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The Perception of Family Conflict by Parents Living with HIV/AIDS and Their Adolescent Children

Li Li
Luohua Jiang
Lynwood Lord
Mary Jane Rotheram-Borus

ABSTRACT. This study explores discrepancies in perceiving family conflict between HIV-infected parents and their adolescent children aged 12 to 22. A representative sample of 382 adolescent children and their HIV+ parents were recruited and assessed over 4 years. Relationships between discrepancies in perception and family demographics and the impact of discrepancies on adolescent adjustment are examined. A significant gap in perceiving family conflict was reported between parents and young adolescents aged 12. A higher level of discrepancy was associated with poor economic status, lower parental education, parental hard drug use, and negative parental coping style. Behavioral intervention programs

Li Li, PhD, Luohua Jiang, MS, Lynwood Lord, BA, and Mary Jane Rotheram-Borus, PhD, are affiliated with UCLA-NPI Center for Community Health, University of California, Los Angeles, CA.

Address correspondence to: Li Li, PhD, UCLA-NPI Center for Community Health, 10920 Wilshire Boulevard, Suite #350, Los Angeles, CA 90024 (E-mail: lililili@ucla.edu).

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for adolescents must consider both parents' and adolescents' psychosocial status and behavioral indicators as well as their impact on perceptions of family conflict. doi:10.1300/J499v08n01_06 [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2007 by The Haworth Press, Inc. All rights reserved.]

KEYWORDS. Adolescence, HIV/AIDS, early adolescence, family conflict, conflict

Early adolescents go through rapid social, physical, emotional, and cognitive changes. As adolescents age, renegotiation of roles is common, with adolescents starting to share in decision-making processes and exercising more independence (Bowen, 1978; Vangelisti, 1992). Combined with the stresses of identity development and individuation, this shifting of authority inevitably sows conflict (Steinberg, 1990; Grotevant & Cooper, 1986).

Numerous researchers have noted that conflict is an integral part of the parent-adolescent relationship (Laursen, 1995; Holmbeck, 1996) as well as a natural response to the intense changes of early adolescence (Steinberg, 1990; Holmbeck, 1996). Hill and colleagues have studied both 7th-grade boys (Hill et al., 1985a) and 7th-grade girls (Hill et al., 1985b), revealing heightened levels of oppositional behavior, conflict, and emotional distancing, as well as lower levels of parenting satisfaction, during the early years of adolescence. Clark-Lempers and colleagues (1991) studied parent-adolescent conflict in a sample of 1,100 adolescents, aged from 11 to 19. More conflict with parents was reported by the early adolescent group (aged 11, 12, and 13) than other age groups, indicating the sensitivity of the transition from early adolescence to late adolescence. More recently, McGue and colleagues (2005) found adolescent perceptions of the quality of the parent-child relationship declined consistently between ages 11 and 14.

Although much has been learned about the nature of parent-adolescent conflict, many researchers have approached the subject by reporting either parent or adolescent perceived family conflict (Rotheram-Borus et al., 1998; Allison & Schultz, 2004). Much less attention has been given to describing parent-child differences in perceiving family conflict. Smetana (1989) evaluated the match or mismatch in parents' and adolescents' reasoning about actual family conflict, and found that

parents and their children generally agreed on which issues caused conflict, but not on their meaning. The ratings of family conflict by both parents and adolescents in a sample of African-American families have been reported (Smetana & Gaines, 1999), but which family factors were associated with the difference in perceiving conflict were not documented. Consequently, the first phase of this study investigated, as adolescent children age, the relationships between discrepancies in perceiving family conflict, demographics, and family environment.

Comparative studies of populations of different heritage have been completed (e.g., Vangelisti, 1992; Lincoln, Chatters, & Taylor, 2003), but few focus on how the developmental tasks of adolescence affect a culturally diverse population. Studies that do discuss ethnicity in adolescent-parent relationships tend to focus on single-race samples, whether they be Caucasian (Holmbeck, 1996; Holmbeck, Paikoff, & Brooks-Gunn, 1995; Spencer & Dornbusch, 1990), African-American (Smetana & Gaines, 1999; Miller, DiIorio, & Dudley, 2002), or Asian (Fuligni, Yip, & Tseng, 2002; Shek & Tang, 2003). The adolescents evaluated for this study were selected from a population of parents living with HIV/AIDS in New York City; the racial composition of the sample was primarily Latino (49%) and African-American (38%), with the remainder White or other.

Montemayor (1983) has suggested that generational differences stimulate conflict during a time that is inherently stressful, and that most families lack adequate coping and communication skills to deal with the stress of transitions. We hypothesized that an adverse family environment, such as low income, lower parental education, and parental substance use, would reduce open communication between parents and adolescents and hence increase discrepancies in perception. Family environment studies have shown that close family bonding and decreased family conflict can protect against adolescent problem behaviors (Farrell & White, 1998; Resnick et al., 1997), and multiple studies have detailed how hostile/coercive exchanges increase the likelihood of adolescent emotional and behavioral problems (Conger et al., 1994; Cui, Lorenz, & Conger, 2005; Rueter & Conger, 1995). In a family with a chronically ill parent, family adjustment may be further strained (West et al., 1991), fanning negative impact on the adolescent-parent relationship (Rosenheim & Reicher, 1986).

Stress generated by medical illness frequently radiates throughout the family, straining both parents' and children's established coping patterns (Rotheram-Borus et al., 2003; Rotheram-Borus, Lee, Lin, & Lester, 2004). Fleishman and colleagues' research (2000), one of few

studies to isolate conflict, coping, and social support in HIV-infected persons, concluded that conflict was significantly related to avoidance coping behaviors such as isolation, anger, and wishful thinking. Moreover, HIV-positive mothers have reported inferior mother-child relationship quality and less monitoring of their children than HIV-negative mothers (Kotchick et al., 1997). Rotheram-Borus and colleagues (1998) revealed that parent-adolescent conflict and stressful parenting events in families with HIV-infected parents were significantly influenced by parents' lifestyle behaviors. Accordingly, in the second phase of this study, we explored the impact of family conflict and discrepancies in perceiving family conflict on psychological and behavioral indicators of the adolescents of parents living with HIV/AIDS.

METHOD

Participants

The New York City Division of AIDS Services (DAS) provides comprehensive case management services to 95% of people with HIV/AIDS who qualify for public assistance. Parents living with HIV/AIDS (PLHA) were selected from a consecutive series of clients registered with DAS. Of the 429 eligible PLHA, 65 (15.1%) were untraceable, 46 (10.7%) refused participation, and 11 (3%) were not recruited due to severe illness or incarceration. Thus, 71.6% ($n = 307$) of eligible PLHA were recruited.

After recruiting PLHA with approved informed consent procedures, further recruitment of their adolescent children required both parental and adolescent informed consent. Of these PLHA, some ($n = 38$) temporarily did not have custody of their children or did not allow their children to participate. A total of 409 adolescents were recruited from the 269 remaining PLHA (average number of adolescents per family = 1.5, $SD = 0.7$, range 1-5).

For inclusion in this analysis, the observations of parents and adolescents were matched. To be treated as being interviewed at the same wave, the parent had to be interviewed less than 3 months before or less than 1 month after the adolescent. For parents who died during the study, neither parent nor children contributed additional data 3 months after the last parent interview. All interviews missing family conflict data were also ineligible for analyses. As a result, a total of 382 adolescents with at least one matching parent and 258 parents with at least one matching adolescent were used for analyses in this paper.

Procedures

The PLHA and their adolescent children were typically interviewed individually in their home, and the assessment took approximately two hours to complete. Similar to the participants, interviewers were predominantly African-American or Latino (62%); about one-third were bilingual in Spanish and English. For the 3% of participants who spoke only Spanish, those assessments were conducted in Spanish. Interviewers were certified only after receiving training in ethics, confidentiality, child abuse, crisis protocols, HIV/AIDS, and conducting in-home assessments using laptop computers. Interview quality was assured by audio taping and routinely monitoring randomly selected tapes (approximately 10%). Parents and adolescents each received \$25 per interview.

Interviews were conducted every 3 months for the first 2 years and every 12 months for the next 2 years ($n = 11$ potential assessments). Parents died over time and the follow-up rate was calculated by removing deceased parents. Because there were multiple assessments each year, at least one annual assessment was conducted at the following rates for years 1 to 4 (PLHA: 88, 94, 98, and 92%; adolescents: 86, 94, 91, and 85%). When assessments were missed, families were re-contacted over time. The exact date of each follow-up interview was recorded and used in the current analysis.

Instrumentation and Measures

The assessment surveys for both parents living with HIV/AIDS and their adolescent children contained questions on family background, family relation, socio-psychological indicators, behavior measures, and demographic characteristics. A key dependent variable in this study was perceived family conflict. For both parents and adolescents, reported family conflict was rated by five items asking participants the perceived frequency of arguments regarding household responsibilities, peers, behavioral trouble at school, academic achievement, and adolescent employment (1 = Never to 5 = Very much). The inter-item reliability alpha values for the family conflict scales were 0.75 for the adolescents and 0.82 for the parents. Discrepancy in perceived family conflict was calculated first by taking the absolute difference between parent perceived and adolescent perceived conflict on each item. A mean score of the five absolute differences was used as an index for discrepancies in perceiving family conflict ($\alpha = 0.80$).

Several variables were used to assess adolescents' psychological and behavior status. Emotional distress was measured by the Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983). This is a 53-item measurement that assesses symptoms of emotional distress, anxiety and depression, interpersonal sensitivity, somatization, obsessive-compulsive, hostility, phobic anxiety, psychoticism, and paranoia, rated for the period of the previous week on a 0 (Not at all) to 4 (Extremely) Likert scale. The Global Index was used for this study ($\alpha = 0.96$), which was calculated as the average response to all questions belonging to the subscales. The Rosenberg self-esteem scale (Rosenberg, 1965), which includes 10 items rated on a scale of 1 (Strongly agree) to 4 (Strongly disagree) ($\alpha = 0.85$), was used. Conduct problems were defined as a sum of 18 recent conduct behaviors (e.g., "snatched someone's purse," "broke into a house, building, or car") ($\alpha = 0.61$). Multiple problem behaviors were measured as the presence (1) or absence (0) of six behaviors during each assessment period: unprotected sex, trouble in school, trouble with peers, drug use, alcohol use, and contact with the criminal justice system (Jessor, 1991).

For parents living with HIV/AIDS, parental coping style was assessed at baseline using 40 of the original 53 items on a previously published Coping with AIDS questionnaire (Namir, Wolcott, Fawzy, & Alumbaugh, 1987). Items were used to measure positive action, spiritual hope, passive problem-solving, social support, self-destructive escape, nondisclosure, and passive problem solving ($\alpha = 0.90$). Items were rated on a 1 (Never) to 5 (Always) Likert scale. Parental coping was categorized as positive (positive action, spiritual hope, and social support) or negative (passive problem solving, self-destructive escape, nondisclosure). Lifetime drug use was indicated by self-reported lifetime use of (1) stimulants, (2) inhalants and/or hallucinogens, and (3) cocaine and/or heroin. Also included in the analyses were parent self-reported age, gender, ethnicity, household economic status (1 = Very poor to 4 = Comfortable), and education level.

Statistical Analyses

Phase 1 analyses were performed to investigate the relationships between baseline covariates and the longitudinally measured discrepancies in perception of family conflict. We fit longitudinal data models with the SAS mixed procedure (SAS Institute, Cary, NC, USA). In these longitudinal models, we assumed the observations from the same subject were correlated instead of being independent. We used a

AR(1) covariance structure to model the correlation of repeated measures for the same adolescent child, and included random parent effects in our model to incorporate the correlation between adolescents within the same family. For model selection, we first fit separate models with child demographic characteristics and one child or parent predictor. A longitudinal model was then tested that included child demographic constructs and all other child and parent baseline predictors, which showed a significant association with the outcome in the separate models. All nonsignificant predictors were gradually deleted until only significant predictors remained.

Phase 2 analyses focused on the impact of family conflict and discrepancies in perception on both binary and continuous outcomes. We included adolescent gender and age, a population intercept and slope, as well as adolescents' perceived family conflict and discrepancies in perception in all models. The last two variables were entered as time varying covariates. For the continuous responses, we allowed for changes in the population slope at 18 and 36 months post study entry. The BSI scales and number of conduct problems were skewed with a long right tail so the scores were log transformed after adding a small constant; the transformation successfully reduced skewness. We used an auto-regressive moving average (ARMA) covariance structure to model the longitudinal correlation for repeatedly measured data. This covariance structure had much higher data support than any other covariance structure. Again, we included random parent effects in our model to incorporate the correlation between adolescents within the same family. For binary responses, we used a longitudinal logistic regression models with compound symmetry covariance structure. All longitudinal models were fit in SAS Proc Mixed for continuous data and SAS Macro Glimmix for discrete outcomes.

RESULTS

Descriptive Statistics for Adolescents and Parents

The average age of the adolescents at baseline was 15.3 years (range = 12-21 years); 53% were female. Ethnicity was 50% Latino, 37% African-American, 3% White, and 10% other. The mean BSI global index 0.5 (SD = 0.6), a score in the normative range for adolescents (Derogatis & Melisaratos, 1983). Problem behaviors varied considerably: 63% had some contact with the criminal justice system, 25% reported alcohol

use, 21% used drugs, 17% reported trouble with peers, 52% had trouble in school, and 22% reported unprotected sex. The average number of conduct problems in the past 3 months was 0.9 (SD = 1.6). The mean score for Rosenberg self-esteem was 3.1 (SD = 0.5).

The vast majority of the parents with HIV/AIDS were mothers (82%), with a mean age of 38.2 years (range = 25-71 years). Ethnicity was 47% Latino, 34% African-American, and 19% White or other. Over half of the parents (55%) reported their financial situation as poor or very poor, with the remaining 45% reporting their financial situation as "having the necessities or comfortable." Fifty-three percent of the parents graduated from high school. In terms of HIV illness staging at the time of entry into the study, 19% of the parents were asymptomatic, 42% were symptomatic but did not meet the criteria for AIDS, and 39% had AIDS. Most of the parents had used alcohol or drugs sometime in their lifetime (88%), with 83% reporting alcohol use, 69% reporting marijuana use, and 68% reporting hard drug use (including amphetamines, inhalants, cocaine, crack, hallucinogens, or heroin). The average score was 2.92 (SD = 0.83) for positive coping, and 2.14 (SD = 0.58) for negative coping.

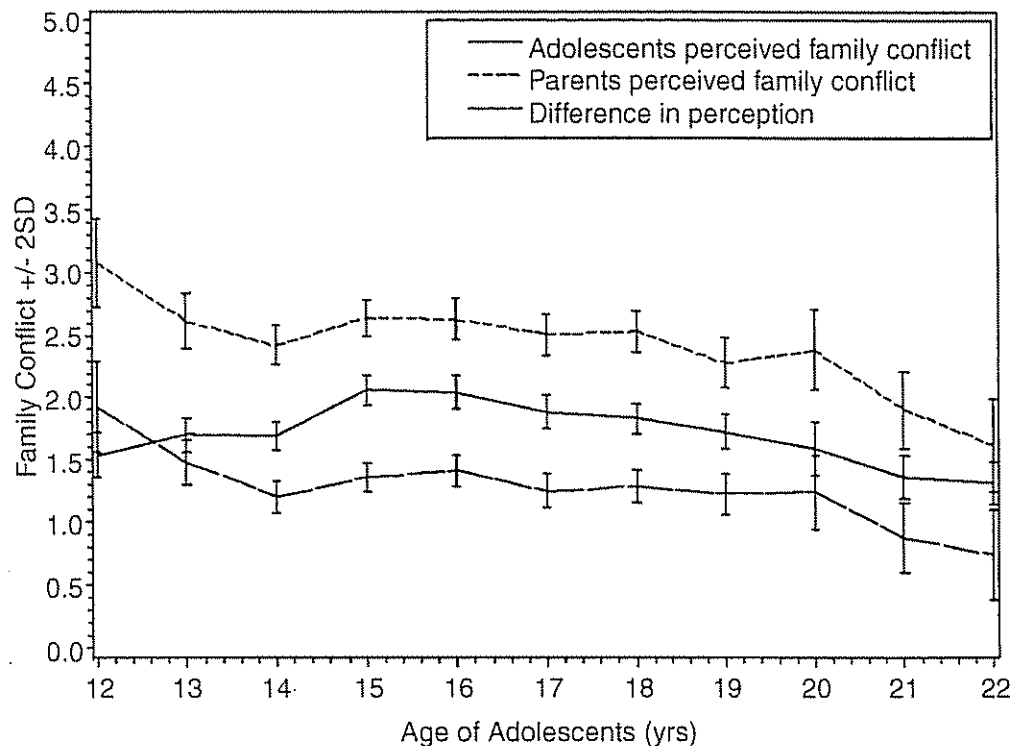
Adolescent-Parent Conflict

The evolution of parent and adolescent perceived family conflict based on adolescent age is depicted in Figure 1. Overall, the level of parents' perceived family conflict was higher than adolescents' perceived family conflict. Parents perceived conflict gradually decreased with adolescent age, while adolescents' perceived family conflict increased from early adolescence to middle adolescence (aged 12-15) and then decreased when adolescents got older. Discrepancies in perceived family conflict between the parents and adolescents are also illustrated in Figure 1. Discrepancies decreased with age for adolescents aged 12 to 14, were flat between ages 14 and 20, and began to decrease with age again after age 20.

Discrepancies in Perceived Family Conflict and Baseline Covariates

The parameter estimates of the final multivariate longitudinal model for discrepancies in perceived family conflict are shown in Table 1. The estimate for ages 12 to 14 is -0.1956 , which means for adolescents aged from 12 to 14, the discrepancies in perceived family conflict

FIGURE 1. Summary Plot of Perceived Family Conflict versus Age of Adolescents



decreased 0.19 units per year. The estimate for slope between ages 14 and 20 was -0.0157 , indicating the time trend for discrepancies in perception was primarily flat. After age 20, discrepancies in perception of family conflict began to decrease with age again at a rate of -0.28 units per year; this relationship can be seen clearly in Figure 1. Although differences in perception over time did not differ significantly by adolescent gender or ethnicity, parents' economic status and education were significantly related to the discrepancies, and gender was marginally related. Specifically, there was a larger discrepancy between mothers and teens than between fathers and teens in the perception of family conflict ($p = 0.054$). Higher longitudinal discrepancies in perception were also significantly correlated with poor or very poor household economic status ($p = 0.029$) and education ($p = 0.045$). In addition, parental lifetime hard drug use ($p = 0.021$) and negative parental coping style ($p = 0.0002$) were significantly associated with discrepancies in perceived family conflict between the parents and adolescents.

TABLE 1. Longitudinal Analysis of Discrepancies in Perceived Family Conflict by Parents and Adolescent Children, Predicted by Adolescent and Parent Baseline Covariates

	Difference in Perception of Family Conflict			
	Parameter	Standard Error	t-Value	p
Child Variables				
Aged 12-14	-0.1956**	0.0650	-3.01	0.0027
Aged 14-20	-0.0157	0.0153	-1.03	0.3047
Age after 20	-0.2804**	0.0930	-3.01	0.0026
Female	-0.0968	0.0578	-1.68	0.0941
Hispanic	-0.0868	0.0728	-1.19	0.2331
Parent Variables				
Female	0.1948	0.1008	1.93	0.0535
Economic status (Poor or very poor)	0.1661*	0.0761	2.18	0.0293
Education (High school graduate)	-0.1547*	0.0769	-2.01	0.0445
Lifetime hard drug use	0.1909*	0.0823	2.32	0.0206
Negative coping	0.2520***	0.0665	3.79	0.0002

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Impact of Perceived Family Conflict on Adolescent Adjustment

The effects of adolescents' perceived family conflict and discrepancies in perception on adolescents' behavioral and psychological indicators are summarized in Table 2. A higher level of adolescent perceived family conflict was significantly related to higher level of the BSI global symptom index ($p < 0.0001$), a lower level of self-esteem ($p = 0.002$), and more conduct problems ($p < 0.001$). Furthermore, perceived family conflict by adolescents had significant effects on multiple problem behaviors, including contact with the criminal justice system ($p < 0.0001$), drug use ($p = 0.0007$), alcohol use ($p = 0.007$), trouble with peers ($p = 0.023$), and trouble in school ($p = 0.0001$).

In addition to adolescents' perceived family conflict, discrepancies in perception between parents and adolescents also significantly affected adolescents' BSI global symptom inventory ($p = 0.037$), level of self-esteem ($p = 0.019$), and number of conduct problems ($p = 0.020$). Adolescents with more discrepancies in perception with their parents reported

TABLE 2. Longitudinal Analysis of the Impact of Family Conflict and the Discrepancies in Perceiving Family Conflict on Adolescents' Adjustments

	Adolescent Perceived Family Conflict		Difference in Perception of Family Conflict	
	Estimate	p-value	Estimate	p-value
Global Severity Index for Emotional Distress (Log)	2.4813***	< 0.0001	0.5587*	0.0374
Self-esteem	-0.2036**	0.0020	-0.1424*	0.0185
Log 2 (# Conduct problems)	0.3714***	< 0.0001	0.1914*	0.0201
Multiple problem behaviors (Y/N)				
Crime	1.9807***	< 0.0001	1.5989***	0.0002
Drug use	1.2806***	0.0007	0.5724	0.1266
Alcohol use	1.0140**	0.0065	0.7772*	0.0324
Trouble with peers	1.1636*	0.0233	0.0378	0.9422
Trouble in school	1.9714***	0.0001	0.3822	0.4037
Unprotected sex	0.6093	0.1496	0.7767	0.0582

Note: All models are adjusted by adolescent's age, gender, follow-up time, and parental HIV status.

* $p < 0.05$ ** $p < 0.01$ *** $p < 0.001$

higher emotional distress overall, more conduct problems, and lower self-esteem. They also reported more contact with the criminal justice system ($p = 0.0002$) and more alcohol use ($p = 0.032$). Additionally, discrepancies in perception were also marginally associated with unprotected sex ($p = 0.058$).

DISCUSSION

This study explores the perception of family conflict over a range of adolescent developmental stages with their HIV-infected parents. The population represented a full spectrum of family structures, socioeconomic conditions, and racial diversity for the area. We first extend knowledge of parent-adolescent conflict during the transitional years of adolescence to early adulthood by exploring the relationships of family background, parental lifestyle, coping, demographic characteristics, and age-related variations in the perception of family conflict. After identifying family factors associated with discrepancies in perceived family conflict, we further examined the impact of family conflict and discrepancies in perception on adolescents' adjustment over time.

Geography and disease status limit the ability to generalize findings about family conflict to the general population. Given that 39% of the parents in our sample had AIDS, researchers should be cautious in applying the results of this study to other populations and other areas such as drug abuse, sexual behavior, or other important events influenced by the interaction of family and environment. Additionally, there were no HIV-negative parents and their adolescent children in this study to compare with the families living with HIV. Thus, we were not able to observe variations in perceived family conflict and its impact on adolescent adjustments for the population under study compared with a normative control group. Our findings have implications for family relations in the context of chronic disease, however, whether it be HIV/AIDS or more manageable illnesses.

Given these limitations, this study not only illustrates the match or mismatch of parent and adolescent perception of family conflict, but also explores the trend over time, as adolescents develop from early adolescence to adulthood. The peak discrepancy point was found at age 12, and then remained stable after age 14. This is consistent with the previous finding that parent-child conflict peaks at the transition to adolescence (Allison & Schultz, 2004). Research has shown that small decreases at each age period collectively resulted in a moderate decline in conflict from early adolescence to late adolescence (Laursen, Coy, & Collins, 1998). Our study illustrates that parental perceived family conflict began at a significantly higher level than adolescents' and, as adolescents aged into their early teens, parent conflict perceptions decreased while adolescent perceptions rose.

Although current research continues to emphasize the adolescent as the source of family conflict, Coleman (1997), among others, has noted the communication process is contributed to equally by both parents and adolescents. It may be that adolescents' perceptions of their parents' behaviors, drug use, or negative coping serve as a release mechanism for youth to later engage in problem behaviors. Furthermore, the process of value transmission and adoption may be derailed as the disease takes its course. In our study, discrepancies in perceived conflict differed significantly not only by drug use and negative coping, but also by economic status and education. This may reflect challenges that low income, minority families face every day, given that the racial composition of the study population was primarily Latino (49%) and African-American (38%). Various explanations for the discrepancy between perception of family conflict are possible (e.g., evolution of developmental tasks, shifting living conditions), as adolescents are influenced

by a complex interaction of parental authority, parental involvement, and peer influence as they age (Riesch, Jackson, & Chanchong, 2003).

With a relatively large sample of parents living with HIV/AIDS and their adolescent children, we were able to address issues related to families coping with a chronic disease while examining parent-adolescent perceived family conflict. Parenting while ill is often challenging; this may result in children being anxious and having more behavior problems (Rotheram-Borus et al., 1998; Siegel et al., 1992). This study provides further evidence that parent negative coping is significantly related to the discrepancy of perceived family conflict, and the difference in perception has an impact on adolescent psychological status and problem behaviors. The results were consistent with our hypothesis that, in families coping with a chronic illness such as HIV/AIDS, psychological burden and health issues may further skew perceptions of family conflict.

Further research needs to advance our understanding of the context of family conflict, methods for effective conflict resolution, and its impact on various developmental stages of adolescence. Interventions for HIV-affected individuals have produced significant reductions in parent and adolescent emotional distress and problem behaviors over the course of six years (Rotheram-Borus, Lee, Gwadz, & Draimin, 2001; Rotheram-Borus et al., 2003, 2004), but family conflict cannot be fully understood without taking into account other dimensions of family functioning. Future interventions need to address the interaction between amount, intensity, and mode of dealing with family conflict while addressing the effects of parental negative coping and poverty, which compound the risk for children of families affected by HIV.

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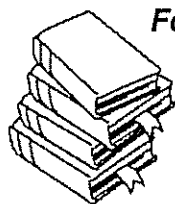
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