais et al. (1998) examined how marriage and family therapists (MFTs) who worked with HIV-positive clients interacted with them, specifically concerning the therapist breaking the confidence of the HIV-positive client who is engaging in high-risk sexual activity. The participants were given vignettes in which a fictitious client told the therapist about engaging in unprotected sex. Although the basic situations were the same, the client variables of age, gender, race, sexual orientation, and HIV status were systematically varied. Vignettes were created and administered to MFTs in which fictitious clients disclosed engaging in unprotected sex. Among each of the vignettes, clients' demographic descriptives (e.g., age, sex, and race) were varied. Results suggest that clinicians are more likely to break the confidence of their clients who are young, male, gay, or Black, and that the clinicians most likely to disclose sensitive information identified as female, religious, and lacking in clinical experience with members of the gay/lesbian population.

This bias may not come as a surprise to those embedded in the MFT profession as the profession has deep ties to strict religious doctrines (e.g., Mormonism and pastoral counseling) that speak against homosexuality (Wetchler et al., 2014). Serovich (2000) exclusively examined the intersection of bias and MSM who are HIV-positive. While they did not directly discuss family bias, Serovich (2000) offered a six-step guide to MFTs working with HIV-positive clients to help their clients understand and create a disclosure process to their families: (a making a

disclosure list, (b), evaluating the nature of each relationship, (c) assessing a recipient's special circumstances, (d) assessing HIV knowledge and anticipated reactions, (e) assessing why disclosure to each person is important to them, and (f) making a decision. Lowe (2007) discussed a three-year treatment process for the entire family, in which one or more members were living with HIV. Lowe (2007), who was working with a family in which both parents were living with HIV/AIDS, espoused that all family unit members must be given nurturing in the form of individual clinical support, since they are all deeply affected by the reality and stigma of the diagnosis. He believed that both the external (e.g., the types of services they receive) and internal (e.g., the inter-family dynamics) systems must be examined and stabilized. The small amount of literature concerning the intersection of the family, MSM, and HIV shows that while there is a discussion on this topic, very little speaks directly to the experiences of the clinician or MSM. Most of the research not related to "risky" behavior is dedicated to the heterosexual or the nuclear family unit.

### **Black MSM, HIV, and the Family**

Literature shows that HIV impacts the Black community disproportionately, with Black MSM contracting HIV at the higher rates compared to all other racial groups within the U.S. (Young & McLeod, 2013). Due to experiences of ostracization, stigmatization, and internalized homophobia, BHPMSM often endure feelings of extreme isolation and sadness that can lead to pathological conditions (i.e., increased depression and SI [Durham et al., 2020]). Moreover, BHPMSM often feel stigmatized within the hetero-cis and queer community, where being accepted in one's friendship community is highly valued (Scott et al., 2014). Searches that include some combination of the words "Black MSM," "gay Black male," "HIV," and "family" yielded the most relevant research on the BHPMSM community. The limited research on this

population mostly attunes to prevention and the family as a risk or protective factor (Bird & Voisin, 2013; Voisin et al., 2013; Williams et al., 2004) or the intersection of education, *stigma* and other learned norms, the family structure, and BHPMSM (Horne et al., 2015; LaSala & Frierson, 2012; Mustanski & Hunter, 2012; Zarwell & Robinson, 2018). Structural racism, systemic discrimination, and the presence of cultural norms nuances BHPMSM interactions with their families, communities, healthcare professionals, and access to institutions of care. Studies such as those by Scott et al. (2014) indirectly demonstrate that Black men must navigate an even more complex set of systems than of non-Black men living with HIV on their care journey because they have to contend with instances of racism and socioeconomic disadvantage on top of homophobia and HIV-related stigma. It is important that studies in the future are even more intentional about including a systems theory perspective when looking at the treatment of BHPMSM.

### ***Family as a Protective or Risk Factor***

Current literature positions the family as both a protective and risk factor within the lives of Black MSM living with HIV (Carter, 2013). The family is primarily discussed as a preventative factor in the spread of HIV (Carter, 2013). More specifically, literature focused on youth and the prevention of HIV is where the family is framed as a protective factor against risky sexual behavior (Mustanski & Hunter, 2012; Voisin et al., 2013) while literature focused on emerging and older adult populations position the family as a risk factor (Carter, 2013). The family plays a truly significant factor that in the lives of BHPMSM because there is a tangible fear of rejection or ostracization from family of origin associated with a positive HIV status.

The emerging adulthood phase includes the years of highest sexual and behavioral risk that carries potential for risk of harm to self or others (Arnett, 1999). Young adults, especially

Black emerging adults from more communal societies, are searching for autonomy during this time, while their parents or caregivers are often struggling to stop seeing their offspring as “children.” Thus, watching their children depart from systems—and the values connected with those systems—in which they were raised, such as the Black church, can be difficult. For these reasons, factors like the presence of religion within the family are noted as a significant source of distress for BHPMSM. This stress derives from fundamental differences in the values learned from the family, school, and in church during childhood that are incongruent to the dominant discourses within the Black queer community (Carter, 2013). Ironically, the presence of spirituality, or the connection to a “higher power,” is viewed as a protective factor for Black MSM (Means, 2017), with many using their connection with the spiritual realm to cope with the reality of a positive diagnosis.

### ***Family Impact on Behavior***

The impact of assumptions or preconceived beliefs about how the biological family might react to BHPMSM HIV status is discussed in the literature as a significant source of distress (Bird & Voisin, 2013). This distress impacts the overall quality of life of BHPMSM because it inhibits their ability to feel as though they are “normal” participants in society (Bird & Voisin, 2013; Bird, LaSalla et al., 2017). Holding such a large secret is perceived as scary to the BHPMSM, and the inability to seek out comfort from close loved ones in such a painful time amplifies feelings of distress. This sense of rejection creates a general sense of mistrust that directly spills over into the BHPMSM community (Bird, Eversman et al., 2017). Williams et al. (2004) conducted a study which included twenty-three-men who participated in four focus groups that examined the sociocultural and behavioral factors including sexual health, sexual identity, and sexual risk among HIV-seropositive African American and Latino men who have

sex with men (MSM) who also have a history of sexual abuse. Participants reported that they did not trust those within the queer community with information about their status. Additionally, some participants mentioned they have seen those within the BHPMSM community use the learned status of their peers maliciously, leading to feelings of extreme isolation for BHPMSM. The contraction of HIV is also seen as a punitive sentence that is a direct consequence of participating in unsafe homosexual-sex-behaviors; thus, making it "okay" for BHPMSM to be intentionally ostracized from participation in sex within the BHPMSM community (Bird & Voisin, 2013). As a result, HIV positive MSM often feel uncomfortable disclosing their status, even to casual sexual partners in some cases (Williams et al., 2004). BHPMSM who belong to constructed families, named-houses, or specialized groups (e.g., ballroom, pageant, or bear) skew younger in age, are less-educated, and are medically uninsured (Zarwell & Robinson, 2018), but they are also more likely to engage in safe sex; suggesting that constructed families, named-houses, and specialized groups influence sexual behaviors.

### ***Psychoeducation to Reduce Stigma***

Literature on psychoeducation (Hamp, 2008; Voisin et al., 2013) and stigmatization (Bird & Voisin, 2013) suggests that BHPMSM of all ages receives very little direct sex education about safe-sex practices from their educational institutions, and messages pertaining to queer-focused sex education are not discussed within school settings at all. Instead, much of the information they receive comes from others within the gay community and from their biological or chosen families (Horne et al., 2015; Voisin et al., 2013; Williams et al., 2004). These familial messages are laced with an anti-gay sentiment that paint those with HIV as pariahs to be pitied, exiled, or taken care of, despite the fact that an overwhelming majority of HIV-positive MSM feel fully capable of taking care of themselves (Voisin et al., 2013; William et al., 2004). Family

acceptance strategies (e.g., the specific treatment of feelings of powerlessness) and resilience-focused social marketing campaigns (e.g., commercial showing Black fathers accepting their gay sons) are suggested as proven solutions towards the production of empathy, reduction of stigma, and positive impact on health outcomes and combat negative stigma (Carter, 2013). Clinicians are uniquely placed to provide this psychoeducation in a controlled and safe manner to reframe the minds, and thus reduce, stigma within Black families around the queer community and HIV (Skinta et al., 2015).

### ***Interventions Involving the Family***

Literature has suggested potential clinical intervention or implications involving the family to treat BHPMSM (Joe et al., 2018; McKay et al., 2004; McKay et al., 2014; Young & McLeod, 2013), but no direct model or clinical interventions have been offered (Simoni et al., 2006; Simoni et al., 2012). For instance, Simoni et al. (2012), who dedicated an entire book chapter to the role of the family in HIV medication adherence in minority families, pointed out that essentially no research existed within the context of the U.S. due to the *individualistic* clinical treatment approach utilized by providers. Moreover, concrete family-based references to treatment focus exclusively on HIV prevention, particularly for Black youth (i.e., those under 18 years of age; Mustkunsti & Hunter, 2012). Large amounts of literature focus on intervention programs (e.g., CHAMP Family Program, ImPACT, Keepin it REAL!, and Parents who Care (McKay et al., 2014; Murry et al., 2012) or data gleaned from focus groups and surveys (Voisin et al., 2013). None of these studies focused on the clinician's experiences as they attempted to integrate the family into the clinical treatment of BHPMSM. There is no mention of clinical models or interventions focused on integrating the family into the clinical treatment of this population. The practitioner perspective is completely missing from the literature and thus from

the overall conversation. The current literature is missing discussion about families in therapy, and the majority of the discussion focuses on the family unit's impact on the mindset and overall well-being of the BHPMSM in order to understand the unique nuances of the Black family and all of its eco-systemic (e.g., the Black family's connection to the Black church) impacts on the mental health of BHPMSM (Carter, 2013; Means, 2017). The current literature also proposes a focus on youth within the queer community and the prevention of HIV, recommending the implementation of family acceptance models as a preventive measure (Bird & Voisin, 2013; Murry et al., 2012; Voisin et al., 2013). However, there is no discussion about clinicians' roles in implementing these models or their recent experiences treating this population.

### **Present Study**

The purpose of the present qualitative study was to gain an understanding of the experiences of clinicians as they treat member of the BHPMSM community. The present study addressed this gap in the literature by addressing the following research question: what are the experiences of clinicians who use the family approach to expand the unit of treatment to treat BHPMSM? Information and knowledge gained from this study were used to provide recommendations for practicing clinicians, clinical training programs, and clinical scholars. For the purposes of this study, a family approach is defined as clinicians introducing—or attempting to introduce—the family into at least one therapy session during treatment., and an expert clinician is operationalized as a fully licensed clinician in public or private practice who is actively treating Black HIV-positive men who have sex with men (BHPMSM) for one or more year.

## Chapter 3: Methodology

### Research Design

Research on the experiences of clinicians who treat BHPMSM who utilize the family approach to expand the unit of treatment is non-existent. This qualitative study, which employed focus groups, explored and described the experiences of clinicians who have contemplated or attempted to integrate the family unit into the treatment process of BHPMSM. Focus groups consist of highly structured and expertly moderated group discussions used to capture participants' feelings, attitudes, and perceptions about a selected topic (Powell & Single, 1996). Focus groups are recognized as a viable research methodology in HIV health education and research to build awareness and facilitate behavioral change (Nyamathi & Shuler, 1990; Wilkinson, 1998).

### *Interpretive Phenomenological Analysis*

Data from the focus group study was analyzed using an interpretive phonological approach (IPA). Smith et al. (2009) described the process of IPA as an approach to qualitative analysis that focuses on how people make sense of their experience. Researchers can collect data via one-on-one interviews or focus groups; with focus groups being the selected modality for this study. Data must be collected in a detailed, reflective, and first-person account from all research participants. The core purpose of the IPA is to provide a sense of “voice” by capturing the principal claims and concerns of research participants and to “make sense” of what has been captured by offering an interpretation of the data collected that is grounded in the accounts of the participants (Larkin & Thompson, 2012).

The IPA approach assumes that: (a) an understanding of the world requires an understanding of experience, (b) that researchers must elicit and engage with the personal

accounts of others who are “always-already” immersed in the world (e.g., linguistically, relationally, culturally and physically) that is being explored, (c) that researchers do not have to have access to experiences directly from accounts but, instead, through a process of intersubjective meaning-making that requires the researcher to self-reflect and identify with their own assumptions when producing interpretations, and (d) that researchers must maintain a commitment to staying grounded in participants views (Larkin & Thompson, 2012). The IPA approach fits well with this study because of its focus on interpreting how participants (i.e., the clinicians treating BHPMSM) make sense of their experience. Larkin and Thompson (2012) described the following data analysis steps:

1. Line by line analysis (coding) of experiential claims and understandings of participants;
2. Identification of emerging themes with a focus on nuance, commonality, convergence, and divergence;
3. Development of a structure or frame that shows the relationship between themes;
4. Organization of material in a format that allows for all analyzed data to be traced through a process, from initial comments on the transcript, to the initial clustering of data into themes, to the development of the final structure of themes;
5. The use of supervision, collaboration, or audit to help test, develop coherence, and plausibility for the interpretation of data;
6. The development of a narrative that is supported via detailed commentary on data extracts that guides the reader through this interpretation in a theme-by-theme manner, and is supported by some sort of visual guide; and
7. Reflection of ones owns perceptions, conceptions and process.

### *Sampling Procedure and Recruitment*

The sampling and recruitment procedure began after approval was granted from the Antioch University New England Institutional Review Board (IRB). The criterion sampling method was used to select licensed clinicians (e.g., LMHC, LMSW, or LMFT) who had been treating members of the BHMSM community for at least one year (Rudestam & Newton, 2014). Studies show that clinicians develop a strong sense of connection with their clients and the ability to understand the unique needs of their clients over time (Thompson et al., 2007). Additional inclusion criteria include clinicians who have attempted or heavily contemplated including the family as a unit of treatment of BHPMSM.

Recruitment material in the form of flyers, emails, and Facebook posts were disseminated and attracted five participants for the focus group from across the United States. According to Creswell (2013), snowball recruitment strategies were also employed as selected participants were asked to identify and invite others that they thought would be willing and eligible participants for the study. Emails were sent to public and private mental health practices within the New England region as well as public and private organizations that serve the HIV+ community. Flyers were posted to local public and private practices across New England. Participants were presented with the informed consent that detailed the purpose of the study and the nature of their participation. All selected participants were given two payments of \$15 equaling a total of \$30 in composition via the money transfer app CASHAPP before and after the completion of participation in the focus group. Additionally, participants were informed that they were able to opt out of the study at any time.

### ***Data Collection Method***

Five clinicians were asked a set of pre-prepared interview questions in a focus group setting, and the discussion was recorded and transcribed verbatim. The semi-structured interview style was used to prompt focus group participants to discuss their thoughts and experiences on the intersection of the family and treatment of BHMSM, attempts to introduce the family into treatment, and how they integrated the family into treatment. This study utilized online focus groups to generate a rich discussion and to allow for the public sharing of ideas among a more diverse pool of clinicians. Given that we are in the midst of a global pandemic, and that the majority of the professional clinical spaces have transitioned to teletherapy, it seemed most safe and logical to conduct online focus groups instead of in-person focus groups. Online focus groups allow for country-wide participation, dramatically widening the potential outreach, and the removal of infrastructural mobility barriers that may inhibit protentional participation, especially given that the population needed to complete this research study is more narrowly tailored (Lobe & Morgan, 2021). Moreover, focus groups allow for the creation of rich group discussion and the creation of a group synergy that generates more nuanced data (Piercy & Hertlein, 2005).

### ***Measures***

The scales presented below were not adopted verbatim for this study, but instead used to inform the creation of interview questions that were created by me to be asked to the focus group participants. Additionally, the survey measures were modified to focus on the experiences of clinicians opposed to the experiences of HIV+ individuals and their family members.

**Stigma.** The Psychometric Assessment of the Chinese Courtesy Stigma Scale [CCSS] is a 10-item stigma-related Likert scale developed to measure degrees of stigma among HIV+

individuals and the HIV-negative family members at the family level (Liu et al., 2014). Although the CCSS was created for members of the HIV+ population in China, I found the questions universally designed enough to be applicable to diverse cultural populations (Liu et al., 2014).

**Self-Efficacy.** The HIV Adherence Self-Efficacy Scale [HIV-ASES] is a 12-item scale that was created to measure patient confidence to carry out important treatment-related behaviors related to their adherence to treatment plans and treatment-related behaviors that include adherence to medication, nutrition, and exercise plans in the face of societal barriers (Johnson, 2007). Participants' responses range from 1 (*cannot do at all*) to 10 (*certainly can do*), and higher participant scores indicate greater self-efficacy.

### ***Interview***

The interview was set at a time by consensus by all participants selected for the study. Participants were supplied with information about the study and encouraged to ask any questions that they may have about the study. A single-semi-structured interview was conducted for about 90 minutes via the zoom-video professional platform (Sevilla, 2020). Since the introduction of the family as a unit of treatment for BHPMSM has not been studied, it was difficult to predict how willing or likely participants would be to step forward and participate in several short interviews, especially given the demanding nature and time-schedules of the clinical profession. Thus, it was more logical to conduct one single, longer, interview where a plethora of data can be collected at one time. The interview was recorded and transcribed via the Zoom platform. All statements from participants were grouped based on themes that arose around their expressed experiences on integrating the family unit into the treatment of BHMSM, as well as their responses to the following questions:

1. How would you describe your process in attempting to integrate the family into the treatment of BHPMSM?
2. How has the introduction of family in treatment influenced your perception of clients' stigmatization, ostracization, or depression in BHPMSM treatment?
3. How has the introduction of the family influenced your ability to adhere to treatment implementation?

Three additional follow-up questions were asked based on the responses of the clinicians to the initial three research questions during the focus group:

1. How has your feelings about HIV impacted or influenced your thoughts on bringing the family into treatment or on treatment in general?
2. What other variables do you think impacted the family integration process?
3. What would you have liked to feel more successful in initially integrating the family into treatment and what were you already doing?

### ***Thematic Analysis***

All study participants were provided with a copy of the interview transcription and codes to rectify any misunderstandings in the transcription. This process is known as member checking (Birt et al., 2016). The information was also analyzed by a second analyst who also coded themes from the transcript. The manual coding process was used to mark-up the transcript on a hard-copy version of the transcript with comments and highlights being used to identify themes and make connections to develop first and second-level codes (Lofland & Lofland, 1971). Manual coding consisted of me going page by page and line by line circling, highlighting, bolding, underlining, or scoring meaningful quotes or passages of text to find repetitive patterns of action and consistency in the data (Lofland & Lofland, 1971). Focused coding was used to

analyze the most frequently occurring themes appearing in the body of the text (Lofland & Lofland, 1971). A specific code was assigned to each theme derived from the recorded focus group discussion analysis.

### ***Data Protection***

All interviews were recorded via zoom and stored in a secure-HIPAA-compliant Google Drive folder that is owned by Antioch University (my student Google-documents folder account). The results were kept until completion of the transcription process. Since the interview was focused on the experiences of the clinicians, there were no major risks involved. However, participants' were be informed that they might have intense emotional responses triggered by the discussion of difficult cases and situations concerning their clinical work. Each participant received a copy of the interview once the data was transcribed and written-up in report form from my school email account in the form of a Google Drive link that was password protected. This document also included the transcription of the interview so that feedback could be provided and kept for their records (Marshall & Rossman, 2016).

### **Researcher Reflexivity and Bias**

I am the lead author and researcher for this study, and I identify as Black, bi-racial, and queer. I am a practicing couple and family therapist who is working towards licensure, and I am interested in primarily treating BHMSM. I was drawn to this work after a dear friend of mine died from complications related to their HIV status. They kept their status secret, and it was only after their death that their close friends and many relatives learned about their status and the mental anguish they passed through after receiving their diagnosis. After their death, it felt as if divine intervention placed me in the path of a Black gay man after Black gay man struggling to manage the challenge that living with HIV placed on their lives and mental health. However,

when I looked for opinions, perspectives, or interventions that I could employ as a member of the chosen family, I was surprised to find that no literature existed that offered any insight or perspective on the issue. I found myself wondering why that was and wanting to contribute to the research.

By focusing my research on the clinician's experiences, I hope to start a needed conversation and contribute to the literature on this topic so that others like me, who seek pathways to intervene clinically or inter-personally, have a real place to start.

Given my strong personal connection to this topic personally and clinically, I kept research notes and utilized the bracketing process to ensure that any preconceived notions that I picked up ecosystemically 'along the way' in my life are not hindering my ability to fully understand the lived experiences of participants (Creswell, 2013; Fisher, 2009). This intentional suspension of judgement, or epoche (Bendall, 2006), allowed me to assume an attitude of noninvolvement towards the remarks of participants, preventing me from unintentionally attaching meaning derived from my own biases to their words, tainting the research process. It was conducted in an ethical manner and I am confident that this study can be used to enhance our almost non-existent body of literature on the BHPMSM population. By conducting this research, I am contributing to this area by highlighting the experiences of clinicians attempting to treat this population and starting the discussion about real-life care (Bednall, 2006).

### **Credibility and Trustworthiness**

I kept a research journal throughout the data collection process that coincided with the data collected from the facilitated focus group sessions. I also utilized researcher triangulation by using video, research notes, journaling observations, and any outside documentation provided (i.e., forms, journals, other notes) to develop a comprehensive understanding of participants'

phenomena. Although no research explicitly studies clinicians' experiences as they attempt to integrate the family as a unit of treatment with BHPMSM, there are many studies that designate the family as both a protective and risk factor in the lives of these men (Bird & Voisin, 2013; Bird & Voisin, 2013; Bird, LaSala et al., 2017). Much of the research on the BHPMSM population and their families focus on dynamics around disclosure, stigma, and ART adherence (Hamp, 2008; Schlossberger & Hecker, 1996; Serovich et al., 2011; Voisin et al., 2013). This research focuses on the specific dynamics with the family, but it does not place the family system or the clinicians' perspective at the core of the discussion. This study integrates the family-system and clinician perspective by contextualizing how the family is uniquely placed in actual clinical practice and the best methods to treat BHPMSM.

## Chapter 4: Results

The present study was designed to understand the experiences of clinicians who use the family approach to expand the unit of treatment to treat Black HIV-positive men who have sex with men (BHPMSM). A single 90-minute focus group was facilitated using a semi-structured interviewing guided by the following research questions:

1. How would you describe your process in attempting to integrate the family into the treatment of BHPMSM?
2. How has the introduction of family in treatment influenced your perception of clients' stigmatization, ostracization, or depression in BHPMSM treatment?
3. How has the introduction of the family influenced your ability to adhere to treatment implementation?

The questions were crafted to understand clinicians' experiences as they treat a member of the BHPMSM community. The study participants consisted of five licensed and practicing clinicians who had experience working with HIV-positive MSM and their families. The participants were assigned pseudonyms to protect their privacy and maintain confidentiality and will be identified as Claire, Denise, Duane, Angela, and Mary from here on out. The participant's experience equated to over 63 years of combined clinical practice. Some participants treated more than one BHPMSM and their families, but each participant referenced their work with only one client during the interview. Further demographic information about each participant is included in table 1

**Table 1***Participant Demographic Information*

<b>Name</b>	<b>Age</b>	<b>Gender</b>	<b>Race</b>	<b>Sexual Orient.</b>	<b>Employment Status/Type</b>	<b>License Type</b>	<b>State of Practice</b>	<b>Years of Exp.</b>	<b>Education</b>
<b>Claire</b>	38	Female	Black	Straight	Private, Self- employed	LMHC	FL, NJ, MA	14	MA, LMHC, Certified sex therapist
<b>Denise</b>	44	Female	Biracial	pan-sexual	Private, Self employed	LMFT	VT, NYC	20	MA, LMFT, Cert in Social Justice and inclusion PHD, Transformative Social Change.

<b>Duane</b>	31	Male	Black	Gay	Private, Full-time, former community mental health	LMFT	CT	7	MA, LMFT Trauma Certified, Men's trauma certified
<b>Angela</b>	37	Female	Other	Lesbian	Private, Part-time	LICSW	RI, MA	7	MA, Clinical Social Work Trauma Certified
<b>Mary</b>	45	Female	Black	Straight	Private, Full-time	LMHC LMFT	RI, MA	15	MA, Counseling Psychology

*Note.* Pseudonyms were assigned to each participant to protect their privacy and personal identity.

## Data Analysis

I followed the steps outlined in Larkin and Thompson (2012) to conduct this IPA focus group study. First, I performed a careful line-by-line reading and analysis of the transcript to gain a general impression and sense of understanding of their shared experiences and understandings of the clinicians. After this careful reading of the transcript, I read the transcript line by line again while also watching the video of the focus group in order to make annotations of the clinician's claims and understanding that captured the full context of their experiences. An example of the annotations process is provided in Table 2.

**Table 2**

*Interview Excerpts, Annotation and Code Example*

Interview Excerpts	Annotation	Code
<p>“It begins for me with joining with my client and finding out who is in their network to begin with and trying to find the strengths and the softer spots for where people would be willing to support, right so you have the choir. And then just outside the choir, how far outside the choir as far as family connections go.” Denise</p>	<p>Denise felt that it was important to assess and possibly establish community for their client.</p>	<p>Establishing community</p>
<p>“I feel that, after we got through all the hurdles in the beginning, putting the family in was very beneficial to me, as a clinician. I had allies in supporting this person.” Mary</p>	<p>Introducing the family felt difficult, but helpful in the end to the clinician.</p>	<p>Supported by the family</p>

“I don't know if this was a bias of mine, but um... I felt incompetent at first um when my client disclose his HIV status and perhaps it was a part of me that felt like oh you can't work with that.”  
Duane

Duane felt incompetent when first presented with the case, despite his own queer status

Incompetent working with a client who has HIV

## Themes

After the line-by-line (coding) analysis using the excerpts and annotations took place, I began the process of identifying emerging patterns. As an extra step, I read through the transcript and created within-interview themes for each clinician to ensure that I captured as much nuance (e.g., the presence of commonality, convergence, and divergence) as I could towards the creation of genuinely holistic overarching patterns and eventually themes. An example of this process is captured in Table 3.

**Table 3**

### *Emergent Clinician Themes*

Clinician	Within-Interview Theme
Claire	<ul style="list-style-type: none"> <li>• Sex Therapist lens applied</li> <li>• Sense of allyship with LGBT community</li> </ul>
Denise	<ul style="list-style-type: none"> <li>• Strong desire to integrate community</li> <li>• Science based</li> <li>• Non-believer in organized religion</li> <li>• Rooted and reliance on clinical ethics</li> <li>• Focused on not challenging client perspective</li> </ul>
Duane	<ul style="list-style-type: none"> <li>• Strong family therapy lens</li> <li>• Pulled from own LGBT experience</li> <li>• Feelings of incompetency</li> <li>• Reliance on outside experts</li> <li>• Influenced by stigma of HIV</li> <li>• High reliance on theory</li> </ul>

Angela	<ul style="list-style-type: none"><li>• Hesitant to include family</li><li>• Feelings of incompetency</li><li>• High reliance on theory</li><li>• Little reliance on intuition</li></ul>
Mary	<ul style="list-style-type: none"><li>• High reliance on intuition</li><li>• Non US-centric perspective</li><li>• Strong desire to integrate family</li><li>• Very spiritual</li></ul>

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After annotating the transcript, I met with a second analyst who shared the emergent patterns that they discovered. The codes that showed commonality and convergence were placed into themes. Places where codes and sentiments diverged, were also examined. Themes were grouped into categories based on the commonality of sentiment and experience by three or more clinicians. In some cases, themes generated in the previous step became subordinate themes because the commonality of sentiment and experiences was just between two instead of three or more clinicians. After conducting the steps mentioned above, I noticed that the text represented two types of clinician experience: (1) personal reflections and (2) professional reflections. Some codes seemed to represent the clinician's reflections on how they attempted to treat BHPMSM and integrate their family into treatment. Other codes represented what the clinicians decided to do clinically during treatment. The final thematic structure of main and subcategory themes is shown in table 4.

**Table 4***Main and Subcategory Themes*

Main Themes	Subcategory Themes
1. Building Community through Self-determination	
2. Navigating Religion	<ul style="list-style-type: none"> <li>• Black Identity</li> <li>• Queer Identity</li> </ul>
3. HIV Stigma	
4. Feelings of Incompetence	<ul style="list-style-type: none"> <li>• Desire for Clinical Training</li> </ul>
5. Family Integration	<ul style="list-style-type: none"> <li>• Femme Participation</li> </ul>

***Building Community through Self-Determination***

Although all of the participants came from different backgrounds and carried different educational experiences, four out of five of the participants mentioned that it felt important to them to help their client build community on their own terms, showing a strong desire from the clinicians to allow their clients to build their own pathways to the introduction of family. Denise stated:

It begins for me with joining with my client and finding out who all is in their network to begin with and trying to find the strengths and the softer spots where people would be willing to support, right, so you have the choir. And then just outside the choir, how far outside the choir as far as family connections go. So figuring out, who is at each level for the individual, and then you know trying of forging paths forward in terms of like how much do you want people to be involved, how do you know, like so doing the self-determination piece first is where I'd start.

Angela seemed to perk-up when Denise mentioned self-determination, stating:

They didn't want to have contact with their family, and after I think two or three sessions of the initial intake they decided they wanted to explore it. So even I was surprised by that, and I think they were as well. Going back to what Denise was speaking about—that self-determination—that's definitely how we both came at it, I should say.

Although Duane did not mention the concept of self-determination explicitly, he did speak directly to the concept, stating:

It wasn't until the six month mark that he finally decided to just tell me “hey, you know I've been thinking about telling my family, and you know through all the therapy that we did, all the sessions that we did together, you know I guess, he was able to accept his status and realize that you know, like, I need support, I need my family support and I need support from the community.

### ***Navigating Religion***

Several clinicians mentioned that their client's religious affiliation deeply impacted their clinical experience. The presence of religious affiliation in the clinical space appeared to be a barrier for clinicians, with them spending large amounts of time sorting through their and their client's complex feelings about it. Claire stated:

I'd say that religion plays a huge role, and how people feel about their family or fear of judgment those types of things when religion is not involved or not in play, you tend to see things differently, right, if it's someone who's agnostic or atheist or Wiccan. It's just a different. The intersectionality's are different, the religious type of pieces is just not a top priority, you know, it's just it's not something that's causing more stressors or on more counter indicators type of thing, you know, this is not that, they're able to actually focus

on what it is helping them find relief from versus having to now deal with this huge cloud over their situation

Duane then referenced the intersection of his clients' nationality, race, and sexually in response, saying that "including his family was really hard, because there was religious stuff you know. Imagine a Caribbean Baptist family, it was just, a lot."

Denise even further nuanced the conversation about the presence of religion by saying:

The way that they identified family with people who supported their religious shaming of homosexuality, so they were the people that they wanted to integrate into their family circle, where people that would help them to be not gay rather than people that would support them in being gay and they wanted more people who saw him, saw HIV as a punishment for gay sex. That's the family that they wanted to connect with, not the family that would normalize being gay.

This conversation started off discussing the presence of religion within the lives of BHPMSM and the Black community in broader terms, but the conversation quickly graduated to a discussion of the direct influence of Black identity and culture on the participant experience, leading to the creation of the sub-theme, Black identity.

**Black Identity.** Some participants explicitly noted that they shared experiences helping their clients navigate the intersection of Black identity (or Blackness) and their affiliation with organized religion. Denise noted that "the relationship between Black folks and Christianity is always such a fascinating to her. She also stated, "You know, that's not something as a therapist that I'm going to tell him, you know, that he shouldn't be believing."

Angela chimed in too, saying:

When it came to Blackness, because my client grew up in the South, in a mostly Black family, when he ran away, his chosen family, because his partner was white, his chosen family was more white presenting and he struggled with that, as far as being a Black angry man because that's how he felt he was perceived he didn't want to have that identity. And so it was a lot of disentangling as you're a Black man who *feels* angry.”

Angela was attempting to make the distinction between her client self-identifying as an angry Black man and simply being a Black man who is *feeling* angry due to his current circumstances. Angela then went on say, “On top of that, when it came to the religion, that was a major component. In fact, when he came out, he was beat up by his family for being gay because it went so against their religion.”

**Queer Identity.** Claire noted that Blackness was not the only thing that impacted her experience with integrating the family as a unit of treatment. She also said that her client’s queer identity had also complicated treatment:

There's a huge double standard and Black and Brown communities as related to same gender loving couples, when it comes to gender, and so men having sex with men is definitely looked at and regarded as a much more negative and/or gross or wrong thing than a woman, you know, having sex or romantic relationship with another woman.

While there is much that can be gleaned from that comment about the in session experience that inspired Claire to make that comment, it most appeared to speak to the presence of homophobia in opposition male-to-male romantic relationships within the Black community.

Claire’s statement highlights an earlier comment made by Denise, where she stated that she terminated services with the client because she did not feel morally able to continue treatment and simultaneously manage his internalized homophobia. She said:

We ended up terminating the therapeutic relationship, because the support he wanted was the kind of support that continued to stigmatize him and stigmatizes his gayness. And he sees his HIV status as punishment for that, and so it really propelled him down the treatment path that I couldn't provide for him right. I ethically would never provide. So, I ended up terminating.

The participants shared similar experiences and sentiments in relationship to dealing with the presence of the compounding intersections of religion and Black and queer identity. Denise went a step further than Claire in opting to terminate. She said that her reason for making this decision as the following:

I mean, I can't, like I said, I can't fault, the family, for it because it was his decision right, but, I mean, there was a ton there that we didn't get to uncover around his relationship with his family. But basically it contributed to the termination of the therapeutic relationship on the grounds that what he wanted and what I would provide we're not compatible.

### *HIV Stigma*

Some participants related over shared feelings of bias towards their BHPMSM clients, with two participants explicitly naming their bias towards their clients' HIV status. The presence of bias in the clinicians appeared to be a barrier to their ability to conceptualize treatment without the influence of their ontological development. Denise stated:

I think my bias about my beliefs that HIV is, you know, that's just a science thing that happens versus you know some deeper psycho spiritual punishment; when my beliefs around homosexuality is just our way of being rather than, you know, again a spiritual

condition, I don't know, umm... made it, I think that bias within me made it so that I couldn't reach the client the way he needed to, you know?

It was in that moment that Denise seemed to also have a real-time realization of the way that her bias against religion might have affected her ability to provide the better treatment to her client, saying:

Rather than having, you know, do like the pillars of white supremacy culture with like one right way, either or thinking, right? There could have been a nuance that I didn't thread well enough that would have brought him further along, you know, rather than challenging the roots of his shame and religion, finding ways to navigate him from where he was.

Duane said that he also had to do “a lot of work internally working with this client” to not “bring in biases.” Denise and Duane’s moment of vulnerability appeared to echo through the group as several of the clinicians shook their head or sighed in agreement. Then Mary said:

For someone like me who's come from a family that has been impacted by HIV, for the last 30 years, there was the hunger, my bias came in, in the hunger of wanting to see someone being supported and accepted by family. I was hungry, to see that, and I think that maybe I might have gone a little bit overboard in trying to include the family as a unit of support, because I understand how important that is. it's good that I was able to manage that, for one or two people that I work with, but there wasn't that hunger, it was my bias of wanting to see someone being loved fully and being accepted and being celebrated for whatever it is that we're bringing to the table, because I know that in my own family, we were not able to do that.

### *Feelings of Incompetence*

Shortly after Denise's vulnerable statement about her reluctance to continue treatment with her client, Duane added:

I don't know if this was a bias of mine, but um... I felt incompetent at first um... when my client disclose his HIV status, and perhaps it was a part of me that felt like oh you can't work with that you know you need to push this time to somebody else.

Duane comment about feelings unprepared to treat his client was made further distinct when he stated:

And, you know, like I said before, being part of the LGBTQ community and having, you know, and having the education around STDs, HIV and all that. There was a still a little part of me or a bias that, you know, that kind of like came up, like, you know, like or used to come up in our sessions like, "you're working with a client that has HIV."

This statement is important because it not only how the impact of the stigma within the queer community that he belonged to, but the impact of that stigma on him.

Duane went on to further explain the pressure he felt by declaring:

I always hear my other gay friends like, "oh, the least thing I want to get is HIV. I'm on PREP [Pre-exposure Prophylaxis], I'm protecting myself and all this," so there is this underlying negative connotation and to have a stigma to this whole thing, so I had to work on myself internally to push that part aside and be present for my client.

Angela seemed to resonate with Duane's experience; most notably his feelings of incompetency and the pressure around the stigma of treating people living with HIV. Angela stated [to Duane]:

I love your humility and being able to say that you felt incompetent because I don't think I would have thought to go there, but when you said it a deeply resonated with me, I too did also feel incompetent.

Claire stated that her bias was not necessarily related to the client explicit HIV status, but to the choices he was making as a person who is living with HIV, saying:

If there was any biases that kind of were coming up for me, more than not, it was just the thought that the client was being very sexually irresponsible with behaviors and mindset, as it related to sexual interactions with others and really having a grave disregard for you know, the health implication. Of course, they were on medication and I believe their partner was on PREP. Breaking vowels and, you know, that type of thing. So that's where the bias kind of came in for me, but it didn't enter into the clinical room.

**Desire for Clinical Training.** Clinicians' feelings of incompetency and hardship related to HIV stigma and religion-based stress is directly connected to the participants feeling stressed about their deficits in clinical training. Angela and Duane mentioned that they had relied on and felt most comfortable using internal family systems (IFS; Schwartz, 1994). For instance, Angela stated:

The reason that I got into IFS is because of this client. I saw that they were having such a physiological response in session, so I wish I had more training on that Polyvagal response. I know it's a theory that's mixed received, so maybe this is my bias but it speaks to me, so I learned more about the polyvagal response when it comes to trauma. And also I would have liked to know more of how trauma does impact identity; the different parts of self. So what I did use was mindfulness, cognitive behavioral therapy, and Motivational Interviewing and then also is learned as much as I could informally about

IFS and so I would incorporate parts of self especially some of that language with him and it seemed to really speak to him.

Duane added in, saying:

Having more clinical training around the specific topic, like, you know, as family therapists I, at least, in my experience, I never had a class on, you know, how to treat a patient or client with an STD or you know what type of modality would or therapeutic modality, would be the most suitable to treat a client with an STD or HIV and all that, so I think that in during my Grad um I guess experience that would have been helpful.

Angela and Mary mentioned that they felt so clinically unprepared to treat members of this population that they started to actively seek out on other aspects of their professional training. Angela stated:

Because of the additional training that I had as a sex therapist really helped me to be more equipped to deal with the client the MSM population and things that might come up as clinical issues and concerns with the MSM population.

Mary chimed into the discussion about training, saying, “I was so overwhelmed I would say that I was leaning more towards the ecological model.”

### ***Family Integration***

Although all the participants mentioned feelings of bias or stress when trying to navigate the complex dynamics that integrating the family into the treatment of BHPSMSM entailed, Claire, Denise, Duane, and Mary indicated that they felt that implementing the family as a unit of treatment had a positive impact on their clients and clinical experience. Several of the clinicians seemed to share the sentiment that integrating the family was deeply challenging at the onset of treatment, but that the integration resulted in better overall treatment. For instance, Mary stated,

“I feel that, after we got through all the hurdles, in the beginning, putting the family in was very beneficial to me, as a clinician. I had allies in supporting this person.”

Angela agreed with Mary, stating, “My client's family was also very supportive” and that, “We came to the understanding that yes, it would be important to include your family because XYZ; because you need the support.” Claire went a step further by claiming that she viewed her client’s family as the treatment plan, “The family was the treatment plan, and it definitely helped because it was able to, you know, view, the severity and frequency of the symptoms.” Angela did not directly disagree with the other participants but made sure to note that she had a different view, claiming that she was “initially against” integrating the family into the treatment of the BHPMSM client and then later stating that she “didn't feel that it had much of an impact” on her ability to adhere to treatment implementation. She then said, “It was more so, it just created more depth for my client and I to work through, so it was more about what it created for my client.”

**Femme Participation.** Participants three and five explicitly mentioned that only the femme identified family members of their clients seemed willing to take part in therapeutic treatment services. Since more than two participants seemed to agree with the sentiments of participants three and five, it seemed reasonable to count it as a sub-theme.

Participants three mentioned: “I only got the sister and the mom to a couple of our sessions, but that was enough for him, you know he felt supported and he felt like, you know, my sister now knows, my mom know and I’m okay with that.” Mary went into a bit more detail by explaining why the femme representation was so powerful, saying:

The fact that the matriarch of the family was so supportive, just like, she loved her son and I think she led with grace. The family was a big family, there were two brothers they never showed up, there were two brothers and all four sisters were there.

## **Summary**

The findings from this study show that family integration is beneficial in the treatment of BHPMSM. The findings also show that clinicians shared commonality in experiences related to five main themes, which include building community through self-determination, navigating religion, HIV stigma, feelings of incompetence, and the family integration process. Issues related to the Black and queer identity were also shown nuanced the experiences of clinicians, their clients, and their clients' families.

## Chapter 5: Discussion

The present study explores the experiences of clinicians as they attempt to integrate the family as a unit into the treatment of BHPMSM. On the whole, the current study aligns with the principles of family systems theory (Wedemeyer & Greotevant, 1982), which focuses on the complex networks of patterned interactions between definable units and their eco-systemic contexts rather than limiting the focus to isolated connections between people. These systems ask practitioners to analyze how their clients process information that comes from their environments as part of the family system. Family members are defined as component units, and the families' society is the eco-system in which they live. It is expected that clients with HIV are treated as individuals in therapy, and connections between them and their families are rarely made (Magezi & Louw, 2006), but the clinicians in this study strived to connect their clients to their familial systems.

Findings of the present study suggest that clinicians who attempt to involve the family in the treatment of BHPMSM had two types of shared experiences: (a) shared personal feelings and sentiments and (b) shared professional feelings and sentiments about the phenomena of family integration in the treatment of members of the BHPMSM community. Specifically, thematic analysis reveals five main themes clinicians believe to be important in working clinically with BHPMSM: *building community through self-determination, navigating religion, HIV stigma, feelings of incompetence, and family integration*. Their designated sub-themes are *Black identity* and *queer identity* (related to navigating religion), the *desire for clinical training* (related to feelings of incompetence), and *femme participation* (related to family integration). The themes are also separated and categorized in terms of personal reflection category, which includes

*navigating religion and feelings of incompetence, and professional experiences: building community through self-determination and family integration.*

## **Shared Personal Experiences**

### ***Navigating Religion***

Means (2017) mentioned the presence of spirituality, or the connection to a higher power, as a protective factor for members of the Black MSM population. Contrarily, Carter (2013) found that the presence of religion within the family is often viewed as a significant source of distress for BHPMSM. Results of the present study suggest the presence of religion is directly regarded as a barrier to clinicians' ability to provide holistic and effective care to their clients and a personal barrier. The clinicians appeared to view religion as fuel for problematic ideologies that created a set of values that made treatment difficult and left some participants feeling conflicted. Denise was most vocal about her ethical and treatment-related dilemmas on the back of religion, noting that she decided to terminate her therapeutic relationship with her client due to the presence of her client's internalized homophobia that was connected to his rigid religious upbringing. The inconsistency in the literature may be connected to the fact that religion has been viewed as both a protective and risk factor in the lives of Black MSM populations (Lassiter, 2014). Many Black MSM uses the underpinnings of their religious backgrounds as a way to cope with adverse psychological and psychosocial experiences, which play a starkly different role in their lives than the presence of religious-based prejudice and discrimination from members of their family (Lassiter, 2014).

Religion was never directly noted as a direct source of strength, but it was referenced source of resiliency for clients. The families of BHPMSM and, in some cases, the clinician's religious or non-religious values impacted their behavior within a session, which did lead to

Christian-like behavior in terms of family acceptance by Mary. This difference in learned values appeared to govern how clinicians and their clients made meaning out of a positive HIV status. Some clinicians felt the impact of religion led their clients to believe that HIV was a punishment from God; others felt that it was the root cause of the behavior that led to their client's estrangement (both self and forced estrangement) from their family units. Family systems theory notes that this type of tension can derive from competing emotional demands felt by some in the family unit, or in this case, the BHPMSM's family members, due to loyalty conflicts within their religious environment (Brown, 1999), where loyalty to their BHPMSM family member and condemnation of their homosexual behavior exist at the same time within the system, leading to a sense of role confusion for BHPMSM and their families and unique challenges for the clinician.

For instance, some of the clinicians expressed shared feelings related to the intersection of religion and other facets of client identity. Denise, who identified as a Black and queer, noted the "complex relationship between the Black and religious community." Duane mentioned the internal pressure he felt as a gay Black man as he attempted to beat back the internal bias that he felt from within the Black-queer community that associated an HIV-positive status with bad sexual behavior and overall health. These shared participant experiences are congruent with literature by Scott et al. (2014), which noted that Black men must navigate an even more complete set of systems than non-Black men living with HIV on their care journey.

The BHPMSM must be willing to disclose his status and subject himself to large amounts of potential harm to integrate their family into treatment, leaving him open to potential emotional harm (Geter et al., 2018). The participants shared experiences show that the intersection of bias and different types of identity did not only intersect with the Black experience, but it intersected

with the queer experience too. Claire's remarks about the "double standard" that she felt was "placed on the backs" of MSM within the Black community in regards to familial acceptance of their queerness and Denise's comments about the eventual termination of her client speak to the potential for a plethora of complex intersections within the clinicians or their clients that can contextualize the family integration process and possibly the outcome of the case. For instance, one participant felt that she was able to help her client and his family overcome the weight of their anti-queerness, and another felt that she could not. Griffin (2000) notes that while the Black communities are not exceptional in their view that homosexuality is immoral, there are few arenas where the dread and condemnation of homosexuality are more visible than the Black Church. No matter the outcome, all participant's cases were racialized and queerized in some way. The clinicians in this study appear to be heavily impacted by the presence of religion and its intersections with their client's Black and queer identities. Clinicians' experiences insinuate that the presence of religion is a therapeutic barrier that complicates the family integration process.

### ***Feelings of Incompetence***

Swartz (2007) noted that while the words *cultural competency* and *training* are popular and used often, many clinicians do not feel competent, especially when treating members of the HIV-positive community. This same sentiment seemed to be expressed by the study participants. All participants possessed several years of clinical training; however, many revealed feelings of incompetence while conceptualizing and attempting to integrate the family as a unit of treatment for BHPMSM. Some participants did mention their years of experience with pride and confidence but stopped short of saying that their accumulated knowledge prepared them for treatment. Participants three and four connected feelings of incompetence to their impact on HIV stigma, with Duane stating he "felt incompetent" when his clients disclosed his status and Duane

that she experienced feelings of incompetence too. These findings suggest that feelings of incompetence around treating HIV-positive individuals may supersede clinicians natural feelings of competence gained from years of practice. Family systems theory might see this imbalance as the result of preconceived notions the clinicians receive from members of their peer or family groups (Wedemeyer & Grotevant, 1982), which can have an impact on their selection of treatment decisions and outcomes (Brown, 1999). The (AAMFT) Clinical Guidelines for LGBTQIA-Affirming Marriage and Family therapy (n.d.a) should also be noted as reliable resource to use explore to increase feelings of competency.

### **Shared Professional Experiences**

#### ***Building Family through Self-Determination***

The process of self-determination is used in psychotherapy to help clients autonomously explore, identify, initiate, and sustain a process of change (Ryan & Deci, 2008). Jia (2013) and Rodgers et al. (2019) posited that utilizing this type of approach is vital to clinicians who wish to help their clients build healthy relationships and create a sense of homeostasis in their lives. Maeda et al. (2013) noted that there is a direct relationship between self-efficacy and depression and that clients with a high level of social support showed less depression and, therefore, a higher adherence to treatment. Clinicians in the present study felt that it was essential to allow their clients the opportunity to create their pathway forward, showing that the participants possessed a strong desire to help clients build a sense of family in their image. The focus on self-determination seemed to stem from participants' desire not overly to influence their client's decisions and to slow down treatment enough to foster stronger bonds with their clients. We see how vital this shared phenomenon is if we look through the lens of family system theory, which speaks to the concept of differentiation or one's ability to separate one's personal choices from

that of the system in which one belongs (Brown, 1999; Ryan & Deci, 2008). By increasing their clients' self-determination, they seemingly increased their differentiation and overall ability to contend with the family integration process too. This point is made evident by Denise and Angela's statements about prioritizing self-determination. This shared sentiment among participants might be best described as a delicate dance that they all, despite their different backgrounds, had to learn as they attempted to effectively integrate the family as a unit of treatment in a meaningful way.

### ***Family Integration***

Serovich et al. (2011) found that biological and chosen-family relationships are essential to members of the HIV-positive MSM population and act as a protective factor. Clinicians in the current study shared that they felt gratified by their decision to integrate the family into treatment even though the pathway to successful integration was not easy or expedited. Mary summed it up nicely, saying, "I feel that, after we got through all the hurdles, in the beginning, putting in the family was very beneficial to me, as a clinician. I had allies in supporting this person." As noted by Mary, it is the first step of a culmination of wading through the drawn-out process of joining, building trust, navigating religious nuance, and challenging the presence of racial and anti-queer stigma within the context of their cases is not easy to study participants. However, it does lead to the successful integration of the family unit. This 'boot camp' experience was shared among several group participants.

Many participants in this study worked closely with all members of the family invited to treatment, providing them with empathy, psychoeducation, and the opportunity to express their concerns. Lowe (2007) stated that it is important that the clinician work with each member of the family, making sure to provide nurturing to all family members since they are all affected by the

reality and the stigma-sickness created by the HIV diagnosis. The clinicians in this study reported that the majority of this work took place and was most successful with the femme-identified family members as the family members that identified as female were more likely to accept an invitation to join sessions and participate in therapy with members of the BHPMSM community. Research exists that posits that the role and influence of Black masculinity within the Black community produces negative attitudes towards Black queer males from both men and women, even though women are more interpersonally connected to Black queer men (Lemelle & Battle, 2004), meaning that bias against Black queer men exists across gender lines. Systemically speaking (Brown, 1999), this also suggests that clinicians should prepare for the same waylay of homophobic messages from femme-identified family members that they would from male-identified family members since they are equally influenced by the same homophobic and stigmatizing relational messages.

### **HIV Stigma**

HIV stigma can be a great source of distress for practicing clinicians (Bird & Voisin, 2013; Bird & Voisin, 2013; Bird, LaSala et al., 2017; Sun & Farber, 2020). Geter et al. (2018) mentioned that the presence of HIV stigma could create an uncomfortable environment and act as a barrier to treatment and care. Previous literature on HIV stigma supports the results of this study. In a moment of vulnerability, the clinicians shared experiences around the impact of bias on their experience personally and professionally, with Denise's comments about the impact of bias on her interpretation of her client's beliefs about redemption, homosexuality, and eventual termination of therapy. However, her self-termed missed opportunity to 'thread' her client's self-deprecating feelings about his status is more complex than a simple difference in perspective. If we view this issue through the lens of family systems theory (Wedemeyer & Grotevant, 1982),

we see that her client was but a mere member of a larger component unit that was his family system and the environment in which his family exists and creates meaning in society. Denise's client came from a family system that appeared to be rooted in a belief system that heavily stigmatized HIV, while the system that informed Denise's clinical lens did not. It was arguably this system-influenced mismatch in perspective more than the intrapsychic difference that blocked her ability to reach her client fully.

### **Clinical Implications**

The results of this study produced meaningful implications for other clinicians and mental health professionals providing services to the BHPMSM population. The participants discussed a plethora of experiences that culminated into a set of themes that offer insight into what one might expect to experience when attempting to treat and eventually integrate the family into the treatment of BHPMSM. These findings could help those in practice know what personal feelings and experiences to expect and prepare for and build a pathway towards practical case conceptualization and treatment.

### ***Encouraging Self-Determination***

The findings of this study show how important it is for clinicians to work with their clients to establish a strong sense of 'self' at the onset of treatment. Self-determination refers to a person's ability to make their own life decisions and choices (Ryan & Deci, 2008). This ideology shined through in the data because it seemed to provide the participants with a concrete place to begin working with their clients in a structured way that protects against accidental over-influence by the clinician. This sense of determination also gives the client a sense of ownership over important factors within their family integration journey, such as time spent in mental preparation for family integration. It also allows the clinician to slow down treatment and helps

the client begin to detangle complex family relationships and personal thoughts. Studies show that when clients feel more self-determined, they also feel more motivated to take on new tasks due to increased autonomy and capability (Ryan & Deci, 2008). Clinicians need to take care not to over-impact their client's decision to integrate into the family and remain aware of their personal feelings (e.g., opinions, anxiety, and feelings) by assessing the clients' desires and allowing them as much time as they need to build up the courage to speak to their family members.

### *Exploration of Community*

After assisting the client in establishing a sense of self-determination, the clinician needs to help clients explore and eventually establish a sense of community that reflects the full scope of their family. The client's biological and chosen family should be examined, and clinicians should consider all relevant relationships (both positive and challenging) as part of the discussion. This critical step may serve two purposes. First, it provides the clinician with a snapshot of their client's current eco-system and its associated protective or risk factors, and secondly, it allows the clients to do the same. Boyd-Franklin and Bry (2001) described the process of building community in family therapy as vital, stating that "clinicians frequently work with only a sub-system of a complex family and extended network, not engaging with individuals who often have a great deal of power to produce or sabotage change" (p. 6). The participants in this study discussed the importance of helping their clients build community. Angela noted that even though she could not locate family members that her client wanted to meet with, the exploration of his family "added more depth" to each session. Like building self-determination, the community-building phase of therapy must last as long as the client needs it to, which means that the clinician should take care to work at the desired pace of their clients

instead of their desired pace and that they should work to include intentional exploration of all individuals deemed necessary to their client.

### ***Involving Family***

The findings from this study show that the family is important and beneficial to the treatment of BHPMSM because it creates a more robust system of support for the clinician and their clients to rely on and expands the overall community that BHPMSM has access to who have a deeper understanding of the complexity of their lives. Duane spoke to his client, feeling "satisfied" and more supported after the successful integration of his mother and sister into therapy, and Mary mentioned that she felt she had "allies" in the clinical space. Clinicians who wish to integrate the family into the unit of treatment of BHPMSM are encouraged to explore and keep this option on the table for their clients. They should also work with their clients to identify members of their client's biological and chosen family to whom they might feel most comfortable disclosing their status too, making sure to place a particular emphasis on the exploration of female family members. After deciding which members of the family to bring into treatment, the clinician should work with their client to establish the disclosure process that feels most comfortable for their client

### ***Intersectional Lens***

This study highlighted the complex relationship between the various identities that members of the BHPMSM hold and must sift through when faced with questions about family integration. Several participants spoke to challenges they experienced while attempting to treat their clients due to the negative impact of non-gay-affirming religious environments and the subsequently internalized homophobia on their clients (Barnes & Meyer, 2008). The chance that the introduction might deepen these internalized negative messages is also present. As such,

clinicians should ensure that they are applying an intersectional lens to their analysis of their clients and themselves by assessing for issues related to their core identities (e.g., their Black, queer, and religious identities) and any personal feelings or beliefs they may carry that cause them to their clients positive status. Through an intentional intersectional lens, the therapist can better explore the interconnected nature of matters such as race, religion, and sexual orientation (Hankivsky, 2022) to prepare better questions and solutions.

### ***Self-of-the-Therapist***

The American Association for Marriage and Family Therapy (AAMFT) Code of Ethics (n.d.b), American Mental Health Counselors Association [AMHCA] (2014), American Psychological Association [APA] (2019), and the National Association of Social Workers [NASW] (2008) all espouse that clinicians make a reasonable effort to understand and prevent the influence of personal bias in treatment. This burden should be a top priority for clinicians considering integrating the family as a unit of treatment for BHPMSM in addition to the application of an intersectional lens. Clinicians must explore and work to resolve self of the therapist issues that may arise. The clinician should spend time outside the session exploring the history of religion in the Black community and how it impacts Black queer identity development, making sure to run their personal views against their clients and their family members. This exercise will help therapist treat their clients in a more culturally responsive way.

### **Limitations**

#### ***Recruitment and Sampling***

The findings of the present study should be viewed alongside a few limitations, one of which being potential issues of sample size. The present study only consists of five participants instead of the recommended six-to-eight participants needed to conduct a focus group study

(Freitas et al., 1998). The dilemma exists in attaining a sample size that would produce the desired results without placing undue amounts of stress on the back of research participants who were all also a part of marginalized racialized and sexual populations and subjected the extra minority stressors connected to those identifies (Pitoňák, 2017). Researchers who want to create a similar study might benefit from allowing more time for clinician recruitment and intentional follow-up in the form of a questionnaire, where follow-up questions can be asked, and reflections can be documented to expand on themes.

### *Demographics*

The demographics of the clinicians in this study are diverse, with all of the participants identifying as people of color, three out of five participants identifying as members of the LGBT community, and four out of the five participants identifying as female and one as male. However, another possible limitation was the lack of White clinical representation, and the study may have benefited from White or another racial category perspectives. The inclusion of the White clinician's experience is especially relevant since the overwhelming majority of the clinicians who practice identify as White and female (Luona & Ginsberg, 2021). Thus, their perspective is vital to understand and consider within the research context. A lack of White clinicians working in the facilities that serve the needs of BHPMSM or the disconnect between many Black people and White clinicians might contribute to their lack of representation in the study (Drustrup, 2020). However, it is impossible to understand why this study did not attract this population. While the study did produce rich results and recruitment included postings on a database with over 19,000 practicing clinicians of color, more time to recruit may have yielded an even more diverse sample population.

### ***Interview Process***

All study participants were interviewed together, and the only follow-up that occurred was in the form of member checking (Birt et al., 2016) to ensure that each participant was satisfied with the transcript. The group dynamic was friendly, professional, and cordial. The conversation flowed naturally as each participant shared their experiences openly. There was a strong desire for participants to share both their reflections and personal experiences, which created a rich discussion. Since there were only five participants in the focus group and the focus group was 90 minutes long, each group member had ample time to speak. However, with the complexity of the topic, having more time might have led to the generation of more themes and sub-themes. The time constraints also impacted the ability to create follow-up questions and responses that would have further contextualized vital points and themes gleaned from the research.

Furthermore, while the focus group is comparatively easier to conduct when compared to other methodologies such as grounded theory (Walker & Myrick, 2006) or ethnographical (Reeves et al., 2008) research because it generates the opportunity to collect data from group interaction, has high 'face validity,' and allows the research to increase sample size quickly, it is not based on a natural atmosphere. The researcher has less control over generated data (Larkin & Thompson, 2012).

### ***Significant Advancement***

Despite these limitations, this study can significantly influence the lives of BHPMSM and mental health and clinical fields. Queer Black people are one of the most marginalized populations in the United States (Stotzer, 2012). This population is also highly over-represented when it comes to the rate of STD contraction, which is due to a host of system barriers, but little

research exists that speaks to their familial experiences, and none exists that takes into account the clinicians' experience (Laurencin et al., 2018; Oster et al., 2011). Thus, sharing experiences between highly trained mental health professionals on their behalf is highly impactful as we now have the first in hopefully a long line of empirically supported steps to expand their eco-system and protective factors. Rubenstein & Sorrentino (2008) noted that family psychotherapists could help patients explore thoughts and concerns, test their thinking against reality, and develop rational expectations about the outcome of revealing their status. This study takes their point one step further by forming a community of clinicians that knows the value as well as the challenges associated with involving the family of BHPMSM. This perspective from the other side of the table starts a much-needed conversation around the impact of self-determination, religion, HIV stigma, Blackness, queerness, gender, and the family integration process.

## **Recommendations for Future Research**

### ***Educational Framework Creation***

This study aimed to explore the experiences of those who attempted to integrate the family into the treatment of BHPMSM. The study provides ample evidence showing that the family is important and beneficial and that those tasked with its integration shared many experiences. The depth of analysis that is possible from one focus group shows that this type of study would offer important data if expanded upon. Recommended explanation of this study could take many forms, with the focus on the experiences of members of the BHPMSM community given the highest priority. This next step of this research should also be in the form of a focus group that mirrors this study and allows for an in-depth comparison of data that shows shared and divergent experiences. This study shows that there are clinicians who, with minimal direct training, are attempting to expand treatment opportunities for members of the BHPMSM

community. The third proposed step for research would be bringing both focus groups (i.e., the clinicians and members of the BHPMSM community) together to create recommendations for the creation of an academic curriculum, clinical training materials, and a clinical framework.

Since four out of five clinicians in this study saw tremendous value in having family members as co-partners in treatment, four out of five said that they felt incompetent regarding methods and techniques for bringing families into the treatment team, and all of them seemed to agree on the importance of encouraging and developing their client's self-determination; I would suggest that clinicians use the six steps detailed by Serovich (2000) concerning the issue of self-disclosure as a guide for to shape their recommendations. Using the six steps outlined would give clinicians a clear pathway to foster their client's self-determination, establish a procedural guideline for getting family members involved, and prevent clinicians from feeling utterly incompetent.

### ***Methodology***

This focus group study utilized the IPA qualitative approach to capture the experiences and perspectives of clinicians using the family to treat members of the BHPMSM community and yielded results that undoubtedly move the field forward. In keeping with the IPA methodology standard of practice, this study used a small sample size. Future researchers might consider establishing a series of focus groups or a qualitative approach that allows for larger sample sizes and includes clinicians who identify as white as well as clinicians who are working in community mental health. Furthermore, the scope of the present study consisted of a single focus group interview without follow-ups. Future research might benefit from hosting follow-up interviews with clinicians to reduce the potential that clinicians withhold information in an attempt to avoid offering counter-narratives that run against that of the groups. This would

provide more information on if the insights acquired from clinicians about their experiences integrating the family into the treatment of BHPMSM are the same as when they are interviewed individually. Lastly, quantitative researchers might consider creating assessments or scales that assess the impact of HIV stigma or feelings of incompetence in clinicians who attempt to treat members of the BHPMSM community and their families.

### ***Further Interview Questions***

The three original questions created for this study aimed to capture the overall experiences of clinicians who attempt to integrate the family unit into the treatment of BHPMSM. This inquiry led to the creation of several variables (e.g., the presence of religion, Black identity, queerness, HIV-Stigma, and gender) and feelings (e.g., feelings of incompetence) shared by the clinicians; the scope of this study did not allow for in-depth follow-up into these themes. Future researchers might consider asking more pointed questions that focus on diving deeper into clinicians' experiences with each of the identified themes and subordinate themes. Some sample questions for the researcher might include: (a) how did the family integration process increase or decrease your feelings of competency, (b) how did you navigate the presence of religion when treating your client and their family, or (c) how did you navigate the presence of both HIV and queer-related stigma the Black family unit.

### **Conclusion**

The purpose of this study was to fill a gap in the research concerning the family-based treatment of BHPMSM and to capture the overall experiences of clinicians attempting to integrate the family of BHPMSM into treatment. This study succeeded in both tasks, adding a much-needed perspective to the mental health field and focusing on the nuance of treating this sensitive population solely. Clinicians now have a more excellent knowledge of the personal and

professional issues they will have to contend with when attempting to treat BHPMSM and an empirically supported roadmap to start adequate case conceptualization. We now know that self-determination matters and should be fostered before integrating the family, that the family does matter and is helpful to the treatment of this population and that factors related to religion, HIV stigma, and the Black and queer perspective should be considered important to pay attention to work most successfully with this underserved population.

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## Appendix I

### Recruitment Flyer

#### Licensed therapists/clinicians wanted for participation in innovative research study!

##### The project?

Steffen Gillom is a PhD student at Antioch University New England who is currently look for practicing clinicians to meet for ONE 1.5hr focus group discussion to share what their experiences are or have been as they attempt to integrate the family into therapeutic treatment of Black HIV-positive men who have sex with men (MSM).

##### The Criteria?

- (1) You are a licensed clinician who holds an LMFT, LMSW, LMHC or another accredited mental health license.
- (2) You are currently, or have in the past, provided clinical services to at least one black-gay man who is HIV positive.
- (3) You have attempted to or have successfully involved the family in the treatment of this individual.

##### The Impact?

Although many from the Black diaspora come from a communal family-centered culture that places high value on family connection, virtually no research exists or is readily available for clinicians to utilize to assist them when attempting to integrate the family into clinical treatment of this population. By sharing your experiences, you will not only help strengthen treatment of this important population, your insights will offer-up important information that other researchers within the mental health profession can use to build upon in the future!

##### Incentive?

Mr. Gillom believes it is important that everyone be paid for their labor. Therefore, all **SELECTED** participants will **RECEIVE a \$30 VISA GIFT CARD** for taking the time to participate in the focus group discussion.

##### Contact Me!

If you are interested in taking part in this study and think you would be a good fit, please contact me and you will have a response within 24hrs!

## Appendix II

### Email

Dear (insert name of clinic/clinician/practice/organization),

My name is Steffen Gillom, and I am a PhD student at Antioch University New England who is currently look for practicing clinicians to meet for one 90 minute focus group discussion to share what their experiences are or have been as they attempt to integrate the family into therapeutic treatment of Black HIV-positive men who have sex with men (MSM).

This research is important because research has shown that connection with family (biological or chosen) and community is highly Important to members of the Black community. However, virtually no research exists or is readily available for clinicians to utilize to assist them when attempting to integrate the family into clinical treatment of this population. By sharing your experiences, you will not only help strengthen treatment of this important population, your insights will offer-up important information that other researchers within the mental health profession can use to build upon in the future!

I believe it is important that everyone be paid for their labor. Therefore, all **SELECTED** participants will **RECEIVE a \$30 VISA GIFT CARD** for taking the time to participate in the focus group discussion. If you are interested in taking part in this study and think you would be a good fit, please contact me and you will have a response within 24hrs.

## Appendix III

### Informed Consent

**Title of Research:** *The Family as a Unit of Treatment for Black HIV+ MSM*

**Principal Investigator** Steffen Gillom

**Additional Affiliations:** *Dissertation Chair* Dr. Denzel Jones

**Institutional Contact:** Antioch University, NE Institutional Review Board (AUNE-IRB)

**Chair** – Dr. Kevin Lyness

**1. Purpose of the Study:** The purpose of this research is to allow practicing clinicians the opportunity to participate in a 90 minute focus group discussion to share their experiences around integrating the family into the therapeutic treatment of Black HIV-positive MSM.

**2. Description of the Research:** Participation in this study will entail participating in a discussion-style focus group that will be 90 minutes long. You will be asked to describe times where you attempted to or did integrate a member of your clients' family into their clinical treatment.

**3. Subject Participation:** It is estimated that 6-8 participants who are licensed (LMFT, LMHC, LCSW), practicing clinicians will enroll in this study. Participants must have been or are currently providing clinical services to at least one client who identifies as Gay, Black, and is HIV-positive and have attempted or successfully integrated a member of their family into the treatment of their client.

**4. Potential Benefits:** People who participate in this study may have a better understanding of additional treatment methods that enable individuals to experience and increase their overall sense of well-being of members of the gay, Black, HIV+ community and their clients that carry

those identities. This research will also help other clinicians and researchers outside of this study gain a better understanding as well. Each participant will also receive a \$30 for their participation in this research study.

**5. Potential Risks and Discomforts:** there are no known risks affiliated with your participation in this study. However, if you experience a response that requires immediate assistance, contact 911, the National Suicide Prevention Lifeline (1-800-273-8255 or visit <https://suicidepreventionlifeline.org/>) or the Crisis Text Line (Text CONNECT to 741-741). Each of these services is available 24/7. Additionally, therapist locator ([www.psychologytoday.com](http://www.psychologytoday.com)) may be used to locate a therapist in your area. Participants in this study can choose to withdraw from this study at any time for any reason, although premature withdrawal might impact compensation.

**6. Confidentiality:** Please be advised that while Mr. Gillom will take every precaution to maintain confidentiality of the data, the nature of focus groups prevents the researchers from guaranteeing confidentiality. The researchers would like to remind participants to respect the privacy of your fellow participants and not repeat what is said in the focus group to others. All information taken from the study will be coded to protect each subject's name. No names or other identifying information will be used when discussing or reporting data. The investigator(s) will safely keep all files and data collected in a secured locked google-doc in the principal investigators HIPAA protected Google office suite. Once the data has been fully analyzed it will be destroyed. Your responses are completely anonymous. No personal identifying information or IP addresses will be collected. Your interview will be transcribed verbatim. I will not use your name in any quotations or reports of my findings. You will be able to review all of the data collected.

Lastly, if you have any questions about your rights as a research participant, you may contact the local IRB Chair or the AUNE Provost at phone number via their email.

**I voluntarily agree to participate in this research program  Yes  No**

**I understand that I will be given a copy of this signed Consent Form.  Yes  No**

**Name of Participant (print):**

Signature:

Date:

**Name of Witness (print):**

Signature:

Date:

**Person Obtaining Consent:**

Signature:

Date:

**Appendix IV**  
**Clinician Screening Tool**

You are considered eligible to participate in this study if you can answer “yes” to one of the following two questions:

1. Have you ever contemplated (i.e., heavily thought about or strongly desired) to include at least 1 family member in the treatment of a BHPMSM client of yours?
2. Have you ever attempted (i.e., engaged a family member in therapy) to include at least 1 family member in the treatment of BHPMSM?

## **Appendix V**

### **Demographics Survey**

Hello! Please fill out all of the questions in which you are able and submit this form via scan, email, word, or pdf. This information will only be used for the purpose of Steffen Gillom's dissertation. All identifiable information will be destroyed after the final submission of the Mr. Gillom's dissertation to the Antioch Public Library. Thank you so much for your participation in this important research.

Name:

Age:

Gender:

Race:

Employment Type (private/public):

Employment Status (full-time, part-time/self-employed/retired):

License Type (LMFT/LMHC/LMSCW):

State(s) of Practice:

Years of Experience:

Educational Background:

Sexual Orientation:

Any other relevant specializations or certifications that they would like to include?