Kids Connection: Optimism and Perception Of Interpersonal Relationships Among Adolescents From A Community Organization

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Pacific University

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Kids Connection: Optimism and Perception Of Interpersonal Relationships
Among Adolescents From A Community Organization

Abstract
There is an increasing need to understand the effects of living with HIV or AIDS among adolescent youth as the virus impacts individuals of all ages as well as families. In particular, HIV/AIDS still carries such a stigma in the US that many families may choose not to tell their children and adolescents about the parent's illness until the illness becomes more severe. Furthermore, family members may be prohibited from speaking with others outside of the immediate family due to the potential for stigma. The purpose of the present study was to determine whether or not a relationship exists between the amount of parental disclosure both within and outside of the home and education about HIV/AIDS on adolescents' optimism and reported quality of relationships. Participants included six youth age 11 to 18 recruited from a local agency dedicated to serving families affected by HIV/AIDS. Results indicated that parental disclosure to their teens about HIV/AIDS at time 3 were significantly and negatively correlated with adolescent pessimism. This finding indicates that more disclosure or discussion about HIV/AIDS is associated with less adolescent pessimism. Additionally, there was a positive relationship between disclosure scores at time 1 and relationship to female peers that approached significance, indicating that as parental disclosure increases, the perceived quality of relationships to female peers also increases. Implications for intervention and future research are discussed.

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KIDS CONNECTION: OPTIMISM AND PERCEPTION OF INTERPERSONAL RELATIONSHIPS AMONG ADOLESCENTS FROM A COMMUNITY ORGANIZATION

A THESIS
SUBMITTED TO THE FACULTY
OF
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BY
EMILY KAY CRAWFORD

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF SCIENCE IN CLINICAL PSYCHOLOGY

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ABSTRACT

There is an increasing need to understand the effects of living with HIV or AIDS among adolescent youth as the virus impacts individuals of all ages as well as families. In particular, HIV/AIDS still carries such a stigma in the US that many families may choose not to tell their children and adolescents about the parent’s illness until the illness becomes more severe. Furthermore, family members may be prohibited from speaking with others outside of the immediate family due to the potential for stigma. The purpose of the present study was to determine whether or not a relationship exists between the amount of parental disclosure both within and outside of the home and education about HIV/AIDS on adolescents’ optimism and reported quality of relationships. Participants included six youth age 11 to 18 recruited from a local agency dedicated to serving families affected by HIV/AIDS. Results indicated that parental disclosure to their teens about HIV/AIDS at time 3 were significantly and negatively correlated with adolescent pessimism. This finding indicates that more disclosure or discussion about HIV/AIDS is associated with less adolescent pessimism. Additionally, there was a positive relationship between disclosure scores at time 1 and relationship to female peers that approached significance, indicating that as parental disclosure increases, the perceived quality of relationships to female peers also increases. Implications for intervention and future research are discussed.
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Introduction

Through 2004, up to 944,305 people in the U.S. were estimated to be living with HIV or AIDS, with up to 27% being unaware of their infection and undiagnosed (Center for Disease Control and Prevention [CDC], 2007). Although in the U.S. HIV and AIDS primarily affected adult homosexual men for some time, the demographics of the current population infected with HIV/AIDS has changed dramatically (CDC). Heterosexual women, minorities, and children are more often presenting with this deadly virus, thereby creating an increased need to understand how to best provide services to those infected with HIV and AIDS (CDC). At least 1,000 new cases of adolescents with HIV or AIDS are estimated to be diagnosed yearly, and thousands more per year will be affected by the diagnosis of HIV or AIDS in one or more parents. In addition, families living with HIV and AIDS continue to struggle to find healthy and productive ways to discuss their illness with one another, to facilitate healthy relationships between children, parents, peers, and other prominent figures like teachers, and to promote protective factors for dealing with their illness (especially for children and adolescents).

Adolescent development

Normal adolescent development consists of a number of challenges that every individual must navigate with the tools available to them. Additionally, this period is characterized by significant developmental changes, such as striving for autonomy, increased importance of peer relationships, an emphasis on both feelings of uniqueness and belonging, sexual and romantic experimentation, and rebellious acts of varying types and degrees (Santrock, 2003). Family systems theory (Bowen, 1978) may be a useful theoretical basis from which to conceptualize the difficulties faced by adolescents coping with parental
illness. If the condition of one family member is compromised, so are the conditions of other family members. Members operate as independent units that continuously and dynamically interact with one another, influencing levels of functioning and balancing constancy as well as responsiveness. In addition, subsystems (like the parent-child relationship) may interact and influence, thereby creating a systemic interaction that can determine the well-being of each independent family member. The illness of a parent may especially disrupt systemic functioning overall, as well as the normal development of the adolescent, involving individual physical, hormonal, and cognitive changes (Worsham & Crawford, 2005).

Many children and adolescents affected by parental illness become young caregivers of their ill parents, providing emotional support, maintaining household chores, and taking responsibility for others in the home and the community at large (Davey & Davey, 2005; Keigher, Zaber, Robinson, Fernandez, & Stevens, 2005). The result of such care giving may lead to feelings of stigma and isolation, constant worry about their parent's health, subsequently feeling compelled to be home at all times, and a conflicting desire to be free of responsibilities (Faulkner & Davey, 2002). The developmental consequences of early care giving may also be quite influential regarding the quality of adolescent relationships as well as individual strengths or abilities (e.g., optimism).

Other terminal parental illnesses

Typical adolescents usually encounter difficult tasks such as hormonal changes, body development, and social pressures. However, adolescents living with parental illness face a much greater obstacle to reaching adulthood than that of navigating normal developmental challenges. For example, adolescents coping with parental cancer often reported abnormally low self-esteem, abnormally high behavioral problems, abnormally low scores on quality of
parent-child relationships, and abnormally low scores on quality of peer relationships (Lewis, 1996). Other researchers reported that if the quality of the parent-adolescent relationship was poor, adolescents reported significantly lower self-esteem and significantly higher anxiety (Lewis & Darby, 2003). Similarly, other researchers discovered that children of parents with Multiple Sclerosis (MS) had greater difficulty relating to others, dealing with distress, and managing their lives (DeJudicibus & McCabe, 2006). A history of chronic illness in a parent has also been found to predict adolescent panic attacks (Hayward, Wilson, Lagle, Killen, & Taylor, 2004). Finally, adolescent girls seem to be the most adversely affected by parental illness, especially if the ill parent is the mother (Compas, et al., 1994).

**HIV/AIDS as a unique illness**

Though other diseases, such as cancer, may cause similar difficulties, HIV/AIDS carries with it a stigma unattached to other terminal illnesses due to the stereotypical contraction of HIV/AIDS: unprotected sex or injection drug use. In fact, many parents decide not to disclose their own HIV status to their children, two of the reasons being fear of the child’s inability to understand and fear of other’s reactions to them and to their children. Unfortunately, HIV/AIDS is affecting children and adolescents in ever increasing numbers; a review of which will be undertaken next.

**Adolescents affected by AIDS**

Adolescents affected by HIV/AIDS often includes both those whose parents have HIV/AIDS and those infected by HIV/AIDS and some consistent themes have emerged among those researchers’ results who have studied this population. For example, some researchers reported a lack of adequate services and needs assessment globally, severe changes in financial situation for the worse in some countries (thereby making children more
vulnerable), the necessity for children and adolescents to care for ill parents, lack of adequate HIV education in schools for those living with HIV/AIDS, and lack of adequate resources to deal with stigma associated with HIV/AIDS (Cree, Kay, Tisdall, & Wallace, 2006; Tisdall, Kay, Cree, & Wallace, 2004; Woodring, Cancelli, Ponterotto, & Merle, 2004). For individual youth and adolescents affected by HIV/AIDS, some researchers also reported negative coping strategies (Okuno, Rotheram-Borus, McCutchan, Newell, & Stein, 2006; Woodring, et al.), more depression, less warm and supportive mother-child relationships (Forehand, et al., 2002), more problems of social adjustment and attention, more externalizing behaviors, and poorer free verbal recall skills than unaffected youth (Esposito, et al., 1999). Others reported that somatic symptoms among adolescents affected by parental HIV/AIDS persisted for one year and these symptoms could be predicted by parents experienced as highly rejecting by the adolescent (Lester, Stein, & Bursch, 2003). Similarly, Rotheram-Borus and Stein (1999) reported that parental HIV/AIDS status was significantly related to their adolescents’ internalizing and somatizing symptoms, with adolescents reporting more somatic complaints related to more symptomatic parents. Therefore, parent-adolescent relationships may influence adolescents’ adjustment to parental HIV/AIDS.

In contrast to the above findings, Lewis, Mellins, and Brackis-Cott (2006) discovered no relationship between maternal HIV/AIDS status and youth engagement in sexual activities or engagement in sexual possibility situations (in which sexual activities are likely to occur). Additionally, other researchers found no relationship between parental injection drug user HIV/AIDS status and childrens’ externalizing or internalizing behaviors (Pilowsky, Zybort, Hsieh, Vlahov, & Susser, 2003). Disclosure was not assessed in the first
study, therefore it is not known whether or not the adolescents’ awareness of maternal HIV/AIDS would have changed these findings. However, Pilowsky and colleagues assessed for parental disclosure and this variable was not associated with children’s outcomes.

Although research on the effects of HIV/AIDS on adolescents is slowly growing, there is still a great deal to be explored and understood. A number of researchers have explored the relationship between certain variables, such as parental injection drug use, parental HIV status and disclosure to children, perceived social support, and youth’s adjustment and functioning. However, knowledge of factors that protect adolescents against the negative effects of living with HIV and AIDS continues to comprise a meagerly researched topic. Resiliency factors such as optimism, discussion of HIV/AIDS in and outside of the home, and perceived social support are three that may prove important for the healthy adjustment of adolescents who live with HIV/AIDS.

Additionally, HIV/AIDS affected populations tend to include a greater number of individuals from minority communities or diverse racial and ethnic backgrounds. Therefore, most research to date has explored African-American, Hispanic or Latino/a, and other non-Caucasian populations living with HIV/AIDS. There is further need, therefore, to understand how Caucasian youth are affected by HIV/AIDS.

Disclosure

When one considers the numerous potential consequences of disclosing HIV/AIDS, it is not surprising that so few parents disclose their HIV status to their children. Many researchers reported a low level of parental HIV/AIDS disclosure to children, in many different countries, from as low as 10% to as high as 60% disclosure rate (Armistead, Tannenbaum, Forehand, Morse, & Morse, 2001; Bettoli-Vaughan, Brown, Brown, &
Baldwin, 1998; Murphy, Steers, & Stritto, 2001; Nostlinger, et al., 2004). In one study, disclosure was related to country of origin, with parents from developing countries disclosing less often than those of European descent (Nostlinger et al.). Armistead and colleagues reported that parents who made less money and who reported more problematic symptoms disclosed more often.

*Reasons for disclosing.* Some researchers explored reasons parents choose to disclose include not wanting their child to learn of the parent's diagnosis from another source, believing that the child has a right to know or the parent wants the child to know, wanting to educate the child about HIV, and preparing the child for what will happen (Andrews, Williams, & Neil, 1993; Ostram, Serovich, Lim, & Mason, 2006; Schrimshaw & Siegel, 2002).

*Reasons for not disclosing.* Many parents reported believing that disclosure would be too emotionally disturbing to the child or adolescent, that the child was too young to understand, that the child or adolescent may experience negative consequences due to associated stigma, that there was no benefit to the child or adolescent from disclosing, that they lacked enough professional support to help the child or adolescent adjust, wanting the child to recover from previous losses, and to protect the child from inappropriate guilt or worry (Andrews, et al., 1993; Murphy, Roberts, & Hoffman, 2006; Nostlinger et al., 2004; Ostram et al., 2006; Schrimshaw & Siegel, 2002; Woodring, et al., 2004). Unfortunately, some research supports many of these fears for not disclosing whereas other research seems to support the potential benefits of disclosing parental HIV/AIDS.

*Positive effects.* Some researchers reported that maternal disclosure of HIV to older children and adolescents may have resulted in both the mothers and the children feeling
closer in their relationships with one another (Shcrimshaw & Siegel; Vallerand, Hough, Pittiglio, & Marvicsin, 2005). Murphy and colleagues (2001) discovered that children who had been disclosed to by their HIV positive mothers had lower levels of aggression and higher self-esteem than those who had not been disclosed to. Murphy, Marelich, and Hoffman (2002), in contrast, discovered that children whose mothers disclosed HIV reported lower self-esteem than children whose mothers had not disclosed HIV, although for both groups of children reported levels of depression decreased over time. Similarly, other researchers found negative emotional responses in children that dissipated shortly after having been disclosed to (Schrimshaw & Siegel, 2002). And finally, some researchers have found no relationship between parental disclosure of HIV status to a child and the child's functioning or adjustment (Armistead et al., 2001; Bettoli-Vaughan, et al., 1998; Yellen, 2004).

**Negative effects.** Researchers have reported that after a parent discloses HIV status, children's psychosocial and psychological adjustment decreases for approximately three years, nearly half of them developing psychological disorders (Asarnow, Joycox, & Anderson, 2002; Lee & Rotheram-Borus, 2002). Several researchers reported that some children developed negative behaviors (e.g., acting out, fighting) or emotional distress associated with maternal disclosure of HIV (Lee & Rotheram-Borus, 2002; Lee, Lester, & Rotheram-Borus, 2002; Vallerand, et al., 2005). One of the primary child or adolescent responses to parental disclosure of HIV/AIDS is self-reported anxiety, although anxiety seems to decrease over time for most (Murphy, Roberts, & Hoffman, 2006). In fact, not disclosing may be better for adolescents' functioning according to some studies. For example, Yellen (2004) conducted a study including disclosure at three levels: low (parents
either did not disclose or only said they were ill), moderate (parents disclosed HIV/AIDS), and high (parents disclosed HIV/AIDS and that they may die from the illness). Adolescents (age 11 to 19) whose parents disclosed the least had significantly better mental health than those whose parent disclosed in the moderate range. No difference was found between teens in the high disclosure group and the other two groups.

Information regarding the effects of the quality or quantity of parental disclosure is also unclear (Brackis-Cott, Mellins, & Block, 2003). O’Sullivan, Dolezal, Brackis-Cott, Traeger, and Mellins (2005) discovered that young adolescents whose mothers had HIV discussed HIV more often and were more comfortable discussing sex and drug-related topics compared to those whose mothers did not have HIV. Therefore, disclosure of a parent’s illness is not necessarily enough to facilitate healthy functioning in adolescents affected by HIV/AIDS. Some researchers have suggested discussing only what is developmentally appropriate (Fair, Spencer, Wiener, & Riekert, 1995; McCue & Bonn, 1994), which, as discussed above, many parents are naturally tend to do. However, the quality of parent-adolescent discussion and the amount of information discussed regarding HIV/AIDS may also be an important factor. Harris and Zakowski (2002) reported that expressiveness within the family mediated the relationship between family cohesion and adolescent anxiety, meaning that adolescents who live in a cohesive family experience less anxiety partly because they are allowed to express their emotions in the family context. The ability to discuss difficult information may have significant effects for adolescents’ optimism and their relationships with parents, peers, and teachers.

Adolescent relationships
Researchers have discovered that families living with HIV/AIDS often report lower levels of social support than families unaffected by HIV/AIDS (Klein, et al., 2000). Therefore, building relationships and social support may be especially important for adolescents infected with or affected by HIV/AIDS. Additionally, HIV/AIDS may cause relationship imbalances in families living with HIV/AIDS (Miller & Murray, 1999). Further attention to the ways in which relationships are impacted or impact adolescents infected with or affected by HIV/AIDS would likely be of value.

*Parent relationships.* Though adolescents begin to increase their reliance on peers and decrease their reliance on parents, parent-adolescent relationships remain influential and even protective during adolescent development (Lewis et al., 2000; Santrock, 2003). From a systems theory perspective, adolescents living in the home will inevitably be influenced by the functioning of other independent units within the family (Bowen, 1978). For example, some mothers were able to actively and effectively reduce their adolescent daughters’ amount of sexual activity (Dancy, Crittenden, & Talashek, 2006). For adolescents dealing with parental HIV/AIDS, that relationship can be altered dramatically, especially directly following parental HIV/AIDS disclosure. For example, some researchers found that children and adolescents who perceived their HIV/AIDS infected parents to be high in caring or who had good, positive parent-child relationships reported lower emotional distress, fewer conduct problems, higher self-esteem, better psychological functioning, fewer adjustment difficulties, and more positive future expectations (Bauman, Camacho, & Silver, 2002; Forchand et al., 2002; Lee, et al., 2002; Rotheram-Borus, Stein, & Lester, 2006). Other researchers discovered that young adolescents reported greater disturbance in the parent-child relationship (characterized by perceived maternal indifference and hostility) as well as
less perceived social support from parents, teachers, and friends (Dane, 1994; Klein, et al., 2000; Kotchick, Summers, Forehand, & Steele, 1997; Reyland, Mahon, Higgins-Delessandro, & Luthar, 2002).

In contrast, some researchers have found no significant relationships between maternal HIV status and mother-infant interaction (Johnson & Lobo, 2001). Comparatively, although no relationship was found between the quality of the parent-child relationship and general psychological functioning in another study, family functioning seemed to moderate the relationship between disclosure type and adolescent mental health (Yellen, 2004). Higher levels of disclosure type were associated with a more positive relationship between family functioning and mental health. Koizumi (1995), however, discovered no relationship between Japanese students' (grade five through nine) optimism scores and reported relations with parents.

Peer relationships. Interestingly, relationships with parents may have a significant impact on peer selection and the influence of peer groups for adolescents. Some researchers discovered that HIV infected fathers' parenting practices significantly mediated the relationship between paternal attributes/environmental factors and the adolescents' vulnerability to engage in risky behaviors (e.g., drug use, gang membership) and peer influences (Brook, Brook, Rubenstone, & Zhang, 2006). Additionally, peer influences were directly related to adolescents' vulnerability, which in turn had a direct relationship with adolescent aggressive behaviors. Relationships with peers may be important because they have the potential to serve very positive, as well as negative, functions for adolescents infected or affected by HIV/AIDS.
Relationships with peers, as discussed above, are extremely important for normal adolescent development. The ability to rely on and converse with peers may be a beneficial outlet and resource for those infected or affected by HIV/AIDS. For children infected by HIV, disclosing their own HIV diagnosis to a peer was associated with a significantly larger CD4 count, indicating a change in health for the better (Sherman, Bonanno, Wiener, & Battles, 2000). Similarly, Woodring and colleagues (2004) reported that adolescents affected by parental HIV/AIDS wanted to disclose their struggle with their parent's illness as a means of purging and a desire to be understood and to feel normal. Perhaps the ability to share information about HIV (either their own diagnosis or potentially their parent’s) with same-age peers allows children to feel less obliged to keep a secret, thereby decreasing their anxiety and positively affecting their immune systems. Being able to share information about living with HIV may have other benefits as well. Dane (1994) suggested that keeping HIV/AIDS a secret may produce anxiety over the fear of discovery and guilt over the cover-up. Not being required to keep such secrets may reduce the amount of anxiety encountered by adolescents affected by or infected with HIV/AIDS.

Additionally, some researchers discovered that among children between third and sixth grade, girls’ peer optimism, meaning positive expectations about making and keeping friends, was significantly negatively associated with feelings of loneliness (Deptula, Cohen, Phillipsen, & Ey, 2006). In contrast, boys’ peer optimism was significantly positively associated with number of friendships and significantly negatively associated with feelings of loneliness, rejection, and victimization. Other research demonstrated that for sixth and seventh grade girls and boys, optimism was significantly positively associated with peer relationships (Koizumi, 1995).
Teacher relationships. For adolescents, teachers may be considered role models and an additional source of support (Santrock, 2003). For example, for many adolescents, learning of their own or a parent’s HIV/AIDS diagnosis may result in subtle or drastic changes in attitude, behavior, and/or grades (Bigger, et al., 2000; Woodring, et al., 2004), making teachers primary candidates for initial referrals to support services. Koizumi (1995) discovered that, during fifth grade, the positive correlation between optimism and relations with teachers approached significance. However, as students progressed to junior high school, this relationship virtually disappeared. Although the previous study indicates that teachers may not in fact be very influential for adolescents, further research is warranted, especially with regard to parental disclosure of HIV/AIDS.

Optimism

Optimism has many definitions but is most frequently described as a positive outcome expectancy or having a belief that future outcomes will be good (Ben-Zur, 2003; Chang & Sanna, 2003; Puskar, Sereika, Lamb, Tusaie-Mumford, & McGuinness, 1999). Although the research on adult optimism has become quite extensive, information regarding children’s and adolescents’ optimism is less ample. However, several researchers have found correlations between optimism and a number of variables to date, specifically among older children and adolescents. For example, Dewberry and Richardson (1990) discovered that anxiety reduced optimism in a sample of British students who had yet to take examinations compared to students who were finished with examinations. Hoekman, McCormick, and Barnett (2005), reported that optimism played a significant role in gifted adolescents’ motivation and success in school. Scheier, Carver, and Bridges (1994) and Scheier and Carver (1985) discovered that optimism was significantly positively correlated
with active coping strategies, planning, and positive reinterpretation whereas Puskar and colleagues (1999) found little to no relationship between optimism and active or avoidance coping strategies among rural adolescents (although the avoidant coping strategies tended toward a negative relationship with optimism). Some researchers have found a negative relationship between optimism and depression, the experience and expression of anger, negative affect, and hopelessness (Ben-Zur; Chang & Sanna; Puskar et al.). Other researchers yielded positive correlations between optimism and positive affect, life satisfaction, positive parent-child interactions as rated by the adolescent, general interest in school, quality of peer relationships, and academic studies (Ben-Zur, Koizumi, 1995). Several research groups demonstrated that optimism was significantly positively correlated to positive health practices (Carvajal, Garner, & Evans, 1998; Yarcheski, Mahon, & Yarcheski, 2004). Specifically, among a sample of primarily African-American high school students, Carvajal and colleagues discovered that optimism was significantly positively correlated with delayed onset of sexual intercourse, fewer sexual partners, perceived condom use self-efficacy (i.e., one’s confidence that he or she will use a condom correctly, when drinking, every time he or she has sex, and insisting on condom use if his or her partner resists), and negative expectancies regarding unsafe sex. Adolescents higher in optimism, self-efficacy, and negative expectancies also had fewer sexual partners, reported using a condom during last intercourse more often, and were more likely to endorse intentions of avoiding unsafe sex in the future. Similarly, Yarcheski and colleagues found a positive correlation between optimism and positive health practices. However, Yarcheski and colleagues did not define the specific health behaviors measure. For children of HIV-infected parents, one group of researchers discovered that ambiguous stories elicited
significantly more negative affect compared to children of uninfected parents (Esposito, et al., 1999), indicating that children of HIV-infected parents may be more pessimistic about ambiguous situations. Additionally, substance abuse has been found to predict lowered future expectations among adolescents affected by parental HIV (Rotheram-Borus, et al., 2006).

In contrast to findings discussed above, Goodman, Chesney, & Tipton (1995) discovered that optimism was not correlated to knowledge about HIV, risk perceptions, self-efficacy, or better condom use expectations. These authors suggested that optimism may have prevented adolescents from objectively perceiving risk, and hence, from adopting positive health behaviors. Similarly, Taylor et al. (2005) reported inconsistent findings in a study of optimism among African-American girls involved in two different sites of the same obesity prevention program. Girls with higher total optimism scores also reported higher quality self-concept with regard to physical activity. However, the pessimism and optimism scores embedded within the total optimism scores were inversely related to reported quality of self-concept regarding physical activity. Individually, therefore, as scores increased on the pessimism and optimism subscales, scores of quality of self-concept regarding physical activity decreased. This unusual and conflicting relationship indicates that further research is necessary.

Age may influence optimism scores as well. In a study of Japanese students, following a transition into middle school, younger adolescents (10 to 15 years old) reported higher optimism scores than older adolescents (Koizumi, 1995). Other researchers also reported that younger adolescents (10 to 13 years old) in the U.S. had higher optimism scores regarding perceived risk to health, lifestyle, and environmental problems for the self
compared to the same perceived risk for other children their age (Whalen, et al., 1994). Life events and experience, therefore, may also impact younger adolescents' optimism.

**Summary of literature review**

Overall, adolescence is a vulnerable time for any individual, but the risks facing most adolescent youth are compounded to a great extent when considering those youth also infected or affected by HIV/AIDS. The effects of living with HIV/AIDS are widespread on an individual, family, and community level and are, therefore, in need of research. With increased understanding of the effects of this virus, youth living with HIV/AIDS can be more efficiently and appropriately served.

Potentially influential factors for youth living with HIV/AIDS include disclosure within the family, relationships between the youth and family or community members, and temperamental optimism. Research on the benefits and risks of disclosure of HIV/AIDS to youth either living with the virus themselves or in a family affected by the virus has been inconclusive. Research seems to indicate that HIV/AIDS can negatively affect youth relationships with parents, peers, and teachers. However, relationships can also have a positive effect on a youths' ability to adjust to living with HIV/AIDS. Finally, research on optimism in relation to HIV/AIDS among infected or affected youth has also yielded inconclusive results. Additionally, research to date has not explored the role optimism plays among adolescents infected with HIV and AIDS or affected by HIV and AIDS, specifically as it relates to disclosure and parent or teacher relationships. More research is needed in order to understand what relationships exist between disclosure, relationship quality, and optimism among youth living with HIV/AIDS.

**Purpose**
The purpose of this study is to examine whether parental disclosure of HIV/AIDS, discussion of HIV/AIDS within the family, and level of impact (positive or negative) of HIV/AIDS on the adolescent are associated with adolescent’s level of optimism and their perceived social support in relationships with their parents, teachers, and same-age peers.

**Hypotheses**

1. It is hypothesized that scores on the disclosure subscale will be positively correlated with adolescent optimism scores.

2. It is hypothesized that scores on the disclosure subscale will be positively correlated with adolescent perceived relationship quality with parents, peers, and teachers.

3. It is hypothesized that scores on the disclosure subscale will be negatively correlated with adolescent pessimism scores.

**Methods**

**Participants**

Cascade AIDS Project (CAP) is an organization dedicated to serving individuals and families affected by or infected by HIV/AIDS. Kids Connection is a teen program developed by staff at CAP and consists of a yearly summer camp for kids as well as occasional teen process groups during the year provided on CAP premises. Participants included adolescents, ages 11 to 18, who were receiving or had received services from Cascade AIDS Project in the past. Participants were initially recruited through the Kids Connection program. The majority of adolescents participating in Kids Connection were aware of their parents’ HIV status. However, for confidentiality related reasons, we recruited only those teens who were aware of their own or their family member’s HIV or AIDS infection in order
to avoid accidental disclosure to youth unaware of the presence of HIV in their families. In order to accomplish this goal, a list was generated by Kids Connection staff directors that included only the names of adolescents who were aware of HIV in their family or themselves. Those who have had a caregiver die as a result of HIV or AIDS infection were also included in the study. Language fluency was determined by participants’ therapists at CAP and only those who spoke English fluently were added on to the list of individuals to recruit. Those whom the staff directors did not believe had been disclosed to or who were otherwise deemed inappropriate for participation in this study were not included on the list. Approval from the university Institutional Review Board was obtained.
Table 1

Demographics of Sample (N=6)

<table>
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</table>

Recruitment

Participants were recruited via a monthly CAP mailing. The mailing included a cover letter provided by the director of the agency introducing the study and a flyer requesting participation of eligible youth as well as indicating the dates and times they could come to
CAP for group administrations of the measures. Fliers were also posted on CAP premises with the principle investigators' contact information so that potential participants could attend a private administration as well. Fliers and parent consent forms were left with family therapists at the agency for additional recruitment and an opportunity for parents to fill out consent forms early. Monthly pizza parties were advertised on the fliers, one of which was mailed to each family on the list generated by Kids Connection and CAP staff. The principle investigators then called the caregivers from families who had been previously identified as eligible for participation. Caregivers were informed of the importance of the study, the benefits and risks of participating in the study, and were asked to sign a consent form for their youth's participation if they agreed. Consent forms were either mailed to the individual's home and returned in a self-addressed, stamped envelope, or were signed on CAP premises (see Appendix A). Consent forms filled out on the agency premises were kept in a secure file cabinet until collected by the principle investigators and securely transported to the advising faculty's office for protected storage.

Procedures

The principle investigators were present at CAP for one group data collection session, providing free pizza and soda as an incentive. Participants who presented a signed parent consent were allowed to complete all measures and their names entered into a drawing for prizes. Prizes included a $50 gift certificate to a local mall, a pair of movie tickets to Regal Cinemas, and a $10 gift certificate to a local supermarket. All participants who did not win one of the prizes were given either three adult tickets to a local children's museum or a $5 gift card to a fast food restaurant. Once parent consent forms had been collected, participants were asked to provide written assent as well. Participants were then
asked to sit by themselves in a large room in order to fill out the measures. One or both of the principle investigators were always present to answer questions, to collect completed measures, and to ensure confidentiality of answers.

Occasionally a youth could not be present at CAP in order to fill out measures. In those cases, a signed parent consent form was either collected in person or sent and returned via mail. Measures were then mailed to the adolescent’s home and were returned in a self-addressed, stamped envelope. One adolescent answered questions over the phone with one of the principal investigators filling in answers on the measures. Any information sent by mail did not include identifying information on the exterior of the envelope so as to protect client confidentiality.

Measures

Some demographic information was solicited from the parent filling out the parent consent form, including the youth’s age, sex, ethnicity, and year in school, parent age and sex, who in the family had been diagnosed with HIV/AIDS, and whether or not HIV/AIDS had been disclosed to the youth.

The Assessment of Interpersonal Relations (AIR) is a self-report measure designed to evaluate the quality of youths’ relationships with their mothers, fathers, male peers, female peers, and teachers (McCallum & Bracken, 1993). It is appropriate for use with children, grades 5-12 and 9-19 years of age. It consists of 105 questions answered on a four-point Likert type scale from strongly disagrees to strongly agree. Questions are divided equally into three subsections for parents (mother and father), peers (male and female) and teachers. The directions indicate an option to refrain from filling out information for mother or father due to 1) death, 2) separation, 3) divorce, or 4) other. Internal reliability coefficients of the
AIR subscales ranged from .93 to .96. In the present sample, Cronbach alpha scores were .73 for the relationship with mother subscale, .81 for the relationship with male peers subscale, .85 for the relationship with female peers subscale, and .91 for the relationship with teachers subscale. Only one adolescent responded to the relationship with father items, therefore Cronbach alpha scores for this subscale could not be determined. The AIR has good concurrent validity with similar measures of social support and is associated with psychological well-being and adaptive coping. Additionally, scores can be divided into categories related to the degree of relationship strength or weakness: $\geq 70 =$ Significant Relationship Strength, 60 to 69 = Mild Relationship Strength, 40 to 59 = Normal Range, 30 to 39 = Mild Relationship Weakness, $\leq 29 =$ Significant Relationship Weakness. This measure has recently been renamed to the Clinical Assessment of Interpersonal Relations (CAIR) (see Appendix B).

The Youth Life Orientation Test (YLOT) is a 19-item measure of participants' positive (optimism) and negative (pessimism) general expectancies about the future (Ey et al., 2005). The participant rates each item on whether it is: 1) true for me, 2) sort of true for me, 3) sort of not true for me, and, 4) not true for me. This measure yields three scores: an optimism score, a pessimism score, and a total optimism score (optimism + reverse scored pessimism subscales). The YLOT has an acceptable level of internal consistency, with a Cronbach’s alpha of .70 (Taylor et al., 2004) to .83 (Ey et al., 2005) for total optimism, and a seven month test-retest reliability correlation of $r = .50$ (Ey et al.; Taylor et al.). In the present study, Cronbach alpha scores were .69 for the total optimism scale, .68 for the pessimism subscale, and .53 for the optimism subscale. The YLOT also has concurrent
validity with similar measures of hope, attributions about the future and is predictive of 
parent and child ratings of psychological adjustment (see Appendix C).

The Children's Need and Resource Scale, Disclosure subscale is one of five 
subscales on the Children's Need and Resource Scale, comprised of four items rated by the 
family's Kids Connection case manager on a continuum of need for case management: (0) = 
Severe negative impact, (1) = Moderate negative impact, (2) = Minimal negative impact, (3) 
= On-going external support required, and (4) = Independent management. The Kids 
Connection case manager rates the family on whether or not the youth have been disclosed 
to, how well the family discusses and engages in education or conversation on HIV/AIDS 
related topics, and how much HIV/AIDS related stress youth are being impacted by in a 
number of areas. For a full description of the items and scoring, please see appendix C. 
Scores of 3-4 points indicate that the child is no longer negatively impacted and 
differentiates the extent to which external support is still required. The CRNS is 
administered once upon beginning to receive services from CAP and subsequently every six 
months. A total of two to three administrations of the disclosure subscale were collected for 
use in this study. This scale was developed specifically for use with CAP clients and have 
not been standardized, therefore reliability and validity coefficients are unknown. In the 
present study, Chronbach's alpha scores were .917 for the disclosure subscale (see Appendix 
D).

Statistical Analyses

Data analysis occurred at the Psychological Service Center (PSC). All data was kept 
in a locked file cabinet to be moved from CAP to the PSC in order to be analyzed and then 
back to CAP to be stored. CAP stored raw data in a locked file cabinet behind a locked door.
The Spearman's rank correlation coefficient is a non-parametric measure of correlation that assesses how well an arbitrary monotonic function could describe the relationship between two variables without making any assumptions about the frequency distribution of the variables (Howell, 2007). Because the current sample was so small, it was deemed appropriate to use a statistical analysis that does not require a normal distribution or a linear relationship between variables. The Kendall's tau rank correlation coefficient is a measure of the degree of correspondence between two rankings and assesses the significance of this correspondence between cross tabulations (Howell). This analysis was used to determine the significance of relationships between variables from a sample of frequency distributions randomly selected by a computer. Kendall's tau analyses were also used as a more stringent measure of relationship significance considering the very small sample used.

Results

Descriptive analyses

Descriptive statistics for the study variables are reported in Table 2. Using single-sample t-tests, the total sample means were compared to the norm means for the variables used. Norm means are reported in Table 3. Scores on the AIR were largely inconsistent with the norms established by Bracken and Newman (1994) for a non-clinical sample for relationship with mother scores \(t(5) = 28.44, p < .001\), relationship with male peers scores \(t(5) = 9.29, p < .001\), and relationship with female peers scores \(t(4) = 8.90, p < .001\). However, relationship with teacher scores appeared to be consistent with previously established norms \(t(4) = 12.40, p < .001\). The number of responses for relationship with father items were insufficient to accurately compare means between this sample and normed scores, but it appears that the one respondent for relationship with father scores was also
inconsistent with the norms reported in table 3. Scores on the YLOT were consistent with norms established by Ey et al., (2005) for a non-clinical sample of 3rd-6th grade children for total optimism \[ t(5) = 13.56, p < .001 \]. Scores were also consistent with those obtained from a sample of 9th and 10th graders from a local private high school for the optimism subscale \[ t(5) = 13.46, p < .001 \]. However, scores on the YLOT among participants from this sample appeared to be inconsistent with those obtained from the sample of 9th and 10th graders for the pessimism subscale \[ t(5) = 9.29, p < .001 \].

Table 2

<table>
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<th>Variable</th>
<th>M</th>
<th>SD</th>
<th>Minimum</th>
<th>Maximum</th>
<th>% Clinical Range</th>
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Table 3

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Correlational analyses

Spearman’s correlational analyses and Kendall’s Tau analyses were conducted in order to determine the relationship between disclosure and optimism and relationship quality. These analyses were used to test the hypothesis that scores on the disclosure subscale were positively correlated with adolescent optimism scores and adolescent perceived relationship quality with parents, peers, and teachers. Assumptions of level of measurement, interdependence of observations, linearity, normality, and homoscedasticity were not met, most likely due to the small number of participants. Therefore, the following results should be interpreted with caution. Results indicated a negative correlation between disclosure scores at time 3 and pessimism, indicating that as the disclosure scores (including disclosure of HIV status to the adolescent, quality of discussion and education regarding HIV/AIDS, and lack of negative impact on the adolescent’s functioning) increase, the level of adolescent pessimism significantly decrease. This finding was only true after the adolescent and family had been receiving education about HIV/AIDS and facilitated family discussion by the agency for at least a year and a half. Additionally, there was a positive relationship between disclosure scores at time 1 and relationship to female peers that approached significance, indicating that as disclosure scores increase, the perceived quality of relationship to female peers also increases. However, this finding was only true for the first administration of the CRNS upon the adolescent’s entrance into the agency program and only approached significance for Spearman’s correlational analyses and not Kendall’s Tau analyses. Spearman’s correlations and Kendall’s Tau probability correlations among the study measures are presented in Table 3 and Table 4, respectively.
Table 4

Spearman's Correlations Among Study Variables (N=6)

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<tr>
<td>Pessimism Subscale</td>
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<td>-0.18</td>
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<td>Disclosure Time 1</td>
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<td>0.87**</td>
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<td>-0.39</td>
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<td>-0.86*</td>
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Table 5
Kendall's Tau Probability Correlations Among Study Variables (N=6)

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<td>-.09</td>
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<td>-.86</td>
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<td>Disclosure Time 3</td>
<td>.00</td>
<td>-</td>
<td>.09</td>
<td>.32</td>
<td>.00</td>
<td>-.60</td>
<td>-.17</td>
<td>-.80*</td>
<td>.40</td>
<td>.44</td>
<td></td>
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**p<.10, Correlation is approaching significance at the 0.10 level, (2-tailed)**

*p<.05, Correlation is significant at the .05 level, (2-tailed)**
Discussion

Description of results

The aim of this study was to determine whether or not a relationship exists between parental disclosure and discussion of HIV/AIDS to youth within and outside of the family and adolescents’ levels of optimism and their perceived social support in relationships with their parents, teachers, and same-age peers. A growing body of literature exists indicating that it is still unclear whether or not disclosure of parental HIV/AIDS to children and adolescents has a positive or negative impact on youth. Additionally, an examination of the association between parental disclosure of HIV/AIDS and youths’ relationships and positive characteristics such as optimism had not yet been undertaken. It was hypothesized that disclosure and discussion of HIV/AIDS would be positively correlated with adolescent optimism scores, that disclosure and discussion of HIV/AIDS would be positively correlated with adolescent perceived relationship quality with parents, peers, and teachers, and that disclosure and discussion of HIV/AIDS would be negatively correlated with adolescent pessimism scores.

Consistent with the third hypothesis, results indicated a negative relationship between disclosure scores at time 3 and adolescent pessimism. Therefore, increased scores on the disclosure subscale (indicating increased communication within and outside the family of HIV/AIDS, lower HIV related concerns for adolescents, and less negative impact of HIV status on the adolescent) was associated with decreased pessimism scores. However, it should be noted again that the adolescents themselves did not fill out the disclosure subscale; rather, CAP clinicians reported on the subscale for the adolescent and family. Therefore, scores may have been different if the adolescents themselves had
reported on their family's functioning regarding HIV/AIDS disclosure, discussion, education, prevention, and use of outside resources. Due to the limited sample size in this study, conclusions must be drawn with caution. However, it seems plausible that the more families communicate about HIV/AIDS and the less severe negative impact HIV/AIDS has on the adolescent the less likely the adolescent would be to think in pessimistic ways. The actual disclosure of HIV/AIDS may be a sign of overall good communication within a family system. Additionally, more information about how to prevent contraction of HIV/AIDS and improving treatments for current patients with HIV/AIDS (via discussion and education within the family and from outside sources) may help adolescents to be less pessimistic about their own probability of being infected with the virus. Perhaps increased communication within the family and with outside agencies teaches youth about available resources or provides practice with more active coping strategies, planning, and positive reinterpretation (Scheier, et al., 1994; Scheier & Carver, 1985) for dealing with anxiety related to familial stressors. However, a lack of pessimism does not necessarily indicate the presence of optimism. Similarly, perhaps increased communication and education renders parental HIV/AIDS infection less of an ambiguous situation, which may decrease adolescents’ levels of pessimism (Esposito et al., 1999).

It must not be overlooked that this sample scored higher on pessimism items than other child and adolescent populations have. It is possible that facing the reality of a terminal illness such as HIV/AIDS might have resulted in more endorsement of pessimistic items. Scheier and Carver (1992) reported that when problem-focused coping can be used, optimism is beneficial and effective. However, when a situation is not
alterable, problem-focused coping may be less adaptive, thereby leaving optimists at a disadvantage. In the case of this study, therefore, it may in fact be more adaptive for adolescents to endorse more pessimistic thinking in order to cope with the true possibility that they or a family member will die as a result of their illness. It should also be noted, however, that mean scores among this sample did not differ a great deal from the established norms for optimism and total optimism scores. Perhaps participants in this sample have discovered a balance between remaining optimistic and remaining realistic about living with HIV/AIDS.

Contrary to the first and second hypotheses (that scores on the disclosure subscale would be positively correlated with adolescent optimism scores and that scores on the disclosure subscale will be positively correlated with adolescent perceived relationship quality with parents, peers, and teachers), no significant relationships were found between scores on the disclosure subscale and adolescent optimism scores or between scores on the disclosure subscale and adolescent perceived relationship quality with parents, peers, or teachers. The lack of findings between disclosure scores and optimism actually appears to be consistent with the contradictory results in the literature reviewed on optimism in the introduction of this paper. It seems that either there is no relationship between parental disclosure of HIV/AIDS and adolescent optimism or there is some variable or relationship between variables that has not yet been elucidated to fully reveal the impact of parental disclosure of HIV/AIDS on adolescents on adolescent optimism. In contrast, it is surprising that no significant relationship was discovered between disclosure scores and relationship quality. Importantly, however, it should be noted that the sample means for relationship with mother scores were in the mild relationship
weakness range. This seems to be consistent with other researchers' findings that adolescents affected by HIV/AIDS often report less warm and supportive mother-child relationships (Forehand, et al., 2002). However, three of the participants' mothers were infected with HIV/AIDS, which may have significantly altered or impacted the mother-adolescent relationship for those teens. Youth whose mothers were infected (rather than fathers or other relatives) may have been exposed to doing more chores around the house, looking after younger siblings, more difficulty getting to and from events and activities, and increased fear of parental death. Perhaps adolescents in this sample are experiencing some of the conflicted feelings that many adolescent caregivers of terminally ill parents feel (Faulkner & Davey, 2002). Additionally, it is possible that adolescent optimism and perceived quality of relationships are hardy and are therefore not as susceptible to being impacted by parental disclosure of HIV/AIDS.

The finding of a positive relationship between disclosure scores and quality of relationship to female peers approached significance at the $p < .10$ level, although it only remained true for disclosure scores at time 1. This finding is consistent with some of the literature regarding adolescent relationships with peers and their desire to share their struggle with HIV/AIDS in the family. However, it is interesting that spending more time involved in an agency dedicated to education and prevention of HIV/AIDS may be linked to a lack of relationship between disclosure scores and quality of relationship to female peers at subsequent administrations of the CRNS. Perhaps with increased knowledge of and ability to discuss HIV/AIDS within the family as well as less negative HIV/AIDS related impact on the adolescent leads to less reliance upon female peer relationships for support. Similarly, this sample of adolescents may be receiving enough support from
CAP staff members to cope with HIV/AIDS in their families so that they do not rely as much on female peer relationships. In contrast, as adolescents learn more about HIV/AIDS, perhaps they feel less inclined to share information regarding their experiences with female peers.

**Strengths**

The present study may be most beneficial to researchers, clinicians, and agency staff if it is viewed as an exploratory experiment. Viewing our results from this perspective, it is encouraging to know that the population targeted for this project can be studied. Participants were able to fill out the measures without much difficulty or need for clarification. Additionally, results of this study may indicate that optimism and relationship quality are not strongly affected by disclosure or discussion of HIV/AIDS within and outside of the home or lack thereof.

**Limitations**

The most important limitation of this study is likely the extremely small sample size procured for data analysis, a fact that may have a number of explanations. Adolescents affected by HIV/AIDS are not often independently mobile, often do not attend school in order to care for sick parents or siblings (Davey & Davey, 2005; Keigher, et al., 2005), and most likely cope with a number of other psychosocial stressors that may or may not be related to HIV/AIDS within the family. Therefore, it is extremely difficult to access these youth and to have them finish measures or surveys on their own time. Specifically, only those youth who had been made aware of the presence of HIV/AIDS in their family were recruited for this study, thereby limiting the number of families that could be contacted initially. Similarly, CAP staff and therapists determined
that some families should not be contacted due to reasons that were kept confidential to
the principle investigators, further limiting the number of families that could be recruited.
Finally, many adolescents could not be contacted due to disconnected phone numbers,
changed addresses, and lack of time or interest to participate. Occasionally a youth was
interested in participating but could not get a parent signature of consent. Contrastingly,
some parents were interested in having their child or adolescent participate but the youth
him or herself was not interested. In addition, although incentives were provided, they
may not have been enticing enough to inspire participation and follow-through for this
particular population.

HIV/AIDS most often affects those from low SES, impoverished, minority, and
marginalized populations (CDC, 2007) and because most research to date has focused on
minority participants, it was hoped that the sample in this study would shed light on the
effects of HIV/AIDS on Caucasian adolescents. Unfortunately, the sample was not
adequate in size or distribution across ethnicities to compare groups by heritage. This
lack of adequate numbers is again illustrative of the difficulty accessing youth affected by
HIV/AIDS and the fact that so many families of ethnic minorities are affected by
HIV/AIDS is illustrative of the nature of those that are most vulnerable to this disease.

Participants from this study were sampled from a local agency that provides
services to families coping with HIV and AIDS. Therefore, few if any generalizations can
be made from the results of this study to other populations affected by HIV/AIDS.
Additionally, it should be noted that very few individuals participated in this study
despite the numerous families served by CAP. It would be beneficial to discover what
kinds of differences exist between those adolescents who seek services from CAP who
participate in research and those who do not participate. Perhaps those who participate in research are already more heavily involved with CAP than other families and therefore feel more obliged or more motivated to contribute to research.

Finally, the cross-sectional nature of this study also limits the interpretations we are able to make from our results because we do not know the developmental course of disclosure to participants, their optimism, or their relationships.

Future Research

Unfortunately, in general, the results of this finding are inconclusive. There is still a great need for further research on factors that may influence levels of optimism and relationship quality in adolescents who are affected by HIV/AIDS. Larger sample sizes from a variety of locations or regions would most likely provide a more thorough and generalizable picture of factors that influence youth affected by HIV/AIDS. Longitudinal research may also be beneficial for better understanding how other life-stressors, relationship development and family system dynamics, the process of disclosure in the family, and the development of optimism influence the relationships between these variables. Specifically, research with this population will likely require greater financial provisions and therefore greater incentives for families to participate. Additionally, when recruiting from local agencies who serve populations affected by HIV/AIDS, it is imperative to gain the trust and support of agency staff in order to connect with those targeted for research.

Specifically related to the findings of this study, it seems important to discover more about the role disclosure, discussion and education related to HIV/AIDS, and the impact of HIV/AIDS on the adolescent in various areas of life play with adolescent
optimism and relationships. It could be especially important to compare adolescents’ reports of family functioning regarding HIV/AIDS disclosure and parents’ or outside sources’ reports. More information regarding family functioning from the adolescent’s perspective as well as from the parent’s perspective may also shed light on how the family as a system (Bowen, 1978) is affected by HIV/AIDS and disclosure within the family. Pessimism may play an explicit part in the adaptation of youth affected by HIV/AIDS, therefore further research on pessimism compared to optimism among this population could also be beneficial. There also exists a growing literature regarding the difference between characterological or dispositional optimism versus (situational) optimism (Scheier & Carver, 1985). It may be useful to differentiate between these two forms of optimism among adolescents affected by HIV/AIDS in order to determine how each is related to other factors such as disclosure and relationship quality. Additionally, it seems important to more explicitly understand the role that female peers play in the lives of youth affected by HIV/AIDS over time. Participants in this study also did not respond to questions about their relationships to their fathers very often, therefore it is important to discover where these adolescents’ fathers are and what kind of a role they play in their children’s lives.

Some researchers have measured a lack of disclosure, or uncertainty regarding parental illness. Steele, Tripp, Kotchick, Summers, and Forehand (1996) found that children and adolescents’ uncertainty about their father’s illness (hemophilia) predicted an increase in self-reported anxiety and depression. It is possible that a lack of disclosure results in increased use of denial among adolescents affected by HIV/AIDS (Duggan, 2000; Murphy et al., 2006; Woodring, et al., 2005). Denial of the existence of an illness
in a parent inevitably leads to confusion and fear, which may then lead to more risky behaviors. Adolescents may not believe they can effectively protect themselves and therefore engage in risky behaviors out of hopelessness (Duggan). It would likely be very useful to compare adolescents who have been disclosed to versus those who have not on measures of optimism, relationship quality, and other measures of adjustment as well.

**Clinical Implications**

Although few if any definitive conclusions can be made from the results of this study, it could be beneficial for clinicians and agency staff to keep in mind the impact that disclosure, HIV/AIDS education and discussion, and monitoring of the impact of HIV/AIDS on the adolescent can have on the adolescent’s functioning and vice versa. Similarly, it could be beneficial to keep in mind the interesting and often conflicting roles that optimism and pessimism can play in youths’ adaptation to and life with HIV/AIDS. Increasing adolescent optimism may be beneficial to the adolescent in some ways, but not necessarily if it is at the expense of maintaining close contact with reality (which may, to some measures, appear pessimistic). It is also striking that mother-adolescent relationships fell into the mild relationship weakness category for participants in this study. Although this trend may not be surprising given that many of the participants’ mothers were infected by HIV/AIDS, it is important for individuals working with this population clinically to spend some time and energy discussing and ideally improving the mother-adolescent relationship. Perhaps most important is for clinicians and agency staff to determine whether or not mother-adolescent relationship weakness is due to normal adolescent developmental challenges (Santrock, 2003) or to maladaptive coping strategies or other difficulties related to living with HIV/AIDS.
Finally, it is encouraging to remember that, although faced with a number of difficult and stressful challenges, the youth in this sample scored in the normal range for all relationships except relationship with mother (which was near the cutoff for the normal range) and relationship with father (due to lack of sufficient information). Additionally, most youth in this sample scored similarly to other youth on scores of optimism. It is apparent that, whatever adolescents affected by HIV/AIDS are doing themselves, with their families, and with the agency staff who serve them, something is working for these youth that researchers might one day be able to discover and capitalize upon to further improve the lives of these brave individuals.
References


Appendix A: Parent Consent Form

PACIFIC UNIVERSITY
INFORMED CONSENT TO ACT AS A RESEARCH PARTICIPANT

Kids Connection: Optimism, Perception of Interpersonal Relationships, and Psychosocial Functioning Among Adolescents from a Community Organization.

Investigator(s) Contact Information

Project Leaders: Emily Crawford, B.A. & Corey Baechel, M.A.
Pacific University
School of Professional Psychology
(503)352-2436 & (503)352-2422
craw5745@pacificu.edu & baec6094@pacificu.edu

Faculty Advisor: Sydney Ey, PhD.
Pacific University
School of Professional Psychology
503-352-2406
Sydney.Ey@pacificu.edu

1. Introduction and Background Information

When a family member is diagnosed with a serious illness like HIV/AIDS, some youth and teens have a hard time coping while others seem to be able to cope effectively with the situation. Some may find it helpful to talk about their concerns with close friends and family; others prefer to keep their concerns private. Some youth and teens may report being hopeful while others are less hopeful about the future. More information, however, is needed to understand how youth and teens are affected by their illness or their family member’s illness and what helps youth and teens be more resilient in the face of this challenge in their lives.

In this study, we want to understand:
- how parents and youth or teens talk about HIV/AIDS
- how hopeful youth or teens are about their future
- how youth or teens see their relationships with their family, friends, and teachers
- what kinds of emotional and behavioral problems youth or teens may be dealing with.

By allowing your youth or teen to participate with this project, you can help the staff at Kids Connection, other organizations, and counselors to better understand what kinds of factors protect youth and teens affected by or infected with HIV or AIDS from becoming emotionally distressed.

Please read this form carefully and ask any questions you may have before agreeing to allow your youth or teen to participate in this project. If you allow your youth or teen to participate, he or she will be asked to answer questions about their views of the future, their relationships with parents, friends, and teachers, and some of their emotional and
behavioral difficulties and strengths. In addition, we would like your permission to use information from your Child’s Needs and Resource Scale (CNRS) already provided to Kids Connection. It should take 30-45 minutes for your youth or teen to finish the questionnaires.

In order to participate in this study, your youth or teen must be aware that a) he or she has been diagnosed with HIV or AIDS or that b) his or her parent(s) have been diagnosed with HIV or AIDS. By including information regarding disclosure of HIV in your family, we will be better able to discover if disclosure plays a role in your youths’ or adolescents’ adjustment.

Finally, if you allow your youth or teen to participate, you are agreeing to waive your right as a parent/guardian to view your teen’s responses to the questionnaires. Youth and teens are often willing to be more honest and open when responding to questions if they know that their information will be kept private, even from their parents/guardians. Thank you for taking the time to consider helping with this project.

2. Study Location and Dates

The project will begin in the Winter of 2006 and will be completed by August, 2007. Your teen will have the option of participating either on Kids Connection premises, over the phone, or we can send you the questionnaires by mail without identifying information on the outside envelope.

3. Procedures

If you agree to allow your youth or teen to help with this project, we will ask you to first give your youth or teen permission to participate. Once he or she has received permission, we will ask her or him to fill out several brief questionnaires about relationships, outlook on the future, and difficulties and strengths. Filling out all of the measures will take 30-45 minutes. You and your youth or teen may discontinue participation at any time without negative consequences.

4. Participants and Exclusion

Only participants who meet the following conditions will be included in the study: he or she must be between the ages of 11 and 18, speak English fluently, and have permission from a parent or legal guardian to participate. Additionally, families who have not disclosed the presence of HIV in the family to their teen will be excluded. Participants who do not meet the above criteria will not be able to participate. If your youth or teen begins filling out the measures and becomes too upset to continue, or does not wish to continue, she or he may stop at any time without penalty. He or she will be entered in the drawing for one of three prizes ($50 gift certificate to Pioneer Square Mall, an ITunes card, and a pair of movie tickets to Regal Cinemas) even if he or she does not complete all questionnaires.

5. Risks and Benefits

There are some benefits and risks to participating in this research. Answering questions about relationships and experiences may be distressing or upsetting. We do not
anticipate that these questions will be very upsetting to most youth or teens, but if she or he does become upset she or he may stop at any time. The project leaders will be available by phone and by email for questions or concerns. Additionally, you may contact the project leaders’ advisor, Sydney Ey, Ph.D. at 503-352-2406 with any questions or concerns. You may request that we not include your information in our project at any time after questionnaires have been completed.

Although your youth or teen may not receive direct benefits from participating in this study, his or her answers may help counselors, social workers, and service agencies better understand what kinds of factors protect youth and teens affected by or infected with HIV or AIDS from becoming emotionally distressed. Answers to on the forms may help Kids Connection staff and other organizations to better serve adolescents and their families. They may also help to create new and better ways to help adolescents cope with difficult experiences and to have more satisfying relationships.

6. Alternatives Advantageous to Participants

Not applicable here.

7. Participant Payment

Every participant will be entered in a drawing for one of three prizes, including a $50 gift certificate to Pioneer Square Mall, an I-Tunes card, and a pair of movie tickets to Regal Cinemas. If your youth or teen becomes too upset to continue filling out the measures, his or her name will still be entered. Prizes will be awarded in April 2007, after all questionnaires have been collected.

8. Promise of Privacy

All information provided on the questionnaires will be kept private, meaning that individual responses will not be shared with parents, legal guardians, or Kids Connection staff within the limits of the law. If, however, your youth or teen reports that he or she is in immediate danger, or that someone else is in immediate danger, then the project leader will contact the youth’s or teen’s Kids Connection therapist or staff to follow up with the youth or teen and to do what is necessary to keep everyone safe.

This consent form will be kept separate from corresponding questionnaires in a locked file cabinet at the Psychological Service Center at Pacific University. Questionnaires will be kept in a locked file cabinet on Kids Connection premises without any identifying information on them. Only the project leaders, their faculty advisors, and a trained research assistant will have access to your youth’s or teen’s data; these individuals will only have access to the data after identifying information has been removed from it. If the results of this study are to be presented or published, we will not include any information that will make it possible to identify your youth or teen as an individual.

9. Voluntary Nature of the Study

Your decision whether or not to allow your youth or teen to participate will not affect your current or future relations with Pacific University or with Kids Connection. If you decide to allow your youth or teen to participate, he or she is free to not answer any question, to stop filling out questionnaires, or to withdraw at any time without prejudice or negative
consequences. If your youth or teen becomes too distressed to complete all questionnaires his or her name will still be entered into the raffle for a prize.

10. Compensation and Medical Care

During participation in this project your youth or teen is not a Pacific University clinic patient or client, nor will your family be receiving complete psychological care as a result of participation in this project. If you or your youth or teen is injured during your participation in this project it is not the fault of Pacific University, the project leaders, or any organization associated with the project. You should not expect to receive compensation or medical care from Pacific University, the project leaders, or any organization associated with the study.

11. Contacts and Questions

The project leaders will be happy to answer any questions you may have at any time during the course of this project. The project leaders can be reached at 503-352-2436 or 503-352-2442 or by email at craw5745@pacificu.edu or baec6094@pacificu.edu. You may also contact the project leaders' advisor, Sydney Ey, Ph.D. at 503-352-2406 with questions or concerns. If you are not satisfied with the answers you receive, please call Pacific University's Institutional Review Board, at (503) 352 - 2215 to discuss your questions or concerns further. All concerns and questions will be kept in confidence.

12. Statement of Consent

I have read and understand the above. All my questions have been answered. My youth or teen is between 11 and 18 years of age and has assented to participate. I am the parent / guardian of this youth or teen and have given consent for his or her participation. I have been given a copy of this form to keep for my records. I understand that I am waiving my right to review my youth's or teen's responses to these questions.

I give my permission for the project leaders to include information already given to Kids Connection on the CNRS: _____ Yes _____ No

________________________
Adolescent's Signature of assent
Date

________________________
Adolescent's Signature of assent
Date

________________________
Adolescent's Signature of assent
Date
Adolescent's Signature of assent
Date

Parent / Guardian's Signature of consent
Date

Participant contact information:
Street address: ________________________________
______________________________

Telephone: ________________________________
Email: ________________________________

This contact information is required in case any issues arise with the project and participants need to be notified.

Project Leader's Signature ____________________________ Date __________

Participant would prefer to fill out questionnaires: ___ in person ___ by phone ___ by mail
Demographic Information

HIV has been diagnosed in our family: ___ mother ___ father ___ participating adolescent ___ other relative

HIV has been disclosed to the participating adolescent: ___ Yes ___ No

Parent Sex: ___ Female ___ Male Parent Date of Birth: ___ Parent Age: ___

Parent Race or Ethnic Heritage: _______________________

1Youth/Teen Sex: ___ Female ___ Male

Youth/Teen Date of Birth: ___ Youth/Teen Age: ___

Youth/Teen Year in School: ___

Youth/Teen Race or Ethnic Heritage: _______________________

2Youth/Teen Sex: ___ Female ___ Male

Youth/Teen Date of Birth: ___ Youth/Teen Age: ___

Youth/Teen Year in School: ___

Youth/Teen Race or Ethnic Heritage: _______________________

3Youth/Teen Sex: ___ Female ___ Male

Youth/Teen Date of Birth: ___ Youth/Teen Age: ___

Youth/Teen Year in School: ___

Youth/Teen Race or Ethnic Heritage: _______________________

4Youth/Teen Sex: ___ Female ___ Male

Youth/Teen Date of Birth: ___ Youth/Teen Age: ___

Youth/Teen Year in School: ___

Youth/Teen Race or Ethnic Heritage: _______________________
Appendix B: CAIR
**Assessment of Interpersonal Relations**

- Bruce A. Bracken

---

**RECORD BOOKLET**

### Section I: Identifying Information

- **Name/ID No.:**
- **Address:**

---

- **Parents' Name:**
- **School/Agency:**
- **Referred by:**

---

- **Place of testing:**
- **Tested by:**

---

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</tbody>
</table>

- **Date Tested:**
  - **Year:** /  
  - **Month:** /  
  - **Day:** /

- **Age**
- **Sex**
- **Grade**

---

### Section II: Directions and Scales

Please rate the following statements according to how well they apply to each of your parents, your male and female peers, and your teachers. Please rate each statement according to how you honestly feel. There are no right or wrong answers, so be sure you are honest with yourself as you rate each statement. You should rate only the parent(s) with whom you are currently living. If you rate only one of your parents (e.g., your mother, but not your father), please check the boxes to indicate the parent with whom you are not living and the reason.

I am not rating my □ mother □ father due to □ death, □ separation, □ divorce, or □ other.

Each statement should be rated as:

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<th>Strongly Agree (SA)</th>
<th>Agree (A)</th>
<th>Disagree (D)</th>
<th>Strongly Disagree (SD)</th>
</tr>
</thead>
</table>

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Additional copies of this form (#6672) are available from PRO-ED, 8700 Shoal Creek Boulevard, Austin, Texas 78757 512/451-3246
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<th>Agree (A)</th>
<th>Disagree (D)</th>
<th>Strongly Disagree (SD)</th>
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<td>MOTHER</td>
<td>MOTHER SCORE</td>
<td>FATHER</td>
<td>FATHER SCORE</td>
</tr>
<tr>
<td>1. I am really understood by my . . .</td>
<td>MOTHER</td>
<td>MOTHER SCORE</td>
<td>FATHER</td>
<td>FATHER SCORE</td>
</tr>
<tr>
<td>2. I like to spend time with my . . .</td>
<td>MOTHER</td>
<td>MOTHER SCORE</td>
<td>FATHER</td>
<td>FATHER SCORE</td>
</tr>
<tr>
<td>3. If I was bothered by a friend’s behavior, I would tell my . . .</td>
<td>MOTHER</td>
<td>MOTHER SCORE</td>
<td>FATHER</td>
<td>FATHER SCORE</td>
</tr>
<tr>
<td>4. I am treated fairly by my . . .</td>
<td>MOTHER</td>
<td>MOTHER SCORE</td>
<td>FATHER</td>
<td>FATHER SCORE</td>
</tr>
<tr>
<td>5. I feel I am being used by my . . .</td>
<td>MOTHER</td>
<td>MOTHER SCORE</td>
<td>FATHER</td>
<td>FATHER SCORE</td>
</tr>
<tr>
<td>6. When I buy things, I value the opinion of my . . .</td>
<td>MOTHER</td>
<td>MOTHER SCORE</td>
<td>FATHER</td>
<td>FATHER SCORE</td>
</tr>
<tr>
<td>7. If I was worried about a friend doing drugs, I would talk with my . . .</td>
<td>MOTHER</td>
<td>MOTHER SCORE</td>
<td>FATHER</td>
<td>FATHER SCORE</td>
</tr>
<tr>
<td>8. When I am lonely, I seek the company of my . . .</td>
<td>MOTHER</td>
<td>MOTHER SCORE</td>
<td>FATHER</td>
<td>FATHER SCORE</td>
</tr>
<tr>
<td>9. I feel trust and stability in my relationship with my . . .</td>
<td>MOTHER</td>
<td>MOTHER SCORE</td>
<td>FATHER</td>
<td>FATHER SCORE</td>
</tr>
<tr>
<td>10. My relationship is stressful with my . . .</td>
<td>MOTHER</td>
<td>MOTHER SCORE</td>
<td>FATHER</td>
<td>FATHER SCORE</td>
</tr>
<tr>
<td>11. I am depended upon heavily by my . . .</td>
<td>MOTHER</td>
<td>MOTHER SCORE</td>
<td>FATHER</td>
<td>FATHER SCORE</td>
</tr>
<tr>
<td>12. I can express my true feelings when I am with my . . .</td>
<td>MOTHER</td>
<td>MOTHER SCORE</td>
<td>FATHER</td>
<td>FATHER SCORE</td>
</tr>
<tr>
<td>13. My happiness is affected by my . . .</td>
<td>MOTHER</td>
<td>MOTHER SCORE</td>
<td>FATHER</td>
<td>FATHER SCORE</td>
</tr>
<tr>
<td>14. It is important to me that I am accepted by my . . .</td>
<td>MOTHER</td>
<td>MOTHER SCORE</td>
<td>FATHER</td>
<td>FATHER SCORE</td>
</tr>
<tr>
<td>15. It is difficult to be myself when I am around my . . .</td>
<td>MOTHER</td>
<td>MOTHER SCORE</td>
<td>FATHER</td>
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Appendix C: YLOT
Instructions

Y-LOC Children: Revised Oct 197

Please answer the following questions about yourself by putting how true or not true each statement is for you. Please COLOR IN the oval that seems to describe you the best. There are no right or wrong answers. Just describe yourself as best as you can.

1. It's easy for me to have fun.
   - true for me
   - sort of true
   - sort of not true
   - not true for me

2. I like to be active.
   - true for me
   - sort of true
   - sort of not true
   - not true for me

3. I'm always hopeful about my future.
   - true for me
   - sort of true
   - sort of not true
   - not true for me

4. Things usually go wrong for me.
   - true for me
   - sort of true
   - sort of not true
   - not true for me

5. When I am not sure what will happen next, I usually expect it to be something good.
   - true for me
   - sort of true
   - sort of not true
   - not true for me

6. Usually, I don't expect things to go my way.
   - true for me
   - sort of true
   - sort of not true
   - not true for me

7. Usually, I don't expect good things to happen to me.
   - true for me
   - sort of true
   - sort of not true
   - not true for me

8. I am a lucky person.
   - true for me
   - sort of true
   - sort of not true
   - not true for me

9. If something nice happens, chances are it won't be to me.
   - true for me
   - sort of true
   - sort of not true
   - not true for me

10. Each day I look forward to having a lot of fun
11. When things are good, I expect something to go wrong.

true for me  sort of true  sort of not true  not true for me

12. I usually expect to have a good day.

true for me  sort of true  sort of not true  not true for me

13. No matter what I try, I do not believe anything is going to work.

true for me  sort of true  sort of not true  not true for me

14. Overall, I expect more good things to happen to me than bad things.

true for me  sort of true  sort of not true  not true for me

15. Each day I expect bad things to happen.

true for me  sort of true  sort of not true  not true for me

16. When things are bad, I expect them to get better.

true for me  sort of true  sort of not true  not true for me

17. Even when people around me are sick, I expect to be healthy.

true for me  sort of true  sort of not true  not true for me

18. If some illness is going around, I am sure to get it.

true for me  sort of true  sort of not true  not true for me

19. When I do not feel well, I expect that I will feel better soon.

true for me  sort of true  sort of not true  not true for me
Appendix D: CRNS
<table>
<thead>
<tr>
<th>Assessment</th>
<th>Stage 1 (10 points)</th>
<th>Stage 2 (10 points)</th>
<th>Stage 3 (10 points)</th>
<th>Stage 4 (1 point)</th>
<th>Stage 5 (4 points)</th>
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<tbody>
<tr>
<td>Medical Needs (physical, dental,</td>
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<td>check-up, immunizations all current</td>
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<td>Nutritional Requirements (balanced</td>
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<td>diet, appropriate quantity, vitamins, and variety)</td>
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<td>Safety of home environment (no hazards, medications, illegal drugs, firearms, child-proof measures, neighborhood/housing safe, appropriate sleeping arrangements)</td>
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<td>Clothing (appropriate for all seasons)</td>
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<td>Physical Activity (proper amount of exercise)</td>
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<td>Insurance (child covered)</td>
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<td>Behavioral, emotional, cognitive</td>
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<td>Issues (appropriateness of conduct, intensity of feeling, and thought process)</td>
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### Legal Preparation

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<tr>
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**TOTAL:**

\[ /100 = \text{SCORE} \]

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*Note: The image contains some text that is partially obscured or not clear enough to be transcribed accurately.*
The Scale

Scores are attributed from the perspective of the affect of the indicator on the child.

0 = SEVERE NEGATIVE IMPACT
1 = MODERATE NEGATIVE IMPACT
2 = MINIMAL NEGATIVE IMPACT

**SCORES OF 3-4 pts indicate that the child is no longer negatively impacted and differentiates the extent to which external support is still required.

3 = ON-GOING EXTERNAL SUPPORT REQUIRED
4 = INDEPENDENT MANAGEMENT

How to score individuals

Physical Well-Being

Medical Needs: (Physical, Dental, Check-ups, Immunizations all current)
- 0 3 or more needs require immediate attention
- 1 2 needs require immediate attention
- 2 1 need requires immediate attention
- 3 No immediate attention required but external support needed to ensure follow through
- 4 Support exists within family to attend to child’s medical needs

Nutritional Requirements: (Balanced Diet, Appropriate quantity, Vitamins, and Variety)
- 0 Child not getting enough food and guardians unable/unwilling to utilize available resources
- 1 Child’s nutritional requirements are not met but guardians are willing to access resources and/or interested in increasing awareness of nutritional requirements
- 2 Child’s nutritional requirements are somewhat met and guardians have made plans to improve child’s situation
- 3 Nutritional needs are basically met but support needed to either ensure variety or continue with needed improvements
- 4 Nutritional needs successfully managed by guardians

Abuse/DV in Home: (No Threat of Harm, Restraining Orders in Place, Exit Strategy if necessary)
- 0 Current abuse, serious threat of harm, restraining orders and exit strategy required but guardian unable/unwilling to improve situation
- 1 Potential threat of harm, restraining orders and exit strategy required guardian supportive and will start process with assistance
- 2 Potential threat of harm but needed restraining orders and exit strategy required have been obtained
- 3 Currently in safe situation, minimal threat of harm, family needs external monitoring/support
- 4 No threat of harm
Safety of home environment: (No Hazards, Medications, Illegal drugs, Firearms, Child-proof measures, Neighborhood/Housing safe, Appropriate Sleeping Arrangements)
0 Multiple hazards evident, guardians unwilling/unable to improve environment
1 Multiple hazards evident, guardians were made aware of risk and willing to improve safety
2 One or more hazards evident, guardian seeking resources to improve situation
3 Minimal hazards evident, Guardian has access to resources to improve home safety, is currently making changes with ongoing support
4 No hazards for child in living environment, all appropriate measures are in place — parents able to independently monitor

Clothing (appropriate for all seasons)
0 Child does not have appropriate seasonal clothing and guardians unable/unwilling to improve situation
1 Child does not have appropriate seasonal clothing, guardians lack resources, but are willing to improve situation
2 Child has minimal clothing for seasons, guardians seeking resources to improve situation
3 Child has adequate clothing for seasons; guardians rely on outside resources to provide clothes
4 Child has sufficient clothing for seasons and guardians able and willing to provide without outside assistance

Physical Activity (proper amount of exercise)
0 Child does not get adequate levels of activity and guardian/child unwilling/unable to address issue
1 Child does not get adequate levels of activity, guardian/child willing to make changes to include more activity
2 Child gets a minimum amount of physical activity, guardians/child need resources (including education) to make further improvement
3 Child gets sufficient activity however guardians/child require continued external support to sustain program
4 Activity sufficient and family can self-sustain program

Insurance (child covered)
0 Child not covered and guardians unable/unwilling to access resources
1 Child not covered, guardians recognize need, willing to access resources
2 Child not covered or has inadequate coverage, guardians willing and acting to improve situation
3 Child adequately covered, guardians need ongoing support to maintain plan
4 Child adequately covered and guardian able to independently maintain plan
Emotional Well-Being

Behavioral, emotional, cognitive Issues (appropriateness of conduct, intensity of feeling, and thought process)

0. Responses inappropriate most of the time and incongruous with environment, no apparent control of response, requires professional attention but family unable/unwilling to recognize issues and/or seek professional help
1. Inappropriate responses to environment less common (when they occur they are intense) or demonstrates signs of emotional turmoil which need to be addressed, family has expressed awareness and willingness to address these issues. Support, if available is not adequate to meet need
2. Child experiences emotional distress occasionally and is receiving professional support
3. Child experiences age appropriate emotional responses and is receiving adequate external support
4. Well adjusted child, demonstrates age-appropriate emotional responses to environment – no external support needed

Family environment is healthy and cohesive (includes communication styles and problem solving)

0. Significant family conflict present and is negatively impacting child. Family members unable/unwilling to address issues
1. Significant family conflict present and is negatively impacting child. Family members are willing to address issues
2. Moderate family conflict present and is negatively impacting child. Family members currently addressing conflict with substantial professional support
3. Minimal conflict present, external support needed to maintain healthy environment
4. Family environment is healthy, communication is positive – independently maintained

Behavior at school appropriate (no harmful, disruptive, avoidant behaviors interfering with progress, or unaddressed problem or disability causing problems in school)

0. Child’s behavior at school is harmful to others or often disruptive and it interferes with progress or;
   Child’s unaddressed disability is causing problems and guardians unable/unwilling to address the issue.
1. Child’s behavior at school is occasionally disruptive but not harmful to others and it interferes with progress, family has been informed and is willing to take appropriate action; or family aware of child’s learning disability and is willing to take appropriate action.
2. Inappropriate school behavior(s) or disability have been identified, yet continue, and treatment or specialized programming begun with professional/school personnel.
3. On-going external support required but child’s behavior or condition no longer negatively impacting child or classmates
4. Child exhibits appropriate school behavior with no external support required and/or appropriate accommodations made to address disability

Healthy peer and social relationships (not subject to bullying or isolation)

0. Negative peer relationships and/or child subject to bullying; child/guardians unable/unwilling to acknowledge or address issue
1. Family/child made aware of negative peer relationships or bullying and are willing to take action
2. Issues appropriately addressed and have improved but child still negatively impacted. Appropriate third parties have been contacted in order to address bullying or negative peer relationships
3. External intervention or support required but child no longer negatively impacted by unhealthy peer relationships
4. Child independently maintains healthy peer relationships
Displays self-harming behavior (cutting, head banging, hitting or kicking objects, AD abuse, suicidal or attempts to put self in high risk situations)

0 Child displays self-harming behavior, immediate attention required however family and/or child unable/unwilling to acknowledge or address
1 Child displays self-harming behavior family/child made aware of situation and is willing to take appropriate action
2 Child displays moderately self-harming behavior and requires on-going support
3 Child no longer displays self-harming behavior and/or currently not at high-risk but requires on-going external support to maintain healthy behaviors.
4 No self-harming behavior displayed — no external support needed

Displays harmful behaviors towards others (physical abuse, poisoning, throwing objects, threats towards people or animals, inappropriate sexual interaction)

0 Child displays harmful behavior towards others, immediate attention required however family and/or child unable/unwilling to acknowledge or address
1 Child displays harmful behavior towards others; family/child made aware of situation and is willing to take appropriate action
2 Child displays moderately harmful behaviors towards others and requires on-going support to sustain progress
3 Child no longer displays harmful behavior towards others and/or currently not at high-risk but requires on-going external support to maintain healthy behaviors
4 Child displays no harmful behaviors towards others.

Emotional support system (appropriate professional, family, and friend support, which are accessed when needed)

0 Child lacks emotional support; family unwilling/unable to access resources to meet child’s need
1 Child lacks emotional support; family made aware of resources and is willing to access appropriate resources
2 Child has some emotional support but additional resources needed to more fully address needs
3 Child’s emotional support system in place; child/family requires external support to maintain
4 Child’s emotional support system is in place — child/family requires no external assistance to maintain

Access to Community Resources
Participates in social/recreational activities (sports, art, non-school classes, after-school programs, summer camps, youth groups)

0 Child and family unable/unwilling to participate in, and/or access, recreational activities outside of home.
1 Child and family are willing to access, or allow, child to participate in recreational activities outside of home
2 Child participates in a few recreational activities but would benefit from additional opportunities
3 Child sufficiently participatory in outside social/recreational activities — family requires ongoing support to maintain
4 Child sufficiently participatory in outside social/recreational activities — family independently manages
### Academic School Functioning (academically stable)

- **0** Child failing many classes and family or school unable/unwilling to address problems actively
- **1** Child failing many classes; family made aware of issues and is willing to access required assistance
- **2** Child failing classes but is receiving significant assistance, including parental support, to improve situation
- **3** Child passing most classes but requires on-going external assistance
- **4** Child academically stable and child/family requires no outside assistance

### Community Support (available activities and organizations within community)

- **0** Child/family significantly isolated; Community support minimally available and/or family unwilling/unable to utilize existing resources
- **1** Child/family significantly isolated; Community support available; family is willing to access resources
- **2** Child/family somewhat isolated; Community support available; family is willing to access resources
- **3** Child/family connected to community resources but needs external support to stay engaged
- **4** Family independently utilizing community resources when needed

### Advocacy (Presence of individual or group advocate in community)

- **0** Child/Family in need of advocacy but unable/unwilling to advocate for self/child
- **1** Child/family in need of advocacy; Potential resource identified and family is willing to access this resource
- **2** Child/family has an advocacy resource and are working together to resolve critical issues
- **3** Child/family's needs for advocacy have been met – ongoing support still needed to ensure progress
- **4** Family able to advocate for child/self independently

### Disclosure

#### HIV Disclosure (Parent/guardian disclosure to children and family HIV status of any family member)

- **0** Lack of HIV disclosure is negatively impacting child; Guardian unable/unwilling to address issues
- **1** Lack of HIV disclosure is negatively impacting child; Guardian is willing to address issues
- **2** Lack of HIV disclosure is negatively impacting child; Guardian is actively engaged in process to disclose to child
- **3** Guardian has disclosed HIV status to child and needs ongoing support to fully address issue
- **4** Guardian has disclosed HIV status to child and are independently discussing as needed

### HIV Education and Prevention (Discussed regularly and appropriately within family)

- **0** Child in need of HIV Education and family unable/unwilling to approach subject
- **1** Child in need of HIV Education and family is willing to approach subject but is need of information/support to adequately address
- **2** Child has some needs for HIV Education; Family has begun the conversation but requires external support on how to further the discussions
- **3** Child has basic information, family discusses HIV regularly within family but requires on-going support to maintain
- **4** Family competently discusses HIV regularly within family
HIV related concerns: (Fear of loss, anxiety, misinformation, current health status)
0 Child exhibiting distress due to HIV related concerns; Family unable/unwilling to address
1 Child exhibiting distress due to HIV related concerns; Family is willing to address
2 Child exhibiting moderate distress due to HIV related concerns; Family is actively addressing relevant concerns with significant support
3 Family has addressed problematic issues within family and requires on-going external support to maintain stable situation
4 Family able to self-manage problematic issues within family and no external support is required

HIV status of child or family causing problems outside of family. (Issues relating to communication about HIV with others, discrimination, service access.)
0 HIV status of child or family causing problems; however family and/or other party unwilling/unable to acknowledge or address problems
1 HIV status of child or family causing problems; family made aware of problems and is willing and able to take action
2 HIV status of child or family causing minimal problems; family and outside party has begun to appropriately address issues
3 HIV status of child or family not presently causing problems; however continual monitoring of situation is required
4 HIV status of child or family is not causing problems; family can independently manage issues that arise

Legal Preparation
Family Health Crisis Plan (Relating to HIV positive families members health; including family members responsibilities, emergency contact, procedures, alternative child care and financial backup)
0 No crisis plan in place and family unable/unwilling to acknowledge need for one
1 No crisis plan in place; family acknowledges need for plan and is willing to address
2 Family is assessing what is needed to complete plan; A complete crisis plan is not currently in place
3 Family Crisis Plan in development stages, family will complete with support
4 Family Crisis Plan in place

Custody Issues (Unresolved custody battles, non sanctioned physical custody of child, visitation disputes, non payment of child support and other unresolved legal issues.)
0 Critical custody issues are present; family currently is unwilling/unable to address
1 Critical custody issues are present; family is willing to address
2 Custody issues are not critical to child’s immediate well-being; family will continue to work to alleviate issues
3 No custody issues are currently present; family requires on-going support to maintain
4 No custody issues are present; issues that arise are managed successfully by family

Permanency Planning (legal provisions completed in case of parent or guardian illness or death)
0 No permanency plan in place and family is unwilling/unable to address
1 No permanency plan in place; family acknowledges need for plan and is willing to develop one
2 Family is assessing what is needed to complete plan, a complete permanency plan is not currently in place
3 Permanency plan in development stages, family will complete with support
4 Permanency plan in place and family can independently update