Minority Stress and Emotional Intimacy among Individuals in Lesbian and Gay Couples: Implications for Relationship Satisfaction and Health

Andrea Guschlbauer

Department of Educational and Counselling Psychology

McGill University

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Abstract

Individuals in lesbian and gay (LG) couples face a particular stress that is unique from their heterosexual counterparts: minority stress, the increased stress experienced as a result of living in an environment that is stigmatizing of their sexual orientation and identity. Research focused on LG individuals demonstrates far-reaching health implications of minority stress. However, there is limited literature examining the effects of minority stress on health among individuals in same-sex couples. Among heterosexual couples, stress negatively impacts health, relationship functioning, and intimacy. Emotional intimacy in particular has been linked to psychological and physical health in heterosexual couples. Among individuals in LG couples, emotional intimacy has been shown to be the most important predictor of relationship satisfaction. Taken together, there is reason to suppose that there is a relationship between minority stress, emotional intimacy, and relationship satisfaction among individuals in LG couples. As such, this study examined the interconnectedness of these three constructs as well as related health implications among 181 individuals in same-sex relationships. It was firstly hypothesized that experiences of minority stress would negatively predict relationship satisfaction and positively predict psychological distress, health symptoms, and health risk behavior. Secondly, it was hypothesized that emotional intimacy would positively predict relationship satisfaction, health symptoms, and health behavior and negatively predict psychological distress. Thirdly, experiences of minority stress were hypothesized to negatively predict emotional intimacy. Finally, it was hypothesized that emotional intimacy would mediate the relationship between minority stress and outcomes

(relationship satisfaction, psychological functioning, health status, and health behavior). Data were analyzed at both the bivariate and multivariate level.

Hypothesis one was partially supported. At the bivariate level, results suggested that all three minority stress variables (experiences of discrimination, internalized homonegativity, and sexual orientation concealment) were significantly negatively correlated with relationship satisfaction. However, at the multivariate level, minority stress was not significantly related to relationship satisfaction or health outcomes, though experiences of discrimination and internalized homonegativity were significantly and positively correlated with psychological distress and the use of substances other than alcohol. In addition, the variable of experiences of discrimination was significantly and positively correlated with health symptoms.

Hypothesis two also was partially supported. At the bivariate level, emotional intimacy was significantly and positively correlated with relationship satisfaction and negatively correlated with psychological distress. At the multivariate level, emotional intimacy positively predicted relationship satisfaction but not any of the health outcomes.

Hypothesis three also was partially supported. At both the bivariate and multivariate levels, internalized homonegativity and sexual orientation concealment were negatively related to emotional intimacy. However, experiences of discrimination were not related to emotional intimacy.

Hypothesis four also was partially supported. Emotional intimacy mediated the relationship between internalized homonegativity and relationship satisfaction, health symptoms, and alcohol use. Emotional intimacy also mediated the relationship between sexual orientation concealment and relationship satisfaction. Emotional intimacy did not

mediate the relationship between experiences of discrimination and rejection and outcomes. Emotional intimacy also did not did not mediate the relationship between the composite variable of the three minority stress components and outcomes.

Findings from the current study highlight the importance of emotional intimacy among individuals in LG couples. The presence of emotional intimacy is associated with a decrease in the negative effect of internalized homonegativity and sexual orientation concealment on relationship satisfaction. Emotional intimacy is also fundamental in terms of health among individuals in LG couples as it can weaken the negative effect of internalized homonegativity on health symptoms and alcohol use. Areas for future research are explored, and implications for future research, clinicians, and policy makers are explicated.

Résumé

Les couples de lesbiennes et de gais (LG) font face à un stress particulier qui leur est unique par rapport à leurs homologues hétérosexuels : le stress minoritaire. Ce stress accru est ressenti en raison d'un environnement qui stigmatise leur orientation sexuelle et leur identité. La littérature scientifique démontre que le stress minoritaire a des implications considérables pour la santé des personnes LG. Toutefois, il existe un manque d'études examinant les effets du stress minoritaire sur la santé au niveau du couple. Parmi les couples hétérosexuels, le stress a un impact négatif sur la santé, le fonctionnement du couple et l'intimité. L'intimité émotionnelle, en particulier, a été reliée à la santé mentale et physique chez les couples hétérosexuels. Parmi les couples LG, il a été démontré que l'intimité émotionnelle est le plus grand prédicteur de la satisfaction de couple. En conséquent, il est raisonnable de supposer qu'il existe une relation entre le stress minoritaire, l'intimité émotionnelle et la satisfaction de couple chez les couples LG. Ainsi, cette étude examine les relations entre ces trois variables et leurs implications pour la santé parmi 181 individus dans une relation avec un(e) conjoint(e) du même sexe. Selon la première hypothèse, les expériences de stress minoritaire prédiraient négativement la satisfaction de couple et prédiraient positivement la détresse psychologique, les effets sur la santé et les comportements à risque pour la santé.

La deuxième hypothèse suppose que l'intimité émotionnelle prédirait positivement la satisfaction de couple, les symptômes sur la santé et les comportements en santé, et prédirait négativement la détresse psychologique. Selon la troisième hypothèse, les expériences de stress minoritaire prédiraient négativement l'intimité émotionnelle. Enfin, la dernière hypothèse suppose que l'intimité émotionnelle aurait un effet médiateur sur la relation entre le stress minoritaire et les variables dépendantes (satisfaction de couple, fonctionnement psychologique,

statut de santé et comportement de santé). L'analyse de données s'est faite aux niveaux bivarié et multivarié.

La première hypothèse était partiellement confirmée. Au niveau bivarié, les résultats ont suggéré que les trois variables de stress minoritaire (expériences de discrimination, homophobie internalisée et dissimulation de l'orientation sexuelle) ont une relation négative statistiquement significative avec la satisfaction de couple. Toutefois, les résultats au niveau multivarié ont suggéré qu'il n'existait pas de relation significative entre le stress minoritaire et la satisfaction de couple ou les effets sur la santé, bien que les expériences de discrimination et l'homophobie internalisée étaient positivement et significativement reliées à la détresse psychologique et à l'utilisation de substances illicites autres que l'alcool. En plus, il y avait une relation significative et positive entre les expériences de discrimination et les effets sur la santé.

La deuxième hypothèse était également partiellement confirmée. Au niveau bivarié, il y avait une relation positive statistiquement significative entre l'intimité émotionnelle et la satisfaction de couple, et une relation négative statistiquement significative entre l'intimité émotionnelle et la détresse psychologique. Au niveau multivarié, l'intimité émotionnelle prédisait positivement la satisfaction de couple mais aucune des variables dépendantes en lien avec la santé.

La troisième hypothèse a également été partiellement confirmée. Aux niveaux bivarié et multivarié, il existait une relation négative entre l'intimité émotionnelle et l'homonégativité internalisée, ainsi que la dissimulation de l'orientation sexuelle. Toutefois, il n'existait pas de relation entre l'intimité émotionnelle et les expériences de discrimination.

La quatrième hypothèse a également été partiellement confirmée. L'intimité émotionnelle avait un effet médiateur dans la relation entre l'homonégativité internalisée et la satisfaction de

couple, les symptômes sur la santé et l'usage d'alcool. L'intimité émotionnelle avait également un effet médiateur dans la relation entre la dissimulation de l'orientation sexuelle et la satisfaction de couple. Il n'y avait pas d'effet médiateur de l'intimité émotionnelle dans la relation entre les expériences de discrimination et de rejet et les variables dépendantes. L'intimité émotionnelle n'avait également pas d'effet médiateur dans la relation entre la variable composite des trois composantes du stress minoritaire et les variables dépendantes.

Les résultats de cette étude démontrent l'importance de l'intimité émotionnelle pour les personnes dans un couple LG. La présence de l'intimité émotionnelle peut diminuer l'effet négatif qu'ont l'homonégativité internalisée et la dissimulation de l'orientation sexuelle sur la satisfaction de couple. L'intimité émotionnelle est également essentielle à la santé des personnes dans un couple LG puisqu'elle peut diminuer l'effet négatif de l'homonégativé internalisée sur la santé et l'usage d'alcool. Nous proposons des pistes de recherche pour l'avenir et explicitons les implications pour la recherche future, les cliniciens et les législateurs.

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PREFACE

Statement of Originality

I (Andrea Guschlbauer) hereby certify that I am the sole author of this dissertation and that no part of this thesis has been published or submitted for another educational degree at any other institution. I confirm that this dissertation is an original work and contribution to the advancement of knowledge. Other scholarly works included in this dissertation are fully acknowledged in accordance with standard referencing practices of the American Psychological Association. I attest that this dissertation does not infringe upon anyone's copyright nor violate any proprietary rights. The dissertation has been approved by a doctoral thesis committee.

Contribution to Knowledge

The current study contributes to knowledge by demonstrating the mediating role of emotional intimacy in the relationship between internalized homonegativity and relationship satisfaction. Same-sex couples must contend with additional stress on top of the general stress faced by all couples - minority stress stemming from living in an environment that is stigmatizing of their sexual orientation and identity. By further demonstrating the deleterious impact of sexual minority stress (over and above general stress) on relationship satisfaction, the current study significantly contributes to minority stress research.

Chapter One: Introduction

Having a satisfying marriage or relationship has been rated as one of the most important goals in life across cultures (Levinger & Huston, 1990). It should come as no surprise then, that distressed intimate relationships have extensive negative effects on partners' psychological and physical well-being. *Couple distress* is an umbrella term that describes the emotional consequence of problematic interactions between two individuals in the context of their relationship (Wheeler, Christensen, & Jacobs, 2001). *Stress*, in the more general and individual-focused (as opposed to couple-focused) sense, is defined as "a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being" (Lazarus & Folkman, 1984, p. 19). Stress results when a person is overwhelmed by something in the environment (a stressor) and the person's ability to successfully deal with the stressor is compromised. Couple distress, therefore, can be understood as any excessive threat, demand, or constraint on the couple (Wheaton, 1997). A *stressor*, as defined in Lazarus and Folkman's theory of stress and coping, is something in the person/environment interaction that taxes the individual's present resources and is a threat to well being. Thus, a *relationship stressor* refers to any threat to the intimate relationship. Examples of relationship stressors might be an infidelity, communication problems, and a partner moving out/separation.

The harmful effects of stress within a couple include vast psychological and physiological outcomes as well as problems in relationship functioning. Couple distress has been linked to emotional and behavioral disorders such as depressed mood, anxiety, and substance use disorders (Whisman, Sheldon, & Goering, 2000), with distressed couples reporting higher rates than nondistressed couples. Accordingly, individuals experiencing stress in their primary

relationship are overrepresented in mental health services (Lin, Goering, Offord, & Campbell, 1996). Distressed couples are also more likely to report higher rates of domestic violence (Whisman et al., 2000). Physiological systems affected by couple distress include the cardiovascular, endocrine, immune, and neurosensory systems, all of which factor in to physical health problems (Kiecolt-Glaser & Newton, 2001).

Stress emanating from outside of the couple has also been shown to affect couple functioning. For example, chronic minor stresses (e.g., work stress, financial stress, and family of origin stress) increase the likelihood of couple tension and conflict (Bodenmann, 2005). Bodenman, Ledermann, and Bradbury (2007) extended these findings in a cross-sectional study examining the association between stress and relationship functioning among 198 heterosexual couples. The authors outlined four ways that chronic external stress affects couple functioning, by: (a) decreasing the time partners spend together, resulting in a reduction in shared experiences and weakening feelings of togetherness, decreasing self-disclosure, and jeopardizing dyadic coping; (b) decreasing communication quality by eliciting less positive interaction and more negative interaction and withdrawal; (c) increasing the risk of psychological and physical problems (e.g., sleep disorders, sexual dysfunction, mood disturbances); and (d) increasing the likelihood that problematic personality traits are expressed between partners (e.g., in the form of rigidity, anxiety, hostility).

Along with psychological and physiological outcomes, stress also affects physical intimacy in relationships. Stress in the form of marital tension and conflict covaries with lower sexual satisfaction and increased prevalence of sexual dysfunction (Hurlbert, Apt, Hurlbert, & Pierce, 2000). Conversely, satisfying sexual relationships (i.e., satisfaction with the quality and frequency of sex and the absence of sexual dysfunction) are linked to lower levels of stress in the

form of marital conflict (Metz & Epstein, 2002). Overall, higher levels of stress have been linked to lower levels of relationship satisfaction (Bodenmann, 2005; Cohan & Bradbury, 1997; Harper, Schaalje, & Sandberg, 2000) and relationship quality (Bodenmann, 2005; Cohan & Bradbury, 1997; Whiffen & Gotlib, 1989; Williams, 1995).

The numerous detrimental stress-related outcomes detailed above have been shown to negatively predict relationship stability (Williams, 1995). In a study of the influence of stress on marriage, Bodenmann and Cina (2000) demonstrated that divorced and distressed couples reported significantly higher rates of stress leading up to separation than stable nondistressed couple. The effect of stress on relationship stability has far-reaching impacts beyond the individual, extending to the community and societal levels. In addition to the personal costs of separation and divorce (e.g., legal and court fees, housing, and loss of revenue due to low work productivity), there are social costs (e.g., bankruptcy, welfare, insurance assistance, crime, and addition) and an increased burden on public institutions to mitigate the negative effects. Considering the range of negative effects of divorce, society has a vested interest in promoting healthy relationships and preventing separation and divorce.

Because close relationships come in diverse forms, it is prudent to examine how relationship distress may affect different types of relationships, including same-sex couples. The vast majority of studies comparing lesbian and gay (LG) and heterosexual couples on various relationship factors have found more similarities than differences. Similarities include comparable predictors and levels of relationship quality (Julien, Chartrand, Simard, Bouthillier, & Begin, 2003; Kurdek, 2004, 2006; Peplau & Fingerhut, 2007), appraisals of as well as contributors to relationship satisfaction (Blumstein & Schwartz, 1983; Cardell, Finn, & Marecek, 1981; Duffy & Rusbult, 1986; Howard, Blumstein, & Schwartz, 1986; Kurdek, 2001; Kurdek &

Schmitt, 1986; Metz, Rosser, & Strapko, 1994); and factors that contribute to relationship commitment (Kurdek, 2000; Peplau & Spalding, 2000). The main difference between couples lies in the unique stress faced by LG couples that is added to the general stressors experienced by all people. This stress has been termed minority stress; the psychosocial stress resulting from minority status (Brooks, 1981). Meyer (1995) explained minority stress specific to lesbian, gay, and bisexual (LGB) individuals as the increased stress LGB people are exposed to as a result of living in an environment that is stigmatizing of their sexual orientation and identity. For example, LGB individuals often face discrimination due to their sexual orientation, may fear rejection and hide their sexual orientation as a result, and may internalize the dominant culture's anti-LGB beliefs.

Although the effects of minority stress on sexual minority individuals are well-researched (see Meyer, 2003), far fewer studies have focused on the link between minority stress and same-sex couple functioning (i.e., relationship quality and satisfaction). Nonetheless, evidence has emerged demonstrating that individuals in LG couples are negatively affected by minority stress (Balsam & Szymanski, 2005; Frost & Meyer, 2009; Jordan & Deluty, 2000; Mohr and Daly, 2008; Otis, Rostosky, Riggle, & Hamrin, 2006; Rostosky, Riggle, Gray, Hattan, 2007). Among individuals in same-sex couples, minority stress has been associated with decreases in relationship duration (Frost & Meyer, 2009), self- and partner-respect (Keller & Rosen, 1988), relationship quality/satisfaction (Balsam & Szymanski, 2005), comfort with sexuality (Green & Mitchell, 2002), and ability to cope with general stress (Elizur & Mintzer, 2003), as well as increases in withdrawal (Green & Mitchell, 2002), relationship problems (Frost & Meyer, 2009), cognitive burden, fatigue, and distress (Smart & Wegner, 2000).

Relationship satisfaction is of particular interest among these outcomes because of its

contribution to relationship stability. Same-sex couples whose partners are highly satisfied with their relationship are more likely to stay in the relationship (Kurdek, 2000; Peplau & Spaulding, 2000). While it is known that minority stress decreases relationship satisfaction, researchers have yet to examine these two variables as related to intimacy (defined as "the level of commitment and positive affective, cognitive, and physical closeness one experiences with a partner in a reciprocal (although not necessarily symmetrical) relationship" (p. 33); Moss & Schwebel, 1993) among same-sex couples. Intimacy has been associated with a multitude of benefits, including an improved sense of well-being (Riggs & Bright, 1997), improved physical health (Fehr &Perlman, 1985), a decreased likelihood of negative responses to stress (Perlman & Fehr, 1987) and lower psychiatric consultation rates (Horowitz & de Sales French, 1979); moreover, it provides purpose in life (Klinger, 1977). Findings from heterosexual samples demonstrate that stress and lack of intimacy decrease relationship satisfaction (Bodenmann, 2005; Cohan & Bradbury, 1997; Schaefer & Olson, 1981). Given that stress and lack of intimacy decrease relationship satisfaction in heterosexual couples, we can expect the same relationship in LG couples. The proposed research seeks to fill this gap in the literature.

Emotional intimacy specifically is of interest among same-sex couples because it has been identified as the most prominent contributor to relationship satisfaction in LG couples (Deenen, Gijs, & Van Naerssen, 1994; Eldridge & Gilbert, 1990). Emotional intimacy was most related to relationship satisfaction above verbal and physical intimacy among gay men (Deenen, Gijs, & Van Naerssen, 1994) and above intellectual, recreational, sexual, and social intimacy among lesbian women (Eldridge & Gilbert, 1990). Emotional intimacy has been defined as the perception of closeness to another (Sinclair & Dowdy, 2005). Thus far, there is a lack of research linking minority stress and emotional intimacy. However, current findings on the experience of

minority stress in same-sex couples provide a basis for supposing that a relationship exists. For example, studies have shown that same-sex couples experience discrimination based on their same-sex relationship (Rostosky et al., 2007). It can be deduced that this social context may make it difficult for same-sex partners to connect and embrace their relationship. The couple may feel less stable and secure; and partners may be less open with one another. It is reasonable to infer that these difficulties (i.e., problems connecting with one's partner, feeling secure, and being open) affect emotional intimacy.

Among heterosexual couples, stress has been shown to increase couple conflict (Bodenmann, 2005), negative interactions, and hostility, and decrease self-disclosure, sense of togetherness, and time spent together as a couple (Bodenmann et al., 2007). All of these negative outcomes can be reasoned to affect intimacy. Moreover, researchers have demonstrated a direct link between stress and intimacy among heterosexual couples (Ditzen, Hoppmann, & Klumb, 2008; Prager, 1995). Considering the many similarities between LG and heterosexual couples, it is hypothesized that there is a similar link between minority stress and emotional intimacy among individuals in same-sex couples.

Rationale for the Proposed Study

The effects of stress on intimate relationships have been well researched in heterosexual couples, including links to psychological and physical health outcomes and decreased relationships satisfaction. Although stress in LG couples is less researched, our understanding of the unique stresses faced by LG individuals provides a framework for possible effects among individuals in same-sex couples. For example, sexual minority stress has been linked to mental health issues, sexual risk behavior, and suicidal ideation and behavior, to name only a few (Hatzenbuehler, Nolen-Hoeksema, & Erickson, 2008; Meyer, 1995; Diaz, Ayala, Bein, Henne, &

Marin, 2001; Mays & Cochran, 2001; Herek, Gillis, Cogan, 1999). It is understandable that if a partner in a same-sex couple experiences any of these factors (i.e., psychological/physical sequelae), the couple as a whole will be affected. In fact, research shows that stress experienced by one member in a couple will have effects on the other (Otis et al., 2006). Although health outcomes have not yet been the focus, research on minority stress in LG couples has demonstrated that the challenges and stressors faced by LG individuals are also present among individuals in same-sex couples. These include experiences of discrimination, internalized homonegativity, concealment, and rejection (Mays, Cochran, & Rhue, 1993; Balsam & Szymanski, 2005; Foster, 2005). In view of the fact that stress contributes to negative psychological and physical health outcomes in heterosexual couples and minority stress similarly affects LG individuals, it can be assumed that minority stress has important implications for the health of individuals in LG couples.

Emotional intimacy has been inversely related to negative health outcomes in heterosexual samples (Orth-Gomer, Rosengren, & Wilhelmsen, 1993); the connection may also be present in LG couples who are highly similar to their heterosexual counterparts. Both stress and a lack of intimacy negatively impact relationship satisfaction in heterosexual couples (Bodenmann, 2005; Cohan & Bradbury, 1997; Schaefer & Olson, 1981), which in turn is an important contributor to relationship longevity (Barnes, Brown, Krusemark, Campbell, & Rogge, 2007). Taking these health and relationship functioning implications into consideration, relationship satisfaction is an important factor to add to the investigation of minority stress and emotional intimacy.

The investigation of minority stress, emotional intimacy, and relationship satisfaction will lend invaluable insight into the psychological and physical health and relationship functioning of

same-sex couples. In addition, the study may provide information about resilience and vulnerability factors related to same-sex couple distress. The findings will also be useful for guiding future treatment of LG couples seeking therapy. On a broader level, considering that universal rights are not yet a reality for nonheterosexual people, findings may be used as incentive in the fight for equality. By demonstrating that sexual minority stress affects same-sex couples in terms of health outcomes, it can be argued that a more egalitarian society would remove the barriers to optimal wellness for partners in same-sex couples.

Chapter Two: Literature Review

The following review of the literature begins with an exploration of scholarship on LG couples, with particular emphasis on unique stressors among this population. Minority stress theory will be outlined, followed by individual and couple level effects, including an emphasis on barriers to intimacy. Studies of intimacy in heterosexual couples will be examined, proceeded by the scant research among LG couples. The final aspect of the review will be an exploration of research on emotional intimacy in heterosexual couples, with a subsequent critical examination of current knowledge of emotional intimacy in same-sex couples. The literature review will conclude by highlighting gaps in our current knowledge.

Overview of Lesbian and Gay Couples Research

As has been the case historically, LG individuals in same-sex relationships live in a social context where they are stigmatized as a result of both their sexual minority identity and their romantic involvement with a same-sex partner (Frost & Meyer, 2009; Peplau & Fingerhut, 2007; Rostosky, et al., 2007; Todosijevic, Rothblum, & Solomon, 2005). Same-sex relationships do not receive the same universal support and recognition as different-sex relationships (Herek, 2006) and as such LG couples experience stigmatization, prejudice, and discrimination. There is a common lay view that committed same-sex relationships are inferior to heterosexual partnerships in various ways, including the belief that individuals in LG couples are psychologically maladjusted (Roisman, Clausell, Holland, Fortuna, & Elieff, 2008). Contributing to this stance is the fact that although progress has been made, some adults in the United States still hold negative attitudes toward same-sex behavior and view it as wrong and unnatural (Avery, Chase, Johansson, Litvak, Montero, & Wydra, 2007). Attitudes toward LG individuals are more positive in Canada (Morrison, Morrison, & Franklin, 2009), yet negative attitudes toward LG individuals

still exist. Also influencing the negative assumptions about LG individuals and couples is the fact that homosexuality was until very recently (1973) pathologized in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) used by professionals in the mental health field. It is reasonable to assume that the current and historical contexts of stigmatization, prejudice, and discrimination faced by LG couples bring about distinct stressors not experienced by heterosexual couples.

In order to conceptualize the relationship between minority stress, emotional intimacy, and relationship satisfaction, a review of the literature comparing heterosexual and same-sex couples is warranted. Examining the differences between them lends insight into the unique stressors faced by LG couples. Studies comparing LG and heterosexual couples focus on three main areas: (a) relationship quality, (b) relationship satisfaction, and (c) relationship commitment. Although relationship satisfaction and commitment tend to be viewed as part of relationship quality, they are often studied independently. The first area of research comparing LG and heterosexual couples focuses on relationship quality. Spanier (1976), combining themes across various preexisting measures of marital satisfaction and adjustment, defined relationship quality as "the degree of (1) troublesome dyadic differences; (2) interpersonal tensions and personal anxiety; (3) dyadic satisfaction; (4) dyadic cohesion; and (5) consensus on matters of importance to dyadic functioning" (p. 17). Nearly all studies comparing LG and heterosexual couples on relationship quality find similar predictors and levels of relationship quality (Julien, et al., 2003; Kurdek, 2004, 2006; Peplau & Fingerhut, 2007). For example, Kurdek (2004) compared gay and lesbian cohabitating couples to heterosexual married couples (80, 53, and 80 couples respectively) across five domains indicative of relationship quality. Participants in this longitudinal study were mainly White. Results demonstrated that relationship quality was

predicted by psychological adjustment (e.g., severity of distress), personality (e.g., neuroticism), relationship styles (e.g., equality), conflict resolution (e.g., effective arguing), and social support (e.g., satisfaction with social support) equally well for heterosexual and LG couples. Thus, processes that influence relationship quality generalized across gay, lesbian, and heterosexual couples. Moreover, Peplau and Fingerhut (2007) reviewed empirical studies of same-sex couples and concluded that same-sex and different-sex couples score remarkably similar on standardized measures of relationship quality such as Spanier's (1976) Dyadic Adjustment Scale.

The second area of research comparing LG and heterosexual couples focuses on relationship satisfaction. In their review of marital satisfaction literature, Bradbury, Fincham, and Leech (2000) stated that, although defined differently over the years, relationship satisfaction reflects a context in which positive features are salient and negative features are more or less absent. Studies show that satisfaction is enhanced by similarity in partners' background, attitudes, and values (Kurdek & Schmitt, 1987), by partners perceiving many rewards, such as companionship, and few costs, such as conflict, from their relationship (Beals, Impett, & Peplau, 2002; Duffy & Rusbult, 1986; Gottman et al., 2003), and by positive emotions (Gottman et al., 2003). Decreased relationship satisfaction, on the other hand, has been linked to arguing about power and intimacy and to the emotions of contempt, disgust, and defensiveness for all couples (Gottman et al., 2003, Kurdek, 1998). Not only are the processes influencing relationship satisfaction similar between different-sex and same-sex couples, but the majority of evidence indicates that there are few, if any, differences in concurrent appraisals of relationship satisfaction among heterosexual, gay, and lesbian partners (Blumstein & Schwartz, 1983; Cardell, Finn, & Marecek, 1981; Duffy & Rusbult, 1986; Howard et al., 1986; Kurdek, 2001; Kurdek & Schmitt, 1986; Metz et al., 1994). These findings that demonstrate similar appraisals

of and contributors to relationship satisfaction, combined with the findings regarding similar levels and predictors of relationship quality, suggest that gay and lesbian relationships operate on essentially the same principles as heterosexual relationships.

Finally, researchers have compared LG and heterosexual couples on relationship commitment, which consists of the decision to stay involved in the current relationship and to maintain the relationship in the future (Sternberg, 1988). Findings indicate that the same factors contribute to relationship commitment and longevity for both different-sex and same-sex couples (Kurdek, 2000; Peplau & Spalding, 2000). These factors include the availability of alternatives to the present relationship (e.g., a more desirable partner), barriers that make leaving difficult (e.g., investments that boost the psychological, financial, emotional, and financial costs of ending the partnership), and positive attraction forces that motivate partners to remain together (e.g., love and satisfaction). While the same factors contribute to relationship longevity among heterosexual couples as among LG couples, there are fewer barriers to relationship dissolution for LG couples because of a lack of universal political and structural recognition of their relationships (Kurdek, 1998). For example, if same-sex marriage was legalized worldwide and consequently more LG couples had to contend with divorce, the barriers to leaving the relationship as well as relationship longevity would likely be more similar across couples.

Stressors unique to lesbian and gay couples. Although studies comparing same-sex and different-sex couples emphasize an abundance of similarities, dissimilarities exist as well. One of the most salient differences warranting special consideration lies in the unique stressors faced by same-sex couples that are not experienced by their heterosexual counterparts. A pivotal challenge for same-sex couples is cultural oppression, specifically homophobia, heterosexism, and the internalization of both (internalized homonegativity), which affect individual functioning

and couple dynamics (Brown, 1995). Homophobia has been defined as hostility and prejudice toward lesbian and gay individuals and their behavior (Herek, 1996). Examples range from violence and victimization to everyday insults in casual conversation (Connolly, 2004). Other areas of homophobia include discrimination in employment, housing, access to education and human services, and the denial of basic human rights (Harper & Schneider, 2003). Closely related to homophobia is heterosexism, which Herek (1992) defined as "an ideological system that denies, denigrates, and stigmatizes any nonheterosexual form of behavior, identity, relationship or community" (p. 89). Heterosexual bias translates into selective privilege; those who fit the heterosexual norm benefit while there is a lack of privilege for individuals who deviate from the norm. While the two terms are similar, homophobia tends to be used to describe individual antigay attitudes and behaviors, whereas heterosexism refers to societal-level ideologies and oppression of nonheterosexual people (Herek, 2000). Continued exposure to homophobia and heterosexism can lead LG individuals to apply anti-LG beliefs to themselves, which is termed internalized homonegativity (Williamson, 2000). LG people may feel self-hatred and guilt and doubt the potential for longevity in same-sex relationships (Ossana, 2000), which in turn can undermine relational confidence (Slater & Mencher, 1991).

Another product of living in a heterosexist culture is that members of LG couples often struggle with the coming out process. It is not uncommon for same-sex couples to uphold multiple identities and expend considerable energy compartmentalizing their relationship, hiding it in some environments while being open in others (Davison, 2001). For example, a couple might be openly lesbian/gay at social gathering with close friends who are aware of their sexual orientation, while they may remain closeted and claim to be roommates when visited by family members who are not aware of one or both partners' sexual minority identity. When the couple is

rendered invisible, same-sex couples are denied the support that heterosexuals experience during times of crisis (Roth, 1985) and important couple milestones such as anniversaries (Johnson & Colucci, 1999). LG couples are faced with enduring the stresses associated with invisibility or risking the consequences of disclosure. Such risks can include rejection from friends and family members, alienation at the place of work, and verbal and physical attacks from strangers. An added complication to the coming out process is the potential for members in the couple to differ in degrees of outness, the level of self-disclosure about one's sexual orientation (Herek, Gillis, Cogan, & Glunt, 1997). For example, if only one partner is out, the out partner may feel devalued by the closeted partner's lack of public acknowledgment of the relationship. Overall, studies of concealment illustrate the social context LG couples face, which can lead to negative psychological consequences. These include preoccupation, suspicion, increased vigilance, negative affective states, increased self-monitoring and impression management, increased social avoidance and isolation, diminished self-efficacy, and negative views of the self (Pachankis, 2007). Understandably, these psychological states are not conducive to emotional intimacy in LG couples.

Heterosexism and homophobia as described above contribute to one of the most prominent differences between heterosexual and LG couples: same-sex couples are less likely to experience social support from family members (Kurdek, 2004). A lack of familial validation of the couple's status can lead to partners feeling pulled between loyalty to the family and to the partner (Bepko & Johnson, 2000). For example, a member of a same-sex couple may be invited to a wedding as a single guest, disregarding his/her longstanding relationship. The individual in question may want his/her partner included in this important family event while at the same time feel obliged to respect the family's decision. This struggle may result in distance and

defensiveness in the couple (Bepko & Johnson, 2000). The findings regarding the potential for a lack of social support from family members signify that LG couples function in a social context that is very different from that of heterosexual couples (Meyer, 2003). Different-sex couples benefit from social support for their relationship and that support from members of one's social network affects the health of one's relationship (Kurdek, 2004). Moreover, different-sex couples are more likely to benefit from legal, social, political, economic, and religious support, all of which contribute to a positive social context unlike that faced by their same-sex counterparts.

Homophobia and heterosexism combined with mainstream gender norms often lead to stereotyped assumptions about lesbians and gay men, which negatively impact same-sex couples (Bepko & Johnson, 2000). Historically, sexual minority status has been equated with gender inversion: gay males have been presumed to be more like women than men, whereas lesbians have been presumed to be more like men (Minton, 1986). Additionally, there is an erroneous belief that one person plays the female role while the other plays the male role in same-sex relationships. Dichotomizing gender in such a way creates a specific stress for LG couples such that violations of traditional gender norms can result in shame, anxiety, and devaluation of self (Bepko & Johnson, 2000). Moreover, the stress of heterocentric stereotyped assumptions about gender roles affects couple functioning (Bepko & Johnson, 2000). For instance, a gay male may act in a masculine manner to hide his feminine side, affecting the couple's sexual repertoire by only assuming the top/insertive position so as to maintain a sense of masculinity within the couple.

Minority Stress Theory

Arguably, the biggest difference between individuals in different-sex and individuals in same-sex relationships is the experience of stressors related to their sexual minority status.

Stigma, prejudice, and discrimination directed at members of stigmatized minority groups engender a social environment that is stressful, which can bring about mental health problems (Friedman, 1999). This phenomenon is often described through minority stress theory (Brooks, 1981; Meyer, 1995). Minority stress is psychosocial stress resulting from minority status (Brooks, 1981). It demarcates the excessive stress that individuals from stigmatized social groups are subject to as a consequence of their marginalized and oppressed status. That is, it is additive to general stressors experienced by all people. Brooks (1981) originally defined the term as "a state intervening between the sequential antecedent stressors of culturally sanctioned, categorically ascribed inferior status, resultant prejudice and discrimination, the impact of these forces on the cognitive structure of the individual, and consequent readjustment or adaptational failure" (p. 84).

Meyer (1995) furthered minority stress theory by applying the construct to lesbian, gay, and bisexual (LGB) individuals specifically and operationalized minority stress into five components: experiences of discrimination, anticipated rejection, hiding and concealing their identities, dealing with internalized homonegativity; and coping strategies. Experiences of discrimination refer to specific instances of discrimination on the grounds of sexual orientation (Harper & Schneider, 2003). Anticipated rejection applies to LGB people's chronic anticipation and expectation of negative regard, discrimination, and violence from members of the dominant culture (Meyer, 2003). Hiding and concealing pertains to concealing one's sexual orientation in order to avoid the negative consequences of stigma (Meyer, 2003). Internalized homonegativity is the application of anti-LGB beliefs to the self, and as such can be viewed as a form of self-stigmatization (Williamson, 2000). Coping strategies are developed by LGB individuals in response to the first four factors (Meyer, 2003).

Experiences of minority stress affect the well-being of LG individuals. For example, studies link it to HIV risk behavior, substance use, depressive symptoms (Hatzenbuehler et al., 2008), generalized anxiety disorder (GAD), and attention deficit hyperactivity disorder (ADHD) (Frisell, Lichtenstein, Rahman, & Langstrom, 2010). Reflecting the first factor of minority stress, experiences of prejudice events specifically have been associated with suicidal ideation and behavior, psychological distress, guilt (Meyer, 1995), anxiety, depression (Diaz et al., 2001), stress-sensitive psychiatric disorders (Mays & Cochran, 2001), anger, post-traumatic stress (Herek, et al., 1999), somatic symptoms, and insomnia (Ross, 1990). Anticipated rejection, the second factor, has been related to chronic vigilance that drains energy and causes psychological distress (Meyer, 2003). The third factor, hiding and concealing one's sexual orientation, has been linked to cognitive burden due to the constant preoccupation with hiding (Smart & Wegner, 2000) as well as adverse psychological, health, and job-related outcomes (Waldo, 1999). Regarding the fourth factor, internalized homonegativity has been shown to relate to depression and anxiety, substance use disorders, suicidal ideation (DiPlacido, 1998; Meyer & Dean, 1998; Williamson, 2000), high levels of demoralization, and low self-esteem (Herek et al., 1997).

The negative effects of minority stress have been demonstrated in various age groups. Lesbian, gay, and bisexual youth who experience at-school victimization have demonstrated higher levels of substance use, suicidality, sexual risk behaviors (Bontempo & D'Augelli, 2002), school-related problems, running away from home, conflict with the law, and engagement in sex work (Savin-Williams, 1994). LGB older adults who experience victimization show low self-esteem, loneliness, and poor mental health outcomes (D'Augelli & Grossman, 2001). Clearly, LG people are at risk for excess mental distress and disorders due to the stress associated with their sexual orientation. Moreover, studies focused on LG relationships have found that minority

stress affecting individuals also affects same-sex couples (e.g., Kurdek, 2000; Otis et al., 2006; Rostosky & Riggle, 2002).

Review of Minority Stress in Lesbian and Gay Couples

Given the interdependent nature of couples, stress experienced by one partner will have a negative impact on the other partner (Kurdek, 2000; Otis et al., 2006; Rostosky & Riggle, 2002). LG couples live in a climate epitomized by prejudice and stigmatization associated with their sexual minority identity and, as a consequence, their relationships. Rostosky et al. (2007) conducted a qualitative study among predominantly White participants (20 female and 20 male couples) that illustrated how the individual effects of minority stress are also experienced at the couple level. For example, the couples shared common manifestations of minority stress in their everyday lives that included experiences of discrimination by legal and religious institutions, a lack of legal rights and protections, and experiences of negative stereotypes and attitudes from others. Couples also anticipated and experienced rejection from their families of origin (e.g., refusal to acknowledge the same-sex partner in a holiday greeting card) and strangers in public (e.g., yelling insults). The decision to disclose or conceal the same-sex relationship often depended on whether or not the partners experienced or anticipated rejection. For instance, if they anticipated rejection, couples monitored their behavior so as not to appear in a relationship and failed to acknowledge their partner with family members. Internalized homonegativity was evidenced in participant statements reflecting negative attitudes about homosexuality directed toward the self or relationship (e.g., “Two women or two men can hardly find any place in the world to have a public, legal marriage ceremony,” p. 396) or a struggle to accept their sexuality (e.g., “I still fight homophobia within myself,” p. 396). Couples demonstrated coping processes and strategies that they used to deal with minority stress, such as self-acceptance, positive views

of the relationship, externalizing rejection experiences, and creating support systems. These qualitative results lend support to the notion that LG people experience minority stress both at the individual and couple level.

While minority stress as experienced by individuals and couples appears similar, research on the links between couple minority stress and relationship functioning (i.e., relationship quality and satisfaction) is limited. The first component of minority stress, experiences of discrimination, has been largely looked at as a contributor to relationship concealment (the third factor). While the link between sexual orientation discrimination and relationship functioning has not been a major focus within same-sex couples literature, three studies merit mention.

Mays and colleagues (1993) conducted a cross-sectional qualitative study that examined the effects of perceived racial/ethnic and sexual orientation discrimination. Eight African American women were interviewed about how discrimination affected their same-sex relationship. Participants reported experiencing homophobia from the African American community. This discrimination affected their psychological well-being, including feelings of anger, frustration, and inferiority. However, the women reported that sexual orientation discrimination did not affect their intimate relationships. The authors highlighted that their findings from eight participants could not be generalized and called for future studies to examine how the negative effects on psychological well-being influence the quality and maintenance of intimate relationships.

Otis and colleagues (2006) conducted a cross-sectional study of the relationship between sources of minority stress and same-sex relationship quality. The sample consisted of 85 lesbian couples and 46 gay male couples, both groups being predominately White. The authors found that perceived discrimination was not a predictor of relationship quality (i.e., partners felt that

their needs were met and they reported high relationship satisfaction). The authors suggested that because minority stress tends to be a pervasive and continuous part of life, discrimination might be experienced as a constant rather than additive aspect. As such, perhaps only the most grievous instances impact relationship quality; however, the study in question did not assess the severity of the discrimination experience. The authors suggested that future analyses should investigate how more traumatic experiences of discrimination may influence the quality of intimate relationships.

Finally, Balsam and Szymanski (2005) conducted a cross-sectional study of the impact of discrimination on relationship quality among women in same-sex relationships. Participants consisted of 272 predominantly White lesbians reporting domestic violence. Findings revealed that discrimination was not related to relationship quality. Even though they experienced discrimination, participants reported positive interactions, affection, harmonious accord, and high appreciation/low strain in their relationships. The authors hypothesized that same-sex couples may be better equipped to cope with experiences taking place outside of the relationship than internal beliefs (e.g., internalized homonegativity), which are more hidden. Otherwise, the couple relationship might serve as a safe haven from discrimination, buffering partners from negative effects. The authors indicated that perhaps the more stressful experiences of discrimination have a greater impact on relationship functioning. As such, they called for future research to measure the perceived impact of discriminatory events in addition to the occurrence.

Although studies have found that sexual orientation discrimination does not impact relationship functioning, studies of the impact of racial discrimination on relationship functioning in heterosexual couples have found positive correlations. Of particular interest are studies that examined degree of discrimination (the severity of the discrimination experience),

which speak to Otis and colleagues' (2006) as well as Balsam and Szymanski's (2005) call for studies to examine discrimination by level. For example, Murry, Brown, Brody, Cutrona, and Simons (2001) investigated the effects of racial discrimination on intimate relationships among 386 African American couples. Findings from the cross-sectional study indicated a main effect between racial discrimination and relationship quality. In addition, the authors found an interaction effect, such that the higher the level of racial discrimination, the stronger the link between psychological distress and decreased relationship quality. This interaction between discrimination and distress demonstrated a moderating effect, such that racial discrimination amplified other ongoing stressors. Being that same- and different-sex couples are similar in many ways, findings from such studies may provide insight into the potential effects of discrimination among LG couples. It may be that if studies examined the degree of sexual minority discrimination, positive correlations with relationship functioning would emerge.

Given the scarcity of studies examining discrimination and relationship functioning, there is a clear need for further study of the impact of discrimination on individuals in same-sex couples. At the same time, the existing studies elicit questions pertaining to intimacy. For example, when a partner feels anger, frustration, or inferiority brought on by an experience of discrimination, he/she may not be in a state of mind conducive to relating intimately with his/her partner. Although it has not been demonstrated that discrimination affects relationship functioning directly, it may be that consequences of discrimination such as psychological distress serve as barriers to connecting with one's partner. Moreover, future studies may find links between experiences of discrimination and relationship functioning by examining the degree of discrimination. Finally, because studies consisted of mainly White participants, this raises questions about the generalizability of findings to couples from a wider range of ethnic

backgrounds.

The second component of minority stress, anticipated rejection, has not been a focus of relationship outcome studies. The construct has mainly been considered as a precursor to the third component, relationship concealment. That is to say, because same-sex partners expect to be rejected by family and friends who stigmatize their relationship, they may hide their relationship. This concealment of the couple must be understood in the context of cultural oppression in that these individuals and couples are constantly confronted with the decision of how and when to disclose their sexual identity and relationship to others who may react negatively. Goffman (1963) posited that people with nonvisible stigmas (e.g., LG individuals) might hide stigmatizing characteristics and "pass" as someone without the characteristics (i.e., pass as heterosexual) so as to manage their public identity.

It stands to reason that under certain circumstances, it is in LG individuals' best interests to conceal their sexual orientation. For instance, someone living in a homophobic environment may risk loss of employment or violence by coming out. Although concealment may result in the avoidance of prejudice and discrimination, researchers have outlined several disadvantages to concealing one's sexual orientation. For example, Smart and Wegner (2000) described how persistent concealment could bring about heavy cognitive burden. Longstanding burden can then lead to fatigue and distress, with the implication that an increase in stress levels can eventually make the relationship less rewarding (Foster, 2005). Concealment has also been linked to decreased relationship satisfaction through a devaluation of the relationship (Berzon, 1988) as well as to anxiety about the relationship (Jordan & Deluty, 2000). Additionally, concealment can deprive LG individuals of social support. For example, an individual can become isolated within the same-sex relationship, decreasing or eliminating external validation and support for the

relationship (Almeida, Woods, Messineo, Font, & Heer, 1994). Decreased support can lessen the couple's ability to effectively cope with the stresses and strains faced by all couples (Elizur & Mintzer, 2003) and can contribute to relationship dissolution by removing a constraint (i.e., social pressure) for remaining in the relationship (Kurdek & Schmitt, 1987). Conversely, sexual orientation disclosure can positively affect relationship quality by increasing acknowledgement and validation of the couple from important others (Beals & Peplau, 2001). Taken together, the consequences of concealment can be presumed to hinder intimacy. It can be deduced, for example, that if partners are experiencing anxiety or fatigue from concealment, they are less likely to be in a state of mind conducive to feel close to one another. Similar to studies of discrimination among LG couples, the above-described studies lacked racial diversity in their samples. Therefore, it is questionable whether the effects of concealment in samples of White couples generalize to racial-minority or mixed-race couples.

The fourth component of minority stress, internalized homonegativity, has been linked to several negative relationship outcomes among individuals in LG couples. These outcomes include: decreased relationship quality (Balsam & Szymanski, 2005; Elizur & Mintzer, 2003), greater relationship problems (Frost & Meyer, 2009), isolation from the community and negative expectations of relationship quality and longevity (Otis et al. 2006), and decreased relationship attractions and constraints (i.e., reduction in the degree that partners and relationships are enjoyed and a reduction in relationship investment and barriers to leaving; Mohr & Daly, 2008). Frost and Meyer (2009) reasoned that to alleviate negative feelings stemming from the application of anti-gay beliefs to the self, individuals may either avoid lasting and deep relationships with other LG people or seek out opportunities for sexual expression lacking in intimacy and interpersonal closeness. In long-term LG relationships, one's partner and shared

experiences become constant reminders of one's own sexual orientation and related negative feelings toward the self as lesbian or gay. Such beliefs reduce both self-respect and respect for one's partner even amid feelings of genuine affection between partners (Keller & Rosen, 1998) and may negatively affect relationship functioning by increasing levels of depression, interpersonal withdrawal, and inhibited sexuality (Green & Mitchell, 2002). Overall, applying anti-LGB beliefs to the self can be reasoned to impact intimacy; it might make it difficult to relate to one's partner when he or she inherently embodies the negative beliefs stemming from internalized homonegativity by being lesbian or gay. The couple might be less stable and secure as a consequence, thus exhibiting less openness and sharing, another hindrance to intimacy. Once again, the studies described above mainly focused on White samples, which raises questions about how internalized homonegativity is experienced in sexual minority couples.

The fifth and final component in the minority stress model, coping, has not been a major focus of LG couple studies. Scholarship as summarized above has tended to concentrate on experiences of minority stress without examining how couples cope with these experiences. However, Rostosky et al. (2007) conducted a notable study that shed light on the coping strategies used by LG couples to deal with minority stress. The authors interviewed 40 same-sex couples (20 male; 20 female) and found four general types of coping processes: reframing negative experiences (as empowering rather than diminishing the experiences), concealing their relationship (when concealing one's identity outweighs the potential benefits of disclosing a relationship), creating social support (composed of family members, friends, other gay couples, and the intimate partner), and affirming self and partnership (i.e., self-acceptance as a sexual minority and positive views of the couple relationship). In their review of the literature on same-sex couples, Peplau and Fingerhut (2007) noted the lack of LG couple studies focused on coping.

They concluded their review by emphasizing that along with research on the ways in which discrimination affects same-sex couples, it is equally important for future studies to examine resilience in the form of coping.

Based on the foregoing review, it is reasonable to deduce that a relationship exists between minority stress and intimacy. As outlined, minority stress has been linked to the following: a decrease in the degree that the partner and relationship are enjoyed, negative attitudes toward the same-sex relationship, greater relationship problems, a reduction in respect for one's partner, and an increase in depression, interpersonal withdrawal, and inhibited sexuality. It is logical for any one of these factors to affect intimacy within a couple. Put differently, the everyday strains of minority stress may make it difficult for partners to connect, hindering intimacy within the relationship.

Review of Intimacy in Lesbian and Gay Couples

Although less studied in LG couples, the importance of intimacy has been consistently highlighted in the literature on heterosexual couples. Failure to develop a close, confiding relationship with a partner has far-reaching consequences for a person's well-being. These include experiences of loneliness (Derlega & Margulis, 1982), decreased relationship satisfaction (Schaefer & Olson, 1981; Waring, McElrath, Mitchell, & Derry, 1981), physical illness (Reis, Wheeler, Kernis, Spiegel, & Nezlek, 1985), and psychiatric symptoms such a depression (Brown & Harris, 1978; Costello, 1982; Hickie et al. 1990). Although people strive for romantic intimacy and it is recognized as promoting health (Frankel, 1982; Greenberg & Johnson, 1986; Medalie & Goldbourt, 1976; Patton & Waring, 1984), there has been no consensus in the literature on a definition of intimacy. The lack of consensus makes it difficult to compare studies; one cannot say for certain that identical constructs are being measured. Moss and Schwebel (1993)

conducted an extensive computer-assisted search of scholarly publications for definitions of intimacy and found 61 definitions. Based on the themes and components generated by their literature review, the authors proposed the following previously-stated definition: "Intimacy in enduring romantic relationships is determined by the level of commitment and positive affective, cognitive, and physical closeness one experiences with a partner in a reciprocal (although not necessarily symmetrical) relationship" (p. 33).

Studies of intimacy in LG relationships have predominantly focused on two areas: fusion in lesbian couples and nonmonogamy in gay male couples. Fusion has been described as the circumstance when partners are so close that their individual identities become embedded in the relationship and one or both partners experience a loss of individuality (Karpel, 1976). The term fusion has been used as an indicator of impaired functioning and is often identified as a target of treatment. Frost and Eliason (2014) conducted a review of the literature and found no empirical evidence that fusion is more commonplace among women in same-sex relationships than among men in same-sex relationships or among men and women in heterosexual relationships. It is important to note that some lesbian partners may consider fusion/closeness natural and satisfactory because the diffusion of boundaries might be experienced positively (Ackbar & Senn, 2010; O'Brien, 2003; Salisbury, 2003; Schreurs & Buunk, 1996; Slater & Mencher, 1991). Specifically, it has been hypothesized that closeness in lesbian couples may reflect high degrees of love, trust, and commitment between partners (Biaggio, Coan, & Adams, 2002).

Studies examining nonmonogamy in gay male couples have shown that they are more likely to condone extradyadic sex than lesbian or heterosexual couples ("Advocate Sex Pole," 2002; Blumstein & Schwartz, 1983; Bryant & Demian, 1994). Over the years, research findings on nonmonogamy have been equivocal, making it unclear whether nonmonogamy is related to

couple functioning (Bell & Weinberg, 1978; Blasband & Peplau, 1985; Blumstein & Schwartz, 1983; Kurdek & Schmitt, 1986; McWhirter & Mattison, 1984; Saghir & Robins, 1973). However, the most recent studies have repeatedly emphasized that nonmonogamous gay relationships are as conducive to satisfactory, functional, and committed relationships as their monogamous counterparts (Bepko & Johnson, 2000; Bonello & Cross, 2010; LaSala, 2004, 2005). Accordingly, earlier heterocentric models linking sexual exclusivity with intimacy might not have reflected the preferences and realities of all gay male couples.

Though studies of intimacy in LG couples have predominately focused on fusion and nonmonogamy, recent research has begun to explore the link between minority stress and intimacy. In the first noted study relating minority stress to intimacy, Frost (2011a) investigated the psychological strategies individuals in same-sex couples ($N = 431$) use to negotiate stigma and its connection to intimacy in their relationships. The study was cross-sectional and participants were predominantly White. The strategies revealed could be categorized as either negative (e.g., framing stigma as a heavy weight or a contamination) or positive (e.g., stigma eliciting activism or reinventing notions of commitment and relational legitimacy). Many participants framed stigma as bringing them closer to their partners and strengthening the bond within their relationships. The findings highlighted that many individuals in same-sex couples describe having satisfying and successful relationships despite persistent experiences of stigma and minority stress. In the same year, Frost (2011b) analyzed the relationship stories of lesbian, gay, and bisexual individuals in same-sex relationships ($N = 99$). The cross-sectional study was qualitative in nature and participants were mainly White. Findings revealed that LGB individuals perceived more devaluation and barriers to achieving intimacy than heterosexuals. The pursuit of intimacy was highly meaningful for both LGBs and heterosexuals, however LGBs experienced

minority stressors from both interpersonal (e.g., negative attitudes) and macrosocial (e.g., discriminatory laws and policies) sources, which interfered with the pursuit of intimacy. Frost's work builds on previous research indicating that minority stress yields negative consequences for same-sex relationships. Furthermore, it is the first research to examine the link between minority stress and intimacy.

Emotional intimacy. While preliminary findings suggest that minority stress affects intimacy, there is a dearth of literature linking minority stress and emotional intimacy, which a small number of studies have identified as the strongest predictor of relationship satisfaction among individuals in LG couples (Deenen et al., 1994; Eldridge & Gilbert, 1990; Koepke, Hare, & Moran, 1992; Schreurs & Buunk, 1996). General intimacy, as previously discussed, is a broader concept and encompasses commitment, affective intimacy, cognitive intimacy, physical intimacy, and mutuality. Emotional intimacy, on the other hand, focuses primarily on a sense of emotional closeness. Though a singular definition has not emerged, the theme of emotional closeness runs throughout various studies of the construct. As mentioned, the bulk of research has focused on general intimacy. To illustrate, a recent PsycInfo key term search for the terms "intimacy" and "emotional intimacy" yielded 8405 and 180 results, respectively. Several investigators have examined emotional intimacy in heterosexual couples (Schaefer & Olson, 1981; Sinclair & Dowdy, 2005; Tolstedt & Stokes, 1983; Waring & Reddon, 1983) yet no singular definition has remained constant throughout the literature. Similar to the case of definitions of intimacy discussed previously, a lack of consensus on the meaning of emotional intimacy hinders the ability to compare studies. Nevertheless, a common thread can be observed when comparing the various definitions. For example, various authors have referred to emotional intimacy as "experiencing a closeness of feelings" (Schaefer & Olson, 1981, p. 53), "the degree

to which feelings of emotional closeness are expressed" (Waring & Reddon, 1983, p. 54), "feelings of closeness and emotional bonding" (Tolstedt & Stokes, 1983, p. 574), and "the perception of closeness to another that allows sharing of personal feelings, accompanied by expectations of understanding affirmation, and demonstrations of caring" (Sinclair & Dowdy, 2005, p. 193). Sinclair and Dowdy's definition of emotional intimacy is the most recent, is based on prior research on the construct, and is an integration of other researchers' definitions (e.g., Schaefer & Olson, 1981; Tolstedt & Stokes, 1983; Waring & Reddon, 1983). Emotional intimacy is differentiated from general intimacy by the emphasis on emotions.

The impact of emotional intimacy on psychological and physical health has been widely studied in heterosexual relationships. Emotional intimacy serves as the foundation for close relationships and can provide a sense of purpose and belonging (Goleman, 1997; Wood, 1984). Furthermore, emotional intimacy has been highlighted as a major factor contributing to emotional/psychological and physical well-being in studies of heterosexual couples (Ornish, 1998). Prager (1995) reviewed research on the positive effects of psychologically-intimate relationships, a term used to denote openness, reciprocity, and interdependence between partners, which is similar to definitions of emotional intimacy. Prager emphasized that people involved in an intimate relationship have the opportunity to communicate their thoughts and feelings about stressful events and receive support by a caring other. Such openness has been shown to reduce stress, boost self-esteem and self-respect, and reduce symptoms of psychological impairment. Studies of individuals who are isolated (Miller & Lefcourt, 1982) and consequently incapable of communicating their inner thoughts and feelings are at risk for developing psychological symptoms, supporting the notion that emotional intimacy is a buffer against psychological problems. Emotional intimacy also has been shown to affect physical health in a variety of

longitudinal studies (Graves, Thomas, & Mead, 1991; Russek & Schwartz, 1997). The incidence of various chronic illnesses (e.g., coronary artery disease) has been inversely correlated with emotional intimacy (Orth-Gomer et al., 1993; Seeman & Syme, 1987). After reviewing the literature on emotional support, Ornish (1998) suggested that individuals who report they have no confidante or person who cares for them have a three- to five-times greater risk of premature death and disease from all causes, including heart attacks, strokes, cancer, and autoimmune and infectious diseases. Compared to no support, the presence of even one intimate relationship that offers emotional support can dramatically improve health outcomes (Ornish, 1998).

A distinction between emotional intimacy and attachment is worth noting. The concept of attachment refers to a style of relating to others that is based on early emotional experiences with caregivers. Attachment styles serve as working models for how to judge and behave in close relationships, including romantic partnerships (Bowlby, 1973). Thus, attachment styles can affect relationship dynamics, such as intimacy. For example, Ackbar and Senn (2010) found that women who had a dismissing attachment style reported lesser closeness to their partners and greater avoidance of intimacy, while those who endorsed a preoccupied attachment style reported the reverse. As such, attachment can be viewed as contributing to the propensity for emotional intimacy. An investigation of the relationship between attachment and emotional intimacy is, however, beyond the scope of this study.

Being that the current investigation focuses on lesbian and gay couples, a review of gender differences in intimacy and emotional intimacy is warranted. Studies have shown that women tend to equate intimacy with love, affection, and the expression of feelings, while men believe intimacy means sexual behavior and physical closeness (Ridley, 1993). The prevailing hypothesis has been that women are more relational than men, which stems from what

researchers have called "the feminization of intimacy" (Wynne & Wynne, 1986). In essence, intimacy has been equated with self-disclosure, which is most commonly characteristic of women. More recent research has highlighted that the sharing of interests and activities (reported by men) are just as important to intimacy as self-disclosure (Kelly & Hall, 1992; Prager, 1995; Twohey & Ewing, 1995). Silence, storytelling, and other forms of expression may be men's way of expressing themselves—all equally valid forms of intimacy. There is a lack of research examining gender differences in emotional intimacy specifically. However, Twohey and Ewing (1995) conducted a review of the literature and found that, like intimacy in general, the mode of achieving emotional intimacy may differ for men, but they are as emotionally intimate as women.

The majority of research on emotional intimacy has been studied in heterosexual couples, and has demonstrated that emotional intimacy is related to psychological and physical well-being, is similar to but distinct from attachment, and is expressed differently based on gender. Despite progress in research on emotional intimacy among heterosexual couples, there is limited literature on emotional intimacy focused on LG relationships. The scant studies that exist focus mainly on emotional intimacy in serodiscordant (i.e., different HIV status) gay male couples. Findings have indicated that as emotional intimacy grows over time, the perception of risk of infection by one's partner decreases and, resultantly, unprotected sex increases (Remien, Carballo-Dieguez, & Wagner, 1995). It may be that men in serodiscordant relationships try to prove their love by trusting each other with their lives; unprotected anal intercourse between serodiscordant partners can represent the most intimate expression of love (Theodore, Duran, Antoni, & Fernandez, 2004). While these studies inform us on the relationship between emotional intimacy and sexual risk-taking, they do not reveal the potential link between

emotional intimacy and minority stress.

Although studies of emotional intimacy in same-sex couples are limited, a small number of studies have consistently indicated that emotional intimacy is particularly relevant for same-sex couples, as it is the most important predictor of relationship satisfaction in this population (Deenen et al., 1994; Eldridge & Gilbert, 1990; Koepke et al., 1992; Schreurs & Buunk, 1996). In a cross-sectional study, Deenen et al. (1994) investigated the relationship between verbal, physical, and emotional intimacy and sexual aspects of relationship functioning (e.g., sexual affection, sexual emotional exclusivity, sexual disinterest) in a sample of Dutch gay men (N = 320). Emotional intimacy was assessed as part of a larger general intimacy questionnaire created by the authors. Relevant questions were primarily derived from Parelman's (1983) dimensions of emotional intimacy. Results showed that gay men value emotional aspects of their relationships above sexual satisfaction. Independent of relationship duration and partners' age, emotional intimacy best predicted relationship satisfaction. In other words, while intimacy is evidently relevant for all couples, emotional intimacy in particular was shown to be especially important in gay male couples. Eldridge and Gilbert (1990) also investigated the construct in a cross-sectional study of 275 lesbian couples. Emotional intimacy was measured using the respective section in the Personal Assessment of Intimacy in Relationships scale (PAIR; Schaefer & Olson, 1981). Of all the intimacy scales used in the study (emotional intimacy, social intimacy, sexual intimacy, intellectual intimacy, and recreational intimacy), emotional intimacy was the most highly correlated with relationship satisfaction. Once again, emotional intimacy was shown to be especially important in LG couples. Although this is an important finding, the studies of emotional intimacy in LG couples to date do not inform us on how minority stress impacts intimacy.

As discussed previously, studies of heterosexual couples demonstrated that emotional intimacy reduced stress and symptoms of psychological impairment. Taking into consideration that similarities outweigh differences in same- and different-sex couples (Kurdek, 2004), it may be that there is a similar link between emotional intimacy and minority stress among individuals in LG couples. That being said, the focus on minority stress as distinguished from the general stress faced by heterosexual couples is important. LG couples may be at a disadvantage to fulfill their needs for connection (emotional intimacy) because of minority stress. Heterosexual couples are privileged in their capacity to experience emotional intimacy without the hindrance of minority stress. Therefore, a deeper understanding of emotional intimacy and psychological and physical health necessitates an examination of how the relationship is impacted by minority stress.

Although research linking emotional intimacy with minority stress among individuals in LG couples has yet to be undertaken, a study conducted by Mackey, Diemer, and O'Brien (2000) study yielded findings that suggested a relationship between the two constructs. Semi-structured interviews were used to gather data from the mainly White participants in different-sex and same-sex relationships ($N = 216$). Factors that were found to be significantly related to emotional intimacy in both heterosexual and LG couples included: quality of communication between partners, minimal relational conflict, conflict management style of partners, couple decision-making, relational equity, quality of sexual relations, importance of sexual relations, and physical affection. Although the study did not examine stress, prior research (e.g., Bodenmann, 2005; Bodenmann et al., 2007; Hulbert et al., 2000) found that similar factors were impacted by stress (e.g., communication, conflict, and sexual relations) in heterosexual couples. As such, it appears that stress affects emotional intimacy. That is, the factors that were found to be related to

emotional intimacy have also been shown to be affected by stress. Therefore, if a couple experiences stress, then the factors related to emotional intimacy will be affected, thus affecting emotional intimacy. In LG couples, minority stress specifically should affect levels of emotional intimacy. The current study will test this hypothesis.

Gaps, Contradictions and Limitations in the Existing Literature

The literature review has suggested a number of disparities in the current minority stress and emotional intimacy scholarship. Although studies have provided a broad sense of how minority stress affects couple functioning, there is a need for fine-tuning of this relationship. For example, is minority stress most strongly linked to any one of the variables that define relationship quality: intimacy, autonomy, equality, constructive problem solving, or barriers to leaving? Another gap in our knowledge pertains to the effects of discrimination (the first minority stress factor) on same-sex couples. Being that the majority of minority stress research has focused on the other four factors, there is a need for research focused on discrimination in order to better our understanding of this factor. Moreover, while there is considerable research on the effects of discrimination and other types of minority stress on individuals, these important variables are under-researched in couples. A limitation in the emotional intimacy literature pertains to the lack of an agreed-upon and repeatedly-used measure or definition of the construct. Consistency in the literature would enable studies to build upon each other and strengthen the reliability, validity, and generalizability of findings on emotional intimacy. Lastly, being that minority stress and emotional intimacy scholarship have been kept separate, there is a lack of understanding as to how they may relate. Both have been implicated in health and relationship functioning outcomes (the latter of which has physiological and psychological repercussions); therefore an investigation into their interconnectedness is needed.

The rationale for the current student was built on the understanding that stress in general, and more specifically minority stress, has well-established psychological and physical health implications. Additionally, being that emotional intimacy has been linked to psychological and physical health in heterosexual couples, this finding should hold true for individuals in LG couples, who share many similarities with heterosexual couples. Finally, research on heterosexual couples has revealed that stress and lack of intimacy decrease relationship satisfaction. Taken together, there is reason to believe that there is a relationship between minority stress, emotional intimacy, and relationship satisfaction among individuals in LG couples. Given our current understanding of the relatedness of these variables (that minority stress is associated with decreased relationship and health outcomes; emotional intimacy is associated with better health and relationship outcomes; no empirical evidence of the association between minority stress and emotional intimacy), the mediating role of emotional intimacy was the major focus of the current study. By broadening our understanding of how minority stress affects relationship and health outcomes, the current study may inform us on how to combat these negative outcomes in the lives of LG people (i.e., through emotional intimacy).

Purpose and Hypotheses

Bearing in mind the strengths and limitations of the literature on minority stress and emotional intimacy, the purpose of the present study was to investigate the extent and nature of the relationship between minority stress, emotional intimacy, relationship satisfaction, and health outcomes in same-sex couples. Specifically, the following hypotheses were examined:

1. Experiences of minority stress will negatively predict relationship satisfaction and positively predict psychological distress, health symptoms, and health risk behavior.

2. Emotional intimacy will positively predict relationship satisfaction and negatively predict psychological distress, health symptoms, and health risk behavior.
3. Experiences of minority stress will negatively predict emotional intimacy.
4. Emotional intimacy will mediate the relationship between minority stress and outcomes (relationship satisfaction, psychological distress, health symptoms, and health risk behavior).

Chapter Three: Methodology

Participants

Convenience sampling was utilized in order to ensure that the sample obtained consisted of the targeted demographics. In order to be included in the study, candidates had to currently be in a same-sex couple that had been intact for a minimum of 6 months. Candidates provided demographic information and were scored on twelve measures. Participants included 181 adults living in Canada (n = 127), the US (n = 49), and countries outside of North American (n = 5) who ranged in age from 18 to 65 (M = 34.56, SD = 12.34). The sample consisted of 107 women (59.1%), 64 men (35.4%), 3 transgender individuals (1.7%), 2 female-to-male individuals (1.1%), and 1 male-to-female individual (.6%). Four people (2.2%) did not identify a gender identity. One hundred and nine participants identified as lesbian (60.2%) and 72 identified as gay (39.8%). Canadian and American participants were given separate racial identification questions as per Statistics Canada and the US Census Bureau, respectively. Because of the heterogeneity of the sample in terms of race, Canadian and US participants were collapsed into the US racial categories. The large majority of participants (85.6%, n = 155) identified as White/European American. Three (1.7%) identified as Black/African American, 3 (1.7%) identified as Latino/Latina, 9 (5.0%) identified as Asian/Asian American/Pacific Islander, 1 (.6%) identified as Native American/American Indian/Aboriginal, and 9 (5.0%) identified as multiracial. One person (.6%) did not identify a racial identity. One hundred and sixty two participants (89.5%) reported to be HIV-negative, five (2.8%) reported to be HIV-positive, and one (.6%) participant did not answer the question.

Relationship status categories were presented in a non-mutually-exclusive manner. Sixty participants (33.1%) identified as being in a relationship, living together; another 60 (33.1%)

identified as being in a relationship, living apart; and 65 (35.9%) identified as being married or in a civil union/domestic partnership/equivalent. Length of time in the relationship ranged from 4 months to 40 years (M = 5.76 years, SD = 7.45). The majority of the sample (74.6%, n = 135) reported having no children; one person (.6%) did not answer the question. Most participants reported an income of less than $30,000 per year, with a sizable minority earning less than $10,000 per year (19.9%, n = 36). Participants reported a variety of occupations, the majority being students (27.6%, n = 50). The sample was highly educated, with 29.8% (n = 54) having completed some college, 24.3% (n = 44) having a bachelor's degree, 24.9% (n = 45) having a master's degree, and 8.8% (n = 16) having a doctoral or professional degree. Twelve (6.6%) participants had a high school diploma or equivalency, and 10 (5.5%) had an associate's degree. Roughly a quarter of participants reported being atheist (25.4%, n = 46), while other participants reported a variety of religious affiliations (see Table 1 for details).

Measures

Minority stress variables. Three minority stress variables were measured. *Experiences of discrimination and rejection* was assessed using the 14-item Heterosexist Harassment, Rejection, and Discrimination Scale (HHRDS; Szymanski, 2006). Participants were asked to rate the frequency with which they had experienced heterosexist harassment, rejection, and discrimination within the past year. Example items include "How many times have you been rejected by family members because you are a lesbian woman/gay man?" and *"*How many times have you been treated unfairly by your employer, boss, or supervisors because you are a lesbian woman/gay man?" Each item was rated on a 6-point Likert scale, from 1 (*the event has never happened to you*) to 6 (*the event happened almost all the time [more than 70% of the time]*). Mean scores were used, with higher scores indicating greater experiences of heterosexist

harassment, rejection, and discrimination in the past year. Reported alpha for scores on the HHRDS full scale was .90. Validity of the original HHRDS was supported by exploratory factor analysis; by significant, positive correlations with measures assessing depression, anxiety, interpersonal sensitivity, somatization, obsessive compulsiveness, and overall psychological distress; and by the demonstration that the HHRDS was conceptually distinct from internalized heterosexism (Szymanski, 2006). Cronbach's alpha for the current study was .91.

Internalized homonegativity was assessed using the Internalized Homonegativity subscale from the Lesbian and Gay Identity Scale (LGIS; Mohr & Fassinger, 2000). The subscale consists of five items that assess the degree to which participants evaluate their LG sexual orientation negatively (e.g., "I wish I were heterosexual") or positively (e.g., "I am glad to be an LG person," reverse-scored). Items are rated on a 7-point Likert subscale ranging from 1 (*agree strongly*) to 7 (*disagree strongly*). Cronbach's alpha for the original subscale was .70. The subscale was scored by reverse scoring items as needed and averaging subscale item ratings. High scores represent a high level of internalized homonegativity and low scores represent a low level of internalized homonegativity. The LGIS was developed through exploratory factor analysis of a set of diverse identity-related items and the factor structure was supported in a separate confirmatory factor analysis. Validity evidence for LGIS subscales has been provided through predicted associations with phase of LG identity development, degree of investment in one's LG social identity, self-esteem, and degree of interaction with heterosexual individuals (Mohr & Fassinger, 2003). In the current study, Cronbach's alpha was .81.

Sexual orientation concealment was assessed using the Sexual Orientation Concealment Scale (Blair, 2006). The 6-item scale measures how often respondents behaved in ways that hid their sexual orientation in the last 2 weeks (e.g., "I concealed my sexual orientation by telling

someone that I was straight or denying that I was LGB"). Participants rated items on a 7-point Likert scale ranging from 1 (*not at all*) to 7 (*all the time*). Psychometric data for the scale are not available, however it was chosen for the proposed study for its clear focus on concealment. The LGIS Need for Privacy Subscale (Mohr & Fassinger, 2000), for example, is more focused on privacy than concealment (e.g., "I prefer to keep my same-sex romantic relationships rather private," "My private sexual behavior is nobody's business"). Cronbach's alpha for the current study was .85.

General stress. A general stress measure was included in addition to the minority stress measures, given that the latter is an additive stress to that experienced by all people (i.e., heterosexuals/heterosexual couples). General stress was controlled for in statistical analyses. The 10-item Perceived Stress Scale (PSS; Cohen, Kamarck, & Mermelstein, 1983) measures the frequency of stressful events in the past month (e.g., "In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?"). Participants rated items on a 5-point Likert scale ranging from 0 (*never*) to 4 (*very often*). PSS scores were obtained by reversing responses to the four positively-stated items (items 4, 5, 7, & 8) and then summing across all scale items. Coefficient alpha reliability for the original scale ranged from .84 to .86. Concurrent validity was established by positive associations with the number and perceived impact of life stressors (correlations ranging from .17 to .35) in college samples. Also, the PSS predicted depressive symptomatology (correlations ranging from .65 to .76), physical symptomatology (correlations ranging from .52 to .65), and social anxiety (correlations ranging from .37 and .48). In the current study, Cronbach's alpha was .91.

Emotional intimacy. Emotional intimacy was assessed using the Emotional Intimacy Scale (EIS; Sinclair & Dowdy, 2005), which measures self-reported perceptions of being

validated (e.g., "My partner completely accepts me as I am"), understood (e.g., "My thoughts and feelings are understood and affirmed by my partner") and cared for (e.g., "My partner cares deeply for me"). The scale consists of five items and is scored on a 5-point scale from 1 (*strongly disagree*) to 5 (*strongly agree*). A mean score was calculated; higher scores indicated greater perceptions of emotional intimacy. The standardized alpha coefficient for the original scale was .88, indicating strong scale reliability. Substantial evidence has been provided for construct and criterion-related validity of the EIS (Sinclair & Dowdy, 2005). Although the EIS has yet to be used with LG samples (the original sample consisted of women with rheumatoid arthritis), it was chosen for the proposed study over other measures due to its brevity and focus on emotional intimacy in the person's closest relationship, rather than an aggregate of support offered in many relationships. The EIS was also selected because of its relation to health, one of the variables in the proposed study. In the original study that described the scale creation, the EIS was shown to be inversely correlated with physical well-being and it predicted psychological and physical outcomes in the sample (Sinclair & Dowdy, 2005). Cronbach's alpha for the current study was .91.

General intimacy. A general intimacy scale was included in addition to the EIS. The 17-item Miller Social Intimacy Scale (MSIS; Miller & Leftcourt, 1982) asked participants to assess the frequency of certain behaviors (e.g., "How often do you show him/her affection?") and evaluate the affect in their close relationships (e.g., "How much damage is caused by a typical disagreement in your relationship with him/her?"). Items were answered on a 10-point Likert scale ranging from 0 (*very rarely*) to 10 (*almost always*) for the six behavior items and 0 (*not much*) to 10 (*a great deal*) for the eight items focused on the effect of the behaviors. Higher scores indicated greater intimacy. Miller and Lefcourt (1982) found that the MSIS had high test-

retest reliability (r = .96). Cronbach's alpha for the original measure was .91. The validity of the measure has been demonstrated by concurrent high scores on the MSIS and the intimacy subscale of the Interpersonal Relationship Scale (IRS; Schlein, Guerney, & Stover, 1971) as well as concurrent low scores on the MSIS and the UCLA Loneliness Scale (Russell, Peplau, & Ferguson, 1978). In the current study, Cronbach's alpha was .94.

Relationship satisfaction. Relationship satisfaction was assessed using two measures. First, the 3-item Kansas Marital Satisfaction Scale (KMSS; Schumm et al., 1986) is a measure that distinguishes between distressed and nondistressed couples. Participants indicated how true each of the following statements was: "I am satisfied with my relationship; I am satisfied with my partner in his/her role as my partner; I am satisfied with my relationship with my partner." Consistent with the usage of this scale in previous studies of same-sex couples (e.g., Kurdek, 1991), the wording of the KMSS was changed slightly to reflect the nonmarital status of some same-sex relationships (i.e., partner instead of husband/wife). Each item on the KMSS has a possible score ranging from one to seven (1 = *not at all true,* 7 = *extremely true)*. Scores of seven indicate a high degree of relationship satisfaction while scores of one indicate a low degree of satisfaction. A total score on the KMSS can range from three to 21. Cronbach's alpha for the KMSS has been reported at .84 (Schumm et al., 1986) and .96 (Jeong, Stephan, & Walter, 1992). Test-retest reliability for the original scale was .71 (Schumm et al., 1986). Regarding validity, couples scoring in the distressed range on the KMSS also scored in the distressed range on the Revised Dyadic Adjustment Scale (RDAS; Busby, Christensen, Crane, & Larson, 1995) and the Dyadic Adjustment Scale (DAS; Spanier, 1976; Crane, Middleton, & Bean, 2000). The KMSS has been widely used with both heterosexual and same-sex couples (e.g., Kurdek, 2000). Cronbach's alpha for the current study was .96.

The second measure of relationship satisfaction, the 10-item Dyadic Satisfaction subscale of the Dyadic Adjustment Scale (DAS; Spanier, 1976), measures the amount of tension in the relationship and the extent to which the individual has considered terminating the relationship. Example items include "In general, how often do you think that things between you and your partner are going well?" and "How often do you discuss or have you considered divorce, separation, or terminating your relationship?" Participants rated items on a 6-point Likert scale ranging from 0 (*all the time*) to 5 (*never*). Low scores on the subscale indicated a problem in relationship satisfaction and high scores indicated that the individual is satisfied with the present state of the relationship and is committed to its continuance. Cronbach's alpha for the original subscale was .81. The DAS has been widely used and has demonstrated high reliability and stable structure with both heterosexual and same-sex couples (Todosijevic et al., 2005). Evidence of construct validity was shown by the finding that couples scoring in the distressed range on the DAS also scored in the distressed range on the KMSS (Crane et al., 2000). In the current study, Cronbach's alpha was .86.

Psychological functioning. Psychological functioning was assessed using the Kessler Psychological Distress Scale (K-10; Kessler et al., 2002), a 10-item instrument that measures nonspecific psychological distress. Participants were asked how frequently they experienced symptoms of psychological distress during the past 30 days using a 5-point Likert scale ranging from 1 (*none of the time*) to 5 (*all of the time*). Item examples include "Did you feel restless or fidgety" and "Did you feel that everything was an effort?" A maximum score of 50 indicates severe distress and the minimum score of 0 indicates no distress. The K-10 has been reported to have excellent internal consistency reliability ($\alpha = .93$). Validation studies have shown that the

K-10 has good concordance with masked clinical diagnoses of serious mental illness in general population samples (Kessler et al., 2010). Cronbach's alpha for the current study was .93.

Health symptoms. Health symptoms was assessed using the Pennebaker Inventory of Limbic Languidness (PILL; Pennebaker, 1982). The 54-item checklist measures physical symptoms such as coughing, insomnia, diarrhea, and nausea. Participants were asked to rate the frequency with which they had experienced these symptoms in the past year by using a 5-point scale ranging from 1 (*have never or almost never experienced the symptom in the past year*) to 5 (*more than once every week in the past year*). Scores were calculated by totaling the item responses, with a possible range of 54-270. Cronbach's alpha for the original measure was .88 (Pennebaker, 1982), demonstrating high internal consistency. Validation support for the PILL has been shown through positive correlations with physician visits, aspirin use, and health-related work absenteeism (Pennebaker, 1982). In the current study, Cronbach's alpha was .94.

Health risk behavior. Two forms of health risk behavior were examined: substance use and sexual risk behavior. Both were chosen due to LG populations being at increased risk for these specific health-related behaviors (Mays & Cochran, 2001). Substance use was assessed using a measure created by Sikkema and her colleagues (Sikkema, Kochman, DiFranceisco, Kelly, & Hoffman, 2003). Participants were asked to describe their use of licit and illicit substances (e.g., alcohol, marijuana, tranquilizers, and cocaine) within the past 30 days. Frequency of use was indicated on a 6-point Likert scale ranging from 0 = *no use* to 6 = *more than once daily use*. Because the substance use measure was a count of frequency of use, Cronbach's alpha was not calculated.

Sexual risk behavior was assessed using questionnaire based on a measure created by Sikkema and her colleagues (Kalichman, Sikkema, DiFonzo, Austin, & Luke, 2002; Sikkema et

al., 2000). Participants were asked about protected and unprotected sexual behavior over the previous three months, both with a primary partner and with partners outside of the primary relationship, as well as the HIV status of partners. Men were asked to indicate the number of times they had engaged in anal and oral sex with a primary partner and anal, oral, and vaginal sex with partners outside of the primary relationship. Women were asked to indicate the number of times they engaged in the following sexual acts with a primary partner: oral sex, sharing of insertive sex toys, and any sexual activity that could lead to bleeding or cuts/breaks/tears in the lining of the vagina or anus. For partners outside of the relationship, women were asked about the same sexual acts with the addition of vaginal and anal sex. Because the sexual risk measure was a count of behavior and partner frequency, Cronbach's alpha was not calculated.

Demographic questionnaire. An author-generated demographic questionnaire assessed various participant characteristics including age, gender, race/ethnicity, relationship status, occupation, income, education, sexual orientation, place of residence, and religious affiliation. Sexual orientation was assessed by participants' self-identification as lesbian, gay, or other.

Informed consent form. An informed consent form ensured that study participants were aware of their rights, the limits of confidentiality, and how the study data would be used. The informed consent form explained the purpose of the study, how data would be collected, compensation for participation, participant rights associated with withdrawal from the study, any known risks associated with participation in the study, and how confidentiality would safeguarded. The primary researcher and the supervisor overseeing the study's contact information as well as the McGill University Research Ethics Board's contact information were provided in order to allow participants to address questions and receive further study information.

Procedure

The study was approved by the McGill University Research Ethics Board. Participants were contacted via recruitment emails sent to LG-focused LISTSERVs, organizations, and academic associations. Emails were sent across Canada and the US to provincial (n = 37) and state (n = 138) LISTSERVs/organizations, national LISTSERVs/organizations (n = 8 Canadian, 12 US), and Canadian (n = 26) and US (n = 16) university groups. Participants were asked to complete a short online survey concerning stress, intimacy, relationship satisfaction, and health in their intimate relationship. The study announcement specified that participants would have the option to be entered in a lottery for the chance to win one of three prizes of $50. It was also specified that only one partner per intimate relationship could complete the survey. Ideally both members of the couple would have participated, however the decision to only include one was made in order to avoid the statistical issues concerning nonindependence of samples inherent in couples data research. Specifically, the scores of the two partners are likely to be correlated in couples research, (Kenny, 1988; Kenny & Kashy, 1991); this nonindependence can bias the tests of significance (Kenny, 1995; Kenny & Judd, 1986). Because of this issue, and consistent with previous studies of individuals in LG couples (e.g., Mohr & Fassinger, 2003; Mohr & Daly, 2008), only one member of the couple was invited to participate in the current study.

Data were collected using a secure online survey platform. LG people can be hard to reach due to the stigma often associated with sexual minority status. Online data collection is a suitable and appropriate method for accessing this hidden population (Rhodes, Bowie, & Hergenrather, 2003) as it ensures anonymity to individuals who may be reluctant to out themselves by participating in-person. Moreover, the proposed study aimed to recruit participants cross-nationally and in the US; as such, in-person data collection was not feasible.

Data remained anonymous and IP addresses as well as the date/time of survey completion were not saved in order to safeguard anonymity. The survey link was included in the emailed study announcement. By clicking the link, participants were taken to a page that described the study in more detail. Individuals who agreed to proceed by giving their informed consent were directed to the survey.

At any point during the completion of the survey, participants could choose to withdraw their informed consent. They could either select the icon to exit and clear survey, present on each survey page, or they could choose the exit and clear survey icon at the end of the survey rather than selecting to submit. Both methods ensured that their answers were not recorded. Participants who choose to enter the prize draw were directed to a separate online survey where they could provide their email address, not linked to their survey responses in order to maintain anonymity. If interested candidates did not have internet access or did not have a location where they could comfortably complete the online survey, they could contact the principal investigator via telephone or email in order to have the questionnaire mailed to them along with a prepaid return envelope. No one chose this option. All data obtained during this study were be kept strictly confidential; data were only be identified by a code number and were kept in a secure digital data storage device in the office of the principal investigator. Only the principal investigator and the supervisor overseeing the study had access to the data, both of whom complied with the Tri-Council ethical guidelines for research with human subjects at all times.

Chapter Four: Results

Data collection took place between January and February 2013. Two hundred and sixty-eight participants began the survey; a total of 181 completed and submitted the questionnaire in its entirety. In order to be included in the current analyses, 80% of a given subscale had to be completed. Mean item substitution was used for missing values, which consists of computing the average of the instrument for each participant and substituting the mean for the missing items. Prior to conducting any analyses, data were tested for univariate outliers. Box plots for all measures were examined for extreme outliers. Twenty such outliers were detected and the respective measure scores were removed from the dataset (i.e., the participant was not removed entirely; only the score for the measure with extreme outliers was removed). SPSS 21 was used for all analyses.

Demographic Differences

A series of independent sample *t*-tests was conducted to determine whether demographic differences were significantly associated with measure scores. These *t*-tests compared variable scores based on gender, race, and country of residence. Because of the small number of participants who identified as a gender identity other than man or woman ($n = 3$), only men and women were included in the analyses. Additionally, because the large majority of the sample was White ($n = 155$), all participants of color ($n = 26$) were collapsed into one group. Internalized homonegativity, relationship satisfaction (KMSS), health symptoms, and alcohol use scores differed significantly by gender. Men had higher internalized homonegativity scores ($M = 2.01$, $SD = 1.24$) than women ($M = 1.53$, $SD = .77$), $t(93) = 2.810$, $p = .006$. Men also had higher alcohol use scores ($M = 1.94$, $SD = 1.08$) than women ($M = 1.52$, $SD = 1.09$), $t(169) = 2.406$, $p = .017$. Women had higher relationships satisfaction (KMSS) scores ($M = 18.71$, $SD = 2.40$) than

men (M = 17.61, SD = 3.12), t(166) = -2.545, p = .012. Women also reported more health symptoms (M = 114.12, SD = 30.61) than men (M = 102.78, SD = 29.61), t(169) = -2.374, p = .019. Scores on sexual orientation concealment differed significantly according to racial identity such that participants of color (M = 1.76, SD = .79) had higher scores on the sexual orientation concealment scale than White participants (M = 1.42, SD = .54), t(29.172) = 2.067, p = .048. Regarding country of residence, significant differences were found when comparing Canadian and US participants' experiences of discrimination and rejection scores and internalized homonegativity scores. American participants (M = 2.12, SD = .75) had higher scores on the experiences of discrimination and rejection scale than Canadian participants (M = 1.78, SD = .58), t(67.323) = -2.828, p = .006. Finally, Canadian participants had higher internalized homonegativity scores (M = 1.84, SD = 1.06) than American participants (M = 1.48, SD = .85), t(174) = 2.107, p = .037.

Analyses of variance (ANOVAs) were conducted to determine whether scores differed according to relationship status. The three relationship status categories (living together, living apart, and married or in a civil union/domestic partnership/equivalent) were collapsed into mutually-exclusive categories. As such, participants who indicated multiple categories (e.g., living together, and married) were placed in a single category (e.g., married). Relationship status was significantly associated with several measures, including internalized homonegativity, F(2, 176) = 3.81, p = .024, sexual orientation concealment, F(2, 173) = 6.50, p = .002, general stress, F(2, 176) = 3.61, p = .029, emotional intimacy, F(2, 171) = 7.67, p = .001, relationship satisfaction, F(2, 174) = 6.82, p = .001 (for the KMSS) and F(2, 174) = 14.15, p = .000 (for the DAS), and psychological distress F(2, 176) = 6.21, p = .002. Follow up Tukey's comparisons showed that participants who did not live with their partners and participants who were married

differed on scores of internalized homonegativity (p = .025), sexual orientation concealment (p = .001), general stress (p = .026), emotional intimacy (p = .001), relationship satisfaction (KMSS, p = .001 and DAS, p = .000), and psychological distress (p = .002). In addition, there were differences between participants who lived with their partners and participants who were married for emotional intimacy (p = .014) and relationship satisfaction as measured by the DAS (p = .000). Means and standard deviations for each measure according to relationship status are presented in Table 2. Those who did not live with their partners had higher internalized homonegativity, sexual orientation concealment, general stress, and psychological distress and lower emotional intimacy and relationship satisfaction (as measured by both the KMSS and the DAS) than those who were married. In addition, those who lived with their partners had lower emotional intimacy and relationship satisfaction (as measured by the DAS) than those who were married.

Correlations Between Predictors, Mediator, and Outcome Variables

Given the number of sexual risk behavior factors, the frequencies of engaging in the various sexual acts are presented in Table 3. The correlation matrix table only includes sexual risk behavior variables with a minimum of ten participants. The means, standard deviations, and bivariate correlations between variables are displayed in Table 4. Although most participants reported low levels on all three minority stress variables (experiences of discrimination and rejection, internalized homonegativity, sexual orientation concealment), the means were comparable to previously reported means using these measures. For the HHRDS, Szymanski (2006) reported a mean of 1.63 (SD = 0.70). For the IHS subscale of the LGIS, Mohr and Fassinger (2000) reported a mean of 1.66 (SD = 0.92), and for the Sexual Orientation Concealment Scale, Blair (2006) reported a mean of 1.50. All three minority stress variables

were significantly negatively correlated with relationship satisfaction and significantly positively correlated with psychological distress. Experiences of discrimination and rejection as well as internalized homonegativity were significantly positively correlated with the use of substances other than alcohol. Only one of the minority stress variables was positively correlated with health symptoms (experiences of discrimination and rejection) as well as to general stress (internalized homonegativity). General stress was significantly negatively correlated with emotional intimacy and both measures of relationship satisfaction, and significantly positively correlated with psychological distress, health symptoms, and the use of substances other than alcohol, and unprotected sexual activity that could lead to bleeding or cuts/breaks/tears in the lining of the vagina or anus with a primary partner among women. Emotional intimacy was significantly positively correlated with both measures of relationship satisfaction and negatively correlated with psychological distress. Internalized homonegativity and sexual orientation concealment were both significantly negatively correlated with emotional intimacy. Neither age nor length of relationship were significantly correlated with any of the variables of interest.

Mediation Model

Prior to conducting the mediation analyses, data distributions were examined for assumptions of normality. As suggested by Fidell and Tabacknick (2003), preparatory data analyses were conducted to locate and correct problems in the data set prior to main analyses. Three variables were transformed with a logarithm transformation due to substantial negative skewness. These variables were: experiences of discrimination and rejection (Heterosexist, Harassment, and Rejection scale), internalized homonegativity (LGIS Internalized Homonegativity subscale) and sexual orientation concealment (Sexual Orientation Concealment scale). Additionally, Mahalanobis distance was used to detect multivariate outliers. The data set

contained four such outliers, which were removed from the dataset prior to mediation analyses. Specifically, only the respective measure scores were deleted, leaving the participants' remaining scores in the dataset. In order to detect multicollinearity, the dataset was examined for values of inflation factors (VIF) above 10 and tolerance below .2, as per the generally accepted rule. No multicollinearity was detected.

To test hypotheses 1 to 4—that experiences of minority stress will negatively predict relationship satisfaction and positively predict health outcomes (psychological distress, health symptoms, and health risk behaviors); that emotional intimacy will positively predict relationship satisfaction and negatively predict health outcomes; that experiences of minority stress will negatively predict emotional intimacy; and that emotional intimacy will mediate the relationship between minority stress and outcomes—the SPSS MEDIATE macro provided by Hayes and Preacher (2013) was used. Traditional mediation analyses (e.g., Baron & Kenny, 1986) consist of running three regression equations (i.e., the c path: x/IV to y/DV; the a path: x/IV to m/mediator; and the b and c' paths simultaneously: x/IV to m/mediator and y/DV; see Frazier, Tix, & Barron, 2004). The Hayes and Preacher model runs one test (i.e., the product of the a and b paths), which lowers the family-wise error rate. In addition, the traditional mediation method is parametric; it assumes that the ab product has a normal sampling distribution, when in fact it tends to be non-normal/positively skewed. Because of the requirement to test multiple effects and the non-normal sampling distribution of ab, the traditional method is underpowered. In contrast, the Hayes and Preacher macro increases statistical power by only testing one effect and creating bootstrapped samples to create a confidence interval for the ab product. Specifically, the macro performs multiple regression analyses and creates 5000 boostrapped samples. Using the boostrapped samples, the macro generates a confidence interval for the indirect effect of the

mediating variable on the outcome variable. When zero is not included in the 95% confidence interval, then there is evidence of mediation. The Hayes and Preacher model for mediation allows for multiple predictor variables (in this case, experiences of discrimination, internalized homonegativity, and sexual orientation concealment) to be handled and coded as one variable (minority stress). This variable is called the omnibus and represents the total, direct, and indirect effects of all predictor variables. Direct and indirect effects are calculated for the omnibus as well as for each individual minority stress predictor variable (i.e., all effects for each variable can be interpreted as independent of the other variables). Hayes and Preacher stipulate that the relationship between x/IV and y/DV does not have to be significant in order to conclude there is evidence for mediation; there simply needs to be a relationship that can be mediated. The mediation model does not allow for multiple dependent variables; therefore each outcome variable was tested separately (two relationship satisfaction measure scores, psychological distress, health symptoms, alcohol use, substance use). Because the model requires a minimum of 25 participants per variable in order to calculate mediation, sexual risk behavior was not analyzed (i.e., not enough participants reported any of the various sexual acts). In order to control for confounding or interacting variables, general stress was entered as a covariate into the model. For all analyses, the confidence interval was set to 95% ($\alpha = .05$). The regression coefficients and bootstrap confidence intervals are presented in Table 5.

For the variable of relationship satisfaction as measured by the KMSS, there was a significant relationship between internalized homonegativity and emotional intimacy and between sexual orientation concealment and emotional intimacy (path a), between emotional intimacy and relationship satisfaction (path b), and between general stress (the covariate) and emotional intimacy. Bootstrap confidence intervals for the indirect effect (path c') of internalized

homonegativity on relationship satisfaction, CI = [-3.277, -.103], did not contain zero, suggesting that the indirect effect was significant. Therefore, emotional intimacy mediated the effect of internalized homonegativity on relationship satisfaction. Additionally, bootstrap confidence intervals for the indirect effect (path c') of sexual orientation concealment on relationship satisfaction, CI = [-4.026, -.155] did not contain zero, suggesting that the indirect effect was significant. As such, emotional intimacy also mediated the effect of sexual orientation concealment on relationship satisfaction.

For the variable of relationship satisfaction as measured by the DAS, there was a significant relationship between internalized homonegativity and emotional intimacy (path a), between emotional intimacy and relationship satisfaction (path b), and between general stress (the covariate) and emotional intimacy. Bootstrap confidence intervals for the indirect effect (path c') of internalized homonegativity on relationship satisfaction, CI = [-5.810, -.889], did not contain zero, suggesting that the indirect effect was significant. Therefore, emotional intimacy mediated the effect of internalized homonegativity on relationship satisfaction.

For the variable of psychological distress, there was a significant relationship between internalized homonegativity and emotional intimacy (path a). In addition, there was a significant relationship between general stress (the covariate) and emotional intimacy and between general stress and psychological distress. All of the bootstrap confidence intervals for the indirect effects (path c') contained zero, suggesting that the indirect effects were not significant. Therefore, emotional intimacy did not mediate the effect of any of the predictor variables on psychological distress.

For the variable of health symptoms, there was a significant relationship between internalized homonegativity and emotional intimacy (path a). In addition, there was a significant

relationship between general stress (the covariate) and emotional intimacy and between general stress and health symptoms. Bootstrap confidence intervals for the indirect effect (path c') of internalized homonegativity on health symptoms, CI = [-14.710, -.378], did not contain zero, suggesting that the indirect effect was significant. Therefore, emotional intimacy mediated the effect of internalized homonegativity on health symptoms.

For the variable of alcohol use, there was a significant relationship between internalized homonegativity and emotional intimacy (path a) and between general stress (the covariate) and emotional intimacy. Bootstrap confidence intervals for the indirect effect (path c') of internalized homonegativity on alcohol use, CI = [-.511, -.008], did not contain zero, suggesting that the indirect effect was significant. Therefore, emotional intimacy mediated the effect of internalized homonegativity on alcohol use.

Finally, for the variable of the use of substances other than alcohol, there was a significant relationship between internalized homonegativity and emotional intimacy (path a) and between general stress (the covariate) and emotional intimacy. All of the bootstrap confidence intervals for the indirect effects (path c') contained zero, suggesting that the indirect effects were not significant. Therefore, emotional intimacy did not mediate the effect of any of the predictor variables on the use of substances other than alcohol.

The mediation analysis results indicate that hypothesis 1 was not supported (that minority stress will negatively predict relationship satisfaction and positively predict health outcomes). None of the individual predictor variables or the composite minority stress variable predicted relationship satisfaction or health outcomes. Hypothesis 2 was partially supported (that emotional intimacy will positively predict relationship satisfaction and negatively predict health outcomes). Emotional intimacy positively predicted relationship satisfaction (as measured by

both the KMSS and the DAS) but did not predict any of the health outcomes. Hypothesis 3 was partially supported (that experiences of minority stress will negatively predict emotional intimacy). Internalized homonegativity negatively predicted emotional intimacy in all mediation models and sexual orientation concealment negatively predicted emotional intimacy in one model. The variable of experiences of discrimination and rejection did not predict emotional intimacy, nor did the composite minority stress variable. Lastly, the mediation analysis results indicate that hypothesis 4 was partially supported (that emotional intimacy will mediate the relationship between minority stress and outcomes). Emotional intimacy mediated the effect of internalized homonegativity on relationship satisfaction (as measured by both the KMSS and the DAS), health symptoms, and alcohol use, as well as the effect of sexual orientation concealment on relationship satisfaction as measured by the KMSS. Emotional intimacy did not, however, mediate the effect of any of the predictor variables on psychological distress or substance use. Also, the omnibus indirect effect was not significant for any of the mediation models, indicating that when the three minority stress variables were entered as a composite, there was no evidence that emotional intimacy mediated the effect of minority stress on relationship satisfaction, psychological distress, health symptoms, alcohol use, or substance use.

Table 1

Demographic Information

Country of residence	*n*	Percentage
Canada	127	70.2
United States	59	27.1
Other	5	2.8
Gender Identity	***n***	**Percentage**
Woman	107	59.1
Man	64	35.4
Transgender	3	1.7
Female-to-Male	2	1.1
Male-to-Female	1	.6
Sexual Orientation	***n***	**Percentage**
Lesbian	109	60.2
Gay	72	39.8
Racial Identity	***n***	**Percentage**
Black/African American	3	1.7
White/European American	155	85.6
Latino/Latina	3	1.7
Asian/Asian American/Pacific Islander	9	5.0
Native American/American Indian/Aboriginal	1	.6
Multiracial	9	5.0
Relationship Status	***n***	**Percentage**
In a Relationship, Living Together	60	33.1
In a Relationship, Living Apart	60	33.1
Married or in a Civil Union/Domestic Partnership/Equivalent	65	35.9
Children	***n***	**Percentage**
No	135	74.6
Yes	45	24.9
Income	***n***	**Percentage**
Below $10,000	36	19.9
$10,001-$20,000	26	14.4
$20,001-$30,000	26	14.4
$30,001-$40,000	14	7.7
$40,001-$50,000	15	8.3
$50,001-$60,000	14	7.7
$60,001-$70,000	10	5.5
$70,001-$80,000	8	4.4
$80,001-$90,000	5	2.8
$90,001-$100,000	3	1.7
$100,001-$110,000	8	4.4
$110,001-$120,000	7	3.9
$120,001-$130,000	2	1.1
$130,001-$140,000	0	0

$140,001-$150,000	2	1.1
$150,001-$160,000	0	0
Over $160,000	5	2.8
Highest Level of Education to Date	*n*	Percentage
High School or Equivalent	12	6.6
Some College	54	29.8
Associate's Degree	10	5.5
Bachelor's Degree	44	24.3
Master's Degree	45	24.9
Doctoral Degree	16	8.8
Religious Affiliation	*n*	Percentage
Agnostic	38	21.0
Atheist	46	25.4
Buddhist	3	1.7
Catholic	12	6.6
Greek Orthodox	1	.6
Islamic	1	.6
Jewish	10	5.5
Protestant	19	10.5
Wiccan	6	3.3
Other	41	22.7

Note. Frequencies not equaling 181 and percentages not equaling 100% reflect non-mutually exclusive categories.

Table 2

Means and Standard Deviations for Measures According to Relationship Status

	Relationship Status					
	Living apart (n = 60)		Living together (n = 55)		Married or equivalent (n = 64)	
Measure	*M*	*SD*	*M*	*SD*	*M*	*SD*
Experiences of Discrimination and Rejection	1.85	.76	1.90	.55	1.78	.55
Internalized Homonegativity	1.90	1.13	1.80	1.08	1.44	.72
Sexual Orientation Concealment	1.66	.66	1.46	.63	1.29	.39
General Stress	19.67	8.11	18.60	6.62	16.13	7.68
Emotional Intimacy	4.50	.58	4.57	.46	4.82	.36
Relationship Satisfaction (KMSS)	17.61	3.21	18.25	2.47	19.30	1.90
Relationship Satisfaction (DAS)	38.92	4.96	39.76	4.85	42.94	3.43
Psychological Distress	22.30	8.86	20.20	7.07	17.60	6.27
Health Symptoms	110.96	30.17	108.07	25.30	107.22	31.50
Use of Alcohol	1.53	1.02	1.58	.99	1.84	1.24
Use of Substances other than Alcohol	.85	1.52	.93	1.64	.75	1.43
UAI with Partner (Men)	7.26	10.34	6.73	9.07	19.29	33.73
UOI with Partner (Men)	17.83	16.31	17.20	11.45	18.69	24.86
UOI with Partner (Women)	17.96	16.76	10.92	11.73	10.27	16.97
Unprotected Shared Toys with Partner (Women)	8.80	8.78	11.00	15.80	8.28	11.21
Unprotected Sexual Activity that Could Lead to Bleeding or Cuts/Breaks/Tears in the Lining of the Vagina or Anus with Partner (Women)	11.33	12.24	2.83	2.23	2.22	1.86

Note. UAI = unprotected anal intercourse; UOI = unprotected oral intercourse.

Table 3

Frequencies and Percentages of Sexual Behaviors

Men	Frequency	*N*	%
Unprotected Anal Intercourse with Primary Partner	0	36	60.0
	1	2	3.3
	2	3	5.0
	3	1	1.7
	4	1	1.7
	5	4	6.7
	6	1	1.7
	7	1	1.7
	10	1	1.7
	> 10	10	16.7
Unprotected Oral Intercourse with Primary Partner	0	11	18.3
	1	1	1.7
	2	1	1.7
	3	1	1.7
	4	2	3.3
	5	5	8.3
	6	3	5.0
	7	2	3.3
	8	1	1.7
	9	1	1.7
	10	6	10.0
	> 10	26	43.3
Unprotected Vaginal Intercourse with Sex Partner Outside of Primary Relationship	0	60	100
Unprotected Anal Intercourse with Sex Partner Outside of Primary Relationship	0	59	98.3
	1	1	1.7
Unprotected Oral Intercourse with Sex Partner Outside of Primary Relationship	0	51	85.0
	1	2	3.3
	2	2	3.3
	3	1	1.7
	6	2	3.3
	10	1	1.7
	> 10	1	1.7
Women	Frequency	*N*	%
Unprotected Oral Intercourse with Primary Partner	0	31	29.25
	1	1	.9

	2	8	7.6
	3	6	5.7
	4	8	7.6
	5	3	2.8
	6	10	9.4
	7	2	1.9
	8	1	.9
	10	12	11.3
	> 10	24	22.64
Sharing of Unprotected Sex Toys with Primary Partner	0	68	64.2
	1	5	4.7
	2	5	4.7
	3	7	6.6
	5	2	1.9
	6	2	1.9
	7	2	1.9
	10	3	2.8
	>10	11	10.4
Unprotected Sexual Activity that Could Lead to Bleeding or Cuts/Breaks/Tears in the Lining of the Vagina or Anus with Primary Partner	0	87	82.1
	1	2	1.9
	2	5	4.7
	3	1	1.9
	4	2	1.9
	5	4	3.8
	6	1	.9
	>10	4	3.8
Unprotected Vaginal Intercourse with Sex Partner Outside of Primary Relationship	0	104	98.1
	2	2	1.9
Unprotected Anal Intercourse with Sex Partner Outside of Primary Relationship	0	106	100
Unprotected Oral Intercourse with Sex Partner Outside of Primary Relationship	0	105	99.1
	1	1	.9
Sharing of Unprotected Sex Toys with Sex Partner Outside of Primary Relationship	0	106	100
Unprotected Sexual Activity that Could Lead to Bleeding or Cuts/Breaks/Tears in the Lining of the Vagina or Anus with Sex Partner Outside of Primary Relationship	0	106	100

Note. n = 106 women, 60 men

Table 4

Correlations Between Predictors, Mediator, and Outcomes Variables

Variable	1	2	3	4	5	6	7	8	9	10
1. Experiences of Discrimination and Rejection[1]	-									
2. Internalized Homonegativity[2]	.164*	-								
3. Sexual Orientation Concealment[3]	.327**	.378**	-							
4. General Stress[1]	.142	.169*	.139	-						
5. Emotional Intimacy[4]	-.097	-.310**	-.264**	-.276**	-					
6. Relationship Satisfaction (KMSS)[3]	-.168*	-.252**	-.230**	-.182*	.673**	-				
7. Relationship Satisfaction (DAS)[3]	-.185*	-.328**	-.221**	-.292**	.631**	.769**	-			
8. Psychological Distress[2]	.200**	.213**	.217**	.758**	-.249**	-.258**	-.328**	-		
9. Health Symptoms[5]	.207**	.044	.127	.441**	-.031	-.090	-.086	.552**	-	
10. Use of Alcohol[2]	-.101	-.059	.038	-.113	.108	.035	.090	-.136	-.045	-
11. Use of Substances Other than Alcohol[5]	.184*	.202**	.038	.166*	-.075	-.117	-.156*	.288**	.286**	-.043
12. UAI with Partner (Men)[6]	.183	.074	-.036	-.150	.080	.247	.358*	-.140	-.146	-.359*
13. UOI with Partner (Men)[7]	.103	.184	-.077	-.021	-.089	.115	.108	-.093	-.095	-.386**
14. UOI with Partner (Women)[8]	.117	-.049	-.031	.116	.109	.166	-.019	.097	.267*	-.008
15. Unprotected Shared Toys (Women)[9]	-.079	-.175	-.052	-.166	.127	.209	.062	-.115	-.049	.040
Mean	1.86	1.72	1.47	18.09	4.63	18.37	40.57	20.15	109.58	1.65
SD	.65	1.01	.60	7.59	.50	2.72	4.85	7.87	30.11	1.10

Variable	11	12	13	14	15
1. Experiences of Discrimination and Rejection[1]					
2. Internalized Homonegativity[2]					
3. Sexual Orientation Concealment[3]					
4. General Stress[1]					
5. Emotional Intimacy[4]					
6. Relationship Satisfaction (KMSS)[3]					
7. Relationship Satisfaction (DAS)[3]					
8. Psychological Distress[2]					
9. Health Symptoms[5]					
10. Use of Alcohol[2]					
11. Use of Substances Other than Alcohol[5]	-				
12. UAI with Partner (Men)[6]	.165	-			
13. UOI with Partner (Men)[7]	.178	.701**	-		
14. UOI with Partner (Women)[8]	.154	[a]	[a]	-	
15. Unprotected Shared Toys (Women)[9]	.189	[a]	[a]	.202	-
Mean	.88	9.38	17.86	12.95	9.27
SD	1.60	17.02	17.39	15.53	12.13

Note. UAI = unprotected anal intercourse; UOI = unprotected oral intercourse. [1]$n = 179$, [2]$n = 181$, [3]$n = 178$, [4]$n = 175$, [5]$n = 180$, [6]$n = 37$, [7]$n = 51$, [8]$n = 75$, [9]$n = 41$. *$p < .05$, **$p < .01$

[a] No valid data points.

Table 5

Multiple Linear Regressions Testing Mediating Role of Emotional Intimacy when Predicting Relationship Satisfaction, Psychological Distress, Health Symptoms, Alcohol Use, or the Use of Substances Other than Alcohol from Either Experiences of Discrimination and Rejection, Internalized Homonegativity, Sexual Orientation Concealment, or the Omnibus.

Relationship Satisfaction (KMSS)				
Predicting Relationship Satisfaction (DV)				
Variable	*B*	*SE B*	*t*	*p*
Constant	4.368	1.422	3.072	0.003
Emotional Intimacy	3.152	0.272	11.575	0.000
Experiences of Discrimination and Rejection	-0.757	1.013	-0.747	0.456
Internalized Homonegativity	-0.328	0.686	-0.478	0.633
Sexual Orientation Concealment	-0.961	0.951	-1.011	0.314
General Stress	-0.002	0.018	-0.086	0.932
Predicting Emotional Intimacy (mediator)				
Variable	*B*	*SE B*	*t*	*p*
Constant	5.040	0.107	47.160	0.000
Experiences of Discrimination and Rejection	0.005	0.291	0.019	0.985
Internalized Homonegativity	-0.478	0.193	-2.475	0.014
Sexual Orientation Concealment	-0.584	0.269	-2.173	0.031
General Stress	-0.014	0.005	-2.801	0.006
Indirect effect(s) through Emotional Intimacy (mediator)				
	Effect	*SE* (boot)	LLCI	ULCI
Experiences of Discrimination and Rejection	0.017	1.033	-1.991	2.027
Internalized Homonegativity	-1.507	0.809	-3.277	-0.103
Sexual Orientation Concealment	-1.842	0.960	-4.026	-0.155
Omnibus	0.223	0.183	-0.013	0.598
Omnibus Test of Direct Effect				
R^2	*F*	*df1, df2*	*p*	
.008	0.946	3, 163	.420	

Relationship Satisfaction (DAS)				
Predicting Relationship Satisfaction (DV)				
Variable	*B*	*SE B*	*t*	*p*
Constant	17.865	2.991	5.973	0.000
Emotional Intimacy	5.371	0.579	9.276	0.000
Experiences of Discrimination and Rejection	-3.052	2.072	-1.473	0.143
Internalized Homonegativity	-0.268	1.432	-0.187	0.852
Sexual Orientation Concealment	-0.591	1.972	-0.300	0.765
General Stress	-0.065	0.036	-1.803	0.073
Predicting Emotional Intimacy (mediator)				
Variable	*B*	*SE B*	*t*	*p*
Constant	4.997	0.102	49.092	0.000

Experiences of Discrimination and Rejection	0.054	0.279	0.195	0.846
Internalized Homonegativity	-0.586	0.187	-3.132	0.002
Sexual Orientation Concealment	-0.361	0.264	-1.368	0.173
General Stress	-0.012	0.005	-2.626	0.010

Indirect effect(s) through Emotional Intimacy (mediator)

	Effect	*SE* (boot)	LLCI	ULCI
Experiences of Discrimination and Rejection	.291	1.748	-3.410	3.544
Internalized Homonegativity	-3.146	1.252	-5.810	-0.889
Sexual Orientation Concealment	-1.936	1.393	-4.947	0.531
Omnibus	0.383	0.316	-0.028	1.056

Omnibus Test of Direct Effect

R^2	*F*	*df1, df2*	*p*
.010	.940	3, 164	.423

Psychological Distress

Predicting Psychological Distress (DV)

Variable	*B*	*SE B*	*t*	*p*
Constant	6.104	4.008	1.523	0.130
Emotional Intimacy	0.074	0.775	0.100	0.924
Experiences of Discrimination and Rejection	-2.720	2.664	-1.021	0.309
Internalized Homonegativity	1.700	1.842	0.918	0.360
Sexual Orientation Concealment	0.687	2.522	0.273	0.786
General Stress	0.747	0.046	16.266	0.000

Predicting Emotional Intimacy (mediator)

Variable	*B*	*SE B*	*t*	*p*
Constant	5.018	0.098	51.457	0.000
Experiences of Discrimination and Rejection	-0.072	0.268	-0.269	0.788
Internalized Homonegativity	-0.621	0.179	-3.465	0.001
Sexual Orientation Concealment	-0.387	0.252	-1.532	0.127
General Stress	-0.011	0.005	-2.389	0.018

Indirect effect(s) through Emotional Intimacy (mediator)

	Effect	*SE* (boot)	LLCI	ULCI
Experiences of Discrimination and Rejection	-0.005	0.289	-0.714	0.538
Internalized Homonegativity	-0.460	0.614	-1.172	1.341
Sexual Orientation Concealment	-0.290	0.436	-0.973	0.848
Omnibus	0.007	0.120	-0.280	0.223

Omnibus Test of Direct Effect

R^2	*F*	*df1, df2*	*p*
.004	.653	3, 163	.582

Health Symptoms

Predicting Health Symptoms (DV)

Variable	*B*	*SE B*	*t*	*p*
Constant	33.829	22.845	1.481	0.141
Emotional Intimacy	8.493	4.423	1.920	0.057
Experiences of Discrimination and Rejection	13.941	15.828	0.881	0.380

Internalized Homonegativity	1.525	10.942	0.139	0.889
Sexual Orientation Concealment	4.400	15.060	0.292	0.771
General Stress	1.703	0.276	6.179	0.000

Predicting Emotional Intimacy (mediator)

Variable	*B*	*SE B*	*t*	*p*
Constant	4.994	0.103	48.485	0.000
Experiences of Discrimination and Rejection	0.056	0.279	0.199	0.843
Internalized Homonegativity	-0.584	0.188	-3.111	0.002
Sexual Orientation Concealment	-0.361	0.264	-1.364	0.175
General Stress	-0.012	0.005	-2.583	0.011

Indirect effect(s) through Emotional Intimacy (mediator)

	Effect	*SE* (boot)	LLCI	ULCI
Experiences of Discrimination and Rejection	0.472	3.309	-4.508	9.533
Internalized Homonegativity	-4.960	3.386	-14.710	-0.378
Sexual Orientation Concealment	-3.062	2.785	-11.552	0.429
Omnibus	0.602	0.611	-0.086	2.372

Omnibus Test of Direct Effect

R^2	*F*	*df1, df2*	*p*
.006	.385	3, 163	.764

Alcohol Use

Predicting Alcohol Use (DV)

Variable	*B*	*SE B*	*t*	*p*
Constant	0.398	0.980	0.406	0.685
Emotional Intimacy	0.320	0.190	1.689	0.093
Experiences of Discrimination and Rejection	-0.337	0.679	-4.496	0.621
Internalized Homonegativity	0.390	0.469	0.831	0.407
Sexual Orientation Concealment	0.389	0.646	0.602	0.548
General Stress	-0.013	0.012	-1.127	0.262

Predicting Emotional Intimacy (mediator)

Variable	*B*	*SE B*	*t*	*p*
Constant	4.997	0.102	49.092	0.000
Experiences of Discrimination and Rejection	0.054	0.279	0.195	0.846
Internalized Homonegativity	-0.586	0.187	-3.132	0.002
Sexual Orientation Concealment	-0.361	0.264	-1.368	0.173
General Stress	-0.012	0.005	-2.626	0.010

Indirect effect(s) through Emotional Intimacy (mediator)

	Effect	*SE* (boot)	LLCI	ULCI
Experiences of Discrimination and Rejection	0.017	0.119	-0.182	0.325
Internalized Homonegativity	-0.188	0.124	-0.511	-0.008
Sexual Orientation Concealment	-0.116	0.101	-0.411	0.016
Omnibus	0.023	0.023	-0.003	0.083

Omnibus Test of Direct Effect

R^2	*F*	*df1, df2*	*p*
.009	.516	3, 164	.672

Use of Substances other than Alcohol

Predicting Use of Substances other than Alcohol (DV)				
Variable	*B*	*SE B*	*t*	*p*
Constant	0.757	1.305	0.580	0.563
Emotional Intimacy	-0.126	0.254	-0.495	0.621
Experiences of Discrimination and Rejection	0.431	0.905	0.476	0.635
Internalized Homonegativity	0.389	0.618	0.631	0.529
Sexual Orientation Concealment	-0.211	0.853	-0.248	0.805
General Stress	0.025	0.016	1.614	0.109
Predicting Emotional Intimacy (mediator)				
Variable	*B*	*SE B*	*t*	*p*
Constant	4.972	0.101	49.362	0.000
Experiences of Discrimination and Rejection	0.168	0.278	0.603	0.547
Internalized Homonegativity	-0.539	0.185	-2.912	0.004
Sexual Orientation Concealment	-0.289	0.261	-1.106	0.270
General Stress	-0.013	0.005	-2.808	0.006
Indirect effect(s) through Emotional Intimacy (mediator)				
	Effect	*SE* (boot)	LLCI	ULCI
Experiences of Discrimination and Rejection	-0.021	0.093	-0.356	0.079
Internalized Homonegativity	0.068	0.138	-0.125	0.466
Sexual Orientation Concealment	0.036	0.090	-0.068	0.366
Omnibus	-0.007	0.022	-0.078	0.019

Omnibus Test of Direct Effect			
R^2	*F*	*df1, df2*	*p*
.004	.214	3, 163	.886

Chapter Five: Discussion

The current study examined the relationships between minority stress, emotional intimacy, relationship satisfaction, and health. Previous research has shown that stress negatively affects heterosexual couple functioning (Bodenman, Ledermann, & Bradbury, 2007) and minority stress negatively affects LG individuals' functioning (Meyer, 1995). Additionally, emotional intimacy has been shown to positively affect health among heterosexual couples (Ornish, 1998) and both stress and lack of intimacy have been shown to decrease relationship satisfaction (Bodenmann, 2005; Schaefer & Olson, 1981). Among individuals in LG couples, emotional intimacy has been shown to be the most important predictor of relationship satisfaction (Deenen, Gijs, & Van Naerssen, 1994; Eldridge & Gilbert, 1990). Same- and different-sex couples have been shown to be more similar than different and preliminary evidence suggests that minority stress affects LG couple functioning (e.g., relationship quality; Balsam & Szymanski, 2005; Elizur & Mintzer, 2003). Thus, one goal of the current study was to examine whether findings from studies of stress among different-sex couples extend to individuals in LG couples. Another goal was to examine whether findings from minority stress studies among LG individuals extend to LG individuals who are in a relationship.

It was hypothesized that minority stress would negatively affect emotional intimacy, relationship satisfaction, and health outcomes. At the same time, emotional intimacy would positively affect relationship satisfaction and health. Moreover, a mediating relationship was hypothesized, such that emotional intimacy would mediate the relationship between minority stress and outcomes (i.e., relationship satisfaction and health outcomes).

Summary of Findings

At the bivariate level, the variable of experience of discrimination was significantly negatively correlated with relationship satisfaction (both the KMSS and DAS measure) and significantly positively correlated with psychological distress, health symptoms, and the use of substances other than alcohol. Internalized homonegativity was significantly negatively correlated with relationship satisfaction (both measures) as well as emotional intimacy and significantly positively correlated with psychological distress and the use of substances other than alcohol. Sexual orientation concealment was significantly negatively correlated with relationship satisfaction (both measures) and emotional intimacy and significantly positively correlated with psychological distress. Emotional intimacy was significantly positively correlated with both measures of relationship satisfaction and negatively correlated with psychological distress.

At the multivariate level, minority stress was not significantly related to relationship satisfaction or health outcomes in any of the mediation analyses, which differs from the bivariate level. This result holds true for the three individual minority stress predictor variables as well as the composite minority stress variable. The multivariate results are consistent with previous research that found that the minority stress variable of experiences of discrimination did not affect the intimate relationship (Mays et al., 1993, Otis et al., 2006, Balsam & Szymanski, 2005). As was highlighted by the authors of these studies, it may be that discrimination only affects the relationship when it is severe. The current study did not assess the severity of the discriminatory experience. While the multivariate results from the current study are not consistent with previous research on the minority stress variables of internalized homonegativity and

sexual orientation concealment, the bivariate results are generally in line with the extant literature. Internalized homonegativity has been found to negatively impact relationship quality (Balsam & Szymanski, 2005; Elizur & Mintzer, 2003) and sexual orientation concealment has been shown to negatively affect relationship satisfaction (Berzon, 1988). Additionally, minority stress and its various components have been found to negatively affect psychological and physical health among LG individuals (Meyer, 1995; Waldo, 1999). Because the minority stress variables were all significantly intercorrelated, the shared variance among the predictor variables may have reduced the amount of variance available to predict the criterion variables at the multivariate level.

At the multivariate level, emotional intimacy positively predicted relationship satisfaction (for both relationship satisfaction mediation models), which is consistent with the bivariate results. Although emotional intimacy was significantly correlated with psychological distress at the bivariate level, it did not predict any of the health outcomes at the multivariate level. Previous research identified emotional intimacy as being the most important predictor of relationship satisfaction (Deenen, Gijs, & Van Naerssen, 1994; Eldridge & Gilbert, 1990), therefore the findings from the current study are consistent with the literature. Although no study to date has examined the relationship between emotional intimacy and health among LG couples, studies of heterosexual couples have shown that emotional intimacy positively affects psychological and physical health (Ornish, 1998). It may be that emotional intimacy was not significantly related to physical health in the current study because the sample consisted of individuals with few health symptoms (average score of 109.58 out of a maximum of 270). Previously reported means from sexual minority samples have ranged from 98.62-109.57. Perhaps

emotional intimacy only becomes a significant predictor of physical health in samples that include people with more health problems. Similarly, participants in the current study had particularly low alcohol and substance use frequency scores. It is possible that emotional intimacy would be significantly negatively related to alcohol and substance use in a sample consisting of individuals who more frequently drink alcohol/use substances.

The minority stress variable of internalized homonegativity negatively predicted emotional intimacy in all mediation models and sexual orientation concealment negatively predicted emotional intimacy in one model (KMSS). These results are in line with the bivariate level analysis. Also consistent with the bivariate results, the variable of experiences of discrimination and rejection did not predict emotional intimacy. The relationship between minority stress and emotional intimacy has not been investigated among LG couples. Studies of heterosexual couples have found that stress negatively impacted factors closely related to emotional intimacy (e.g., communication, conflict, sexual relations, Bodenmann, 2005; Bodenmann et al., 2007), suggesting that stress impacts emotional intimacy among this group. As such, the finding from the current study (that internalized homonegativity and sexual orientation concealment negatively predicted emotional intimacy) is consistent with the literature on different-sex couples. The nonsignificant finding for the relationship between experiences of discrimination and rejection and emotional intimacy may speak to low levels of experienced discrimination and rejection (M = 1.86 out of a total score of 6.00) and the high levels of emotional intimacy in this sample (M = 4.63 out of a total score of 5.00). Previous reported means in similar samples were 1.66-2.09 and 4.44 respectively. Discrimination and rejection may only negatively affect emotional intimacy at higher levels or among individuals who

experience low levels of emotional intimacy in their relationship. The current findings on the relationship between the minority stress variables and emotional intimacy in the LG population are novel; as such future research is warranted to replicate findings.

Emotional intimacy mediated the relationship between internalized homonegativity and relationship satisfaction (for both of the relationship satisfaction models), health symptoms, and alcohol use. That is, the relationship between internalized homonegativity and outcomes was explained by emotional intimacy: internalized homonegativity was related to decreased emotional intimacy; decreased emotional intimacy, in turn, was related to decreased relationship satisfaction and increased health symptoms and alcohol use. In other words, the relationship between internalized homonegativity and relationship satisfaction is indirect; it operates through the relationship of internalized homonegativity and emotional intimacy. Moreover, when the effect of emotional intimacy was controlled for (i.e., the variance accounted for by emotional intimacy was kept the same throughout analyses), the strength of the relationship between internalized homonegativity and relationship satisfaction, health symptoms, and alcohol use was reduced. Thus, emotional intimacy explained the relationship between internalized homonegativity and outcomes. These findings highlight the importance of emotional intimacy in LG couples: in the presence of emotional intimacy the relationship between internalized homonegativity and outcomes (relationship satisfaction and certain health outcomes) is weakened. Considering that LG individuals are at increased risk for negative health outcomes and LG couples experiencing minority stress are at increased risk of negative relationship outcomes, emotional intimacy may be a key contributor to optimal wellness among sexual minority

individuals and couples. One of the many negative effects of internalized homonegativity is the erosion of emotional intimacy, which is especially detrimental since emotional intimacy contributes to higher relationship satisfaction and decreased health symptoms and alcohol use. The current study is the first to examine the mediating role of emotional intimacy in the relationship between minority stress and relationship satisfaction, health symptoms, and substance use among the LG population. As such, further investigation is necessary to establish the robustness of emotional intimacy as a highly desirable quality among individuals in LG couples.

Emotional intimacy also mediated the relationship between sexual orientation concealment and relationship satisfaction (for the KMSS model). Therefore, the presence of emotional intimacy was associated with a decreased relationship between sexual orientation concealment and relationship satisfaction. Concealment has been found to be particularly harmful to LG couple functioning (e.g., decreased relationship satisfaction, anxiety about the relationship, lack of social support due to hiding the relationship, and decreased coping; Berzon, 1988; Jordan & Deluty, 2000; Almeida et al., 1994; Elizur & Mintzer, 2003) and knowing how the impacts of concealment can be decreased is an important finding.

Emotional intimacy did not mediate the relationship between experiences of discrimination and rejection and outcomes. As was previously stated, the current sample had low levels of reported experiences of discrimination and rejection. Emotional intimacy may only be a mediator in a sample with higher experiences of discrimination and rejection scores. Low levels of discrimination and rejection might not have a strong effect on an LG person's relationship satisfaction or health, therefore emotional intimacy

is less impactful as a mediator. For individuals experiencing higher levels of discrimination and rejection, however, emotional intimacy might serve to help decrease negative outcomes. Future research examining the relationship between experiences of discrimination and emotional intimacy is warranted to better understand the implications of levels of discrimination. Given that emotional intimacy weakened the relationship between the two other minority stress variables and relationship satisfaction, such an investigation might yield similar findings.

Emotional intimacy did not mediate the relationship between the omnibus variable (composite of three minority stress variables) and outcomes. This finding is reasonable given that emotional intimacy did not mediate the relationship between experiences of discrimination and rejection and outcomes and only mediated the relationship between sexual orientation concealment and relationship satisfaction (not the four other outcomes). Moreover, experiences of discrimination and rejection did not affect any of the outcomes at the multivariate level and sexual orientation concealment only affected one outcome (KMSS relationship satisfaction model). Combining the effect of the three minority stress variables appears to have only served to decrease the mediation potential of emotional intimacy.

In summary, the findings from the current study highlight the important role of emotional intimacy in the intimate relationships of LG individuals. Researchers have previously found that sexual orientation concealment and internalized homonegativity negatively impact LG relationships. Studies have also highlighted that emotional intimacy is the most important predictor of relationship satisfaction among individuals in same-sex couples. Consistent with LG couple literature, the present study demonstrated

that the presence of emotional intimacy can help decrease the negative effect of internalized homonegativity and sexual orientation concealment on relationship satisfaction. Emotional intimacy is also important in terms of health among individuals in LG couples as it can weaken the negative effect of internalized homonegativity on health symptoms and alcohol use.

Limitations

While a strength of the current study is that it was the first to explore the relationships between emotional intimacy, minority stress, and relationship and health outcomes, several limitations should be taken into consideration. Data from the current study are cross-sectional survey data, which does not allow for the assumptions of causal relationships between variables. For example, emotional intimacy may cause relationship satisfaction. However, it is also plausible that LG individuals who are satisfied with their relationship are in a more conducive state of mind to be emotionally intimate with their partner. Partners who are not satisfied with their relationship, on the other hand, may be more likely to distance themselves from their partner. Similarly, internalized homonegativity may lead to decreased emotional intimacy. However, it is equally likely that individuals who lack emotional intimacy are more susceptible to internalized homonegativity. In other words, a person who lacks supportive emotional interactions with his or her partner may be more vulnerable to internalizing society's negatives views of sexual orientation. Next, all questionnaires were self-report, making them subjective. Results could have been strengthened by more objective measures, such as having a clinician rate emotional intimacy and health symptoms/risk behavior. Likewise, only one partner in the couple was permitted to participate in the current study. Allowing both to

participate would have allowed for comparisons between how partners scored on the various measures. Likewise, analyses could have been at the dyad level rather than the individual level, which would have allowed for conclusions about LG *couples* as opposed to conclusions about only *individuals* in LG couples.

The generalizability of these findings is limited by the racially-homogenous, well-educated, and largely-unmarried sample. The experiences of White LG individuals may be different from LG individuals of color. For example, studies have found that Black individuals report greater disapproval of homosexuality than White people (Lewis, 2003). Minority stress may therefore be more salient among LG individuals of color and may have a greater impact on emotional intimacy and relationship satisfaction within a couple. Similarly, LG people of color may face multiple oppressions (racial oppression in addition to sexual orientation oppression), which may make their experiences different from White people. Participants were also highly educated; their experiences may differ from individuals with less education. Furthermore, the majority of the sample (63.5%) consisted of individuals who were not married. People with legalized couple status may have different experiences than the majority of individuals surveyed in the current study. Indeed, individuals who were married, in a civil union, or equivalent were different than those who were not on a number of variables. Lastly, the sample consisted of individuals who were fairly open about their sexual orientation, experiences of gay-related stress, and sexual behavior. Given their openness to participate in a survey on these topics, they likely have well-developed gay identities compared to individuals who saw the advertisement and chose not to participate. These characteristics may not be representative of the larger LG population that includes individuals who conceal their

sexual orientation and thus may not be open about their experiences. Taking this into consideration, the results should be viewed with caution.

The sampling procedure used in the present study also limits the generalizability of findings. Participants were recruited online mainly though LG-focused LISTSERVs. Individuals who did not have access to the Internet or who were not registered with the LISTSERVs were not likely to have seen the study advertisement. Additionally, there may have been differences between those who volunteered to participate and those who did not. For example, individuals who are in troubled relationships may be less motivated to share their experiences via a research study. The study advertisement also limits the generalizability of findings. The call for the study requested lesbian and gay individuals in same-sex couples. Individuals who did not consider themselves to be lesbian or gay (e.g., queer or other) but who may have been in same-sex/same-gendered relationships may have opted not to participate. Similarly, individuals who were in same-gendered relationships but did not consider their relationship to fall under the same-sex umbrella may have disregarded the study advertisement; this scenario may have included trans individuals whose gender (i.e., their felt sense of masculinity, femininity, androgyny, or other) was the same as their partner but whose sex (i.e., biological sex) was different. Relatedly, the sexual risk behavior portion of the questionnaire may have been problematic for some participants. The section for women included questions about vaginal sex. Although some women may have answered assuming this was understood to mean the insertion of a penis, any type of insertion (finger, fist, dildo) would have qualified.

Related to the sampling procedure, a statistical limitation in the current study was the strong positive skew in internalized homonegativity and sexual orientation concealment scores (i.e., low scores). This may be due to self-selection bias, wherein only the individuals who were motivated to participate in a study on lesbian and gay couples chose to fill out the survey. Such participants may be less likely to apply society's anti-LGB beliefs to the self and less likely to conceal their sexual orientation and same-sex relationship than individuals who are not motivated to share their experiences.

Directions for Future Research

Given that only a small amount of research exists on minority stress and relationship satisfaction, further research is warranted in order to better understand the links between minority stress and relationship functioning and identify mediators associated with negative outcomes. The present study identified emotional intimacy as a mediator in the relationship between both internalized homonegativity and sexual orientation concealment and relationship satisfaction and between internalized homonegativity and both health symptoms and alcohol use. Both internalized homonegativity and sexual orientation concealment have been shown to negatively impact relationship satisfaction and minority stress has been found to negatively impact psychological and physical health among LG individuals. In light of the current findings, it is likely that emotional intimacy is implicated in a number of important outcomes. Specifically, when emotional intimacy is present in a couple's life, it is likely that minority stress will have less of an impact on relationship satisfaction, health symptoms, and alcohol use. Identifying mediators provides insights into how to reduce the negative

effects of minority stress on LG individuals and couples. As such, the identification of other mediators may lend further insight into factors that protect against minority stress. One such mediator is social support, which positively affects the overall functioning of different-sex relationship (Kurdek, 2004). Perhaps minority stress is associated with social support by rendering the couple invisible due to relationship concealment, which in turn affects relationship satisfaction because of a decreased ability to cope with everyday stressors. Future research might also examine moderators, such as legal recognition of marriage. Marriage inequality creates an environment associated with negative psychological outcomes for individuals in LG couples (Rostosky et al., 2009). It may be that individuals whose relationship is legally recognized are advantaged in terms of psychological health and thus experience a decreased effect of minority stress on relationship satisfaction.

Next, future research might re-examine the relationship between the variable of experiences of discrimination and relationship satisfaction. Although the current study found a nonsignificant relationship, which aligned with previous findings, addressing study limitations may alter the findings. It will be important to refine the measurement of discrimination so that researchers can better capture the experiences of those individuals most affected. Indeed, studying samples where discrimination is low or moderate may not give us insight into the effects of minority stress on relationship satisfaction. Such investigations are worthwhile in light of the fact LG individuals and couples continue to face societal oppression that could understandably affect the intimate relationship. Similarly, because minority stress has been found to negatively affect psychological and physical health, further research examining the effect of experiences of discrimination on

health is warranted. At the same time, many individuals in same-sex couples describe having satisfying and successful relationships (Frost, 2011a) despite persistent experiences of stigma. Further research is necessary in order to determine under what conditions couples are able to successfully navigate the negative effects of stigma, as well as under what conditions stigma takes hold and negatively impacts couples' relational and psychological well-being. Mohr and Daly (2008) pointed out that while the study of stigmatized couples increases knowledge about the adverse consequences of prejudice on couples, it also provides insight about ways that couples can become stronger by successfully facing adversity.

Another focus for future studies entails the relationship between sexual orientation concealment and emotional intimacy. Although the current study found a significant relationship in only one of the five mediation models performed, this lack of significant findings may have been due to the restricted variance in the concealment measure (most participants had low scores on concealment and there was little variation). Emotional intimacy is less likely to be negatively affected in a sample of people who do not conceal their sexual orientation (i.e., who have well-developed gay identities). When societal prejudice and discrimination lead LG individuals to conceal their sexual orientation and same-sex relationship, these individuals are less likely to fulfill their needs for emotional intimacy. Specifically, consequences of concealment include cognitive burden and fatigue (Smart & Wegner, 2000), devaluation of the relationship (Berzon, 1988), anxiety about the relationship (Jordan & Deluty, 2000), deprivation of social support (Almeida et al., 1994), and decreased coping (Elizur & Mintzer, 2003), to

name a few. Any of these factors could arguably interfere with the individual's ability to connect with his/her partner.

Yet another variable that warrants investigation in relation to emotional intimacy and minority stress is race. The large majority of the sample in the current study was White; as such, findings are not generalizable to people of color. However, an examination of demographic differences showed that participants of color had higher scores on sexual orientation concealment than White participants. As noted above, sexual orientation concealment can interfere with emotional intimacy. There is a paucity of empirical research on minority stress in racial minority LG couples. It has been found, however, that racial discrimination can produce psychological distress in both heterosexual (Murry et al., 2001) and lesbian couples (Mays et al., 1993). As previously described, such distress has been linked to difficulties connecting with one's partner. Racial discrimination can also decrease relationship quality (Murry et al., 2001). Therefore, it would be important to explore, for example, whether LG individuals of color who experience psychological distress and decreased relationship quality stemming from racial discrimination are at a disadvantage for connecting emotionally with their partner.

In addition, gender warrants further investigation in relation to emotional intimacy. Scholars (e.g., Kurdek, 1998) often note that lesbian women experience gender role socialization that reinforces nurturance, expressiveness, and caring, which can be argued to be conducive to emotional intimacy. However, as discussed, emotional intimacy is an important aspect of both lesbian and gay relationships in predicting relationship satisfaction. The current study found that men and women did not

significantly differ on emotional intimacy scores. In order to bolster this finding and address gendered stereotypes suggesting that lesbians may be more capable of relating intimately than gay male couples, future studies should continue to test for gender differences in levels of emotional intimacy as well as the relationship between emotional intimacy and other variables.

Next, relationship status merits continued examination in relation to minority stress, emotional intimacy, relationship satisfaction, and health. Compared to their married counterparts, unmarried participants in the present study had higher scores on internalized homonegativity, sexual orientation concealment, general stress, and psychological distress, and lower scores on emotional intimacy and relationship satisfaction. Since marriage is not a universal right, these findings are striking. Indeed, it has been shown that marriage amendments denying same-sex couples the right to marry result in greater minority stress and higher levels of psychological distress (Rostosky, Riggle, Horne, & Miller, 2009; Rostosky, Riggle, Horne, Denton, & Huellemeier, 2010). It may be that if marriage were a right granted to all individuals, same-sex couples would experience decreased stress and, as a result, increased emotional intimacy. Because this dissertation did not examine whether participants lived in areas where same-sex marriage was legal, future research is needed to explore this hypothesis. Indeed, as more jurisdictions in North America and around the world grant same-sex couples the same rights to marriage as different-sex couples, continued research can help to shed light on the mental and relationship health impacts of marriage equality.

Another area warranting attention is the lack of unity regarding measurement of emotional intimacy. Numerous investigators have created measures that assess emotional

intimacy in a range of close relationships. As Sinclair and Dowdy (2005) outlined in their review of the measurement of emotional intimacy, about a half dozen measures are commonly used. Emotional intimacy tends to be assessed with a subscale in a larger measure of general intimacy. For example, the PAIR (Schaefer & Olsen, 1981) and the Intimate Relationship Scale (Hetherington & Soeken, 1990) assess emotional intimacy as one of several types of intimacy. Aside from subscales, sometimes constructs that are related to emotional intimacy are measured, such as affection and compatibility (e.g., the Waring Intimacy Questionnaire; Waring & Reddon, 1983) and these scores are used to represent emotional intimacy. With the large number of measures and constructs being used across studies, it becomes difficult to compare study findings. Moreover, study findings cannot be seen as exact replications of previous works if the variables are not measured using the same instruments. Replication is important for a number of reasons, including the validity and reliability of results, the generalizability of findings, and the creation of new research based on the combination of findings from previous studies. Additionally, there is no measure uniquely tailored to lesbian and gay individuals. It has been shown that different-sex and same-sex couples share certain features; however, there are distinct issues only relevant to the latter.

A final direction for future research is the investigation of whether attachment style and emotional intimacy are related. Although the constructs have not yet been linked in LG couples, attachment has been linked to difficulties with self-acceptance and low levels of self-disclosure (Mohr & Fassinger, 2000). A key component of emotional intimacy is the sharing of personal feelings; as such, low levels of self-disclosure stemming from insecure attachment could affect emotional intimacy within the couple.

Also, difficulties with self-acceptance rooted in insecure attachment may manifest as internalized homonegativity in LG couples. Internalized homonegativity may impede emotional intimacy by making it difficult to relate to one's partner and by decreasing openness and sharing. Taken together, future research might focus on the relationship between emotional intimacy and attachment, including whether attachment styles impact emotional intimacy.

Clinical and Training Implications

In addition to the implications for research as described above, there are numerous implications for practice. One such implication is that of social justice, which is a major tenant of counseling psychology. The goal of social justice is "full and equal participation of all groups in a society that is mutually shaped to meet their needs. Social justice includes a vision of society in which the distribution of resources is equitable and all members are physically and psychologically safe and secure" (Bell, 1997, p. 3). Sexual minority stress literature highlights the need for social change in order to mitigate the stress LG couples face due to societal discrimination. At the macro level, the dissemination of knowledge gained from research on the effects of minority stress on same-sex couples can inform discriminatory policies affecting sexual minority individuals and couples. Social science research ought to be used to better the lives of stigmatized individuals through policy changes and improved educational practices. Part of working within a social justice framework has to do with practice at the micro level; therapists can help to facilitate agency in clients by educating same-sex couples about the social context of their problems as well as helping them to create and implement coping strategies that will empower them (Rostosky et al., 2007). The new knowledge garnered

by the present study can help therapists to better understand the social contexts of discrimination in which their LG clients might be situated and help them to inspire in their clients new ways of coping, such as increasing emotional intimacy.

The present study demonstrated that emotional intimacy is associated with a decreased effect of minority stress on relationship and health outcomes. As such, it would be worthwhile for practitioners to include emotional intimacy as a therapeutic focus when working with LG individuals and couples. One such way would be to use emotion-focused coping strategies, which Austenfeld and Stanton (2004) point out may be as helpful or even more helpful than traditional problem-focused coping strategies for couples with stigmatized identities. A perfect example of such a model is Emotion Focused Therapy (EFT), which focuses on the connection between partners and increasing emotional engagement (Johnson & Greenman, 2006; see Hardtke, Armstrong, & Johnson, 2010, for an examination of the use of EFT with lesbian couples). EFT suggests identifying the problematic interactional cycle and underlying emotions maintaining relationship distress and identifying with disowned aspects of self (e.g. shame, unworthiness) (Johnson & Greenman, 2006). Two distinctive sources of gay-related stress that can contribute to a problematic interaction cycle are internalized homonegativity and sexual orientation concealment. Both these variables could also be seen as related to disowned aspects of the self. The current study found that emotional intimacy mediated the relationship between sexual orientation concealment and relationship satisfaction, and between internalized homonegativity and relationship satisfaction, alcohol use, and health symptoms. By directly focusing on emotional intimacy, EFT is a well-suited therapeutic model for LG couples, targeting a vital

protective factor against negative outcomes for LG couples experiencing minority stress. There are a number of potential routes for future studies within the clinical framework: an examination of the effectiveness of EFT for increasing emotional intimacy in lesbian and gay couples; an exploration of how EFT therapists address sexual minority issues impacting emotional intimacy; and an investigation of lesbian and gay couples currently in EFT regarding their views of how EFT may and may not be sensitive to their unique experiences and concerns.

Lesbian and gay couples may wish to see a therapist who is well informed of sexual minority issues. As such, it is vital for practitioners working with same-sex couples to be sensitive to sources of stress that may be above and beyond the stresses faced by their heterosexual counterparts. These unique stressors as previously outlined include contending with experiences of homophobia and heterosexism, differences in the degree of outness within the couple, a potential lack of support from family and friends, and the strain of mainstream gender norms applied to LG individuals (Bepko & Johnson, 2000). Being knowledgeable about these possible sources of conflict may bolster practitioners' ability to accurately address the couple's issues. For example, practitioners might avoid the pitfall of misdiagnosing an external source of stress as being rooted within the couple. In addition to educating themselves about the unique stressors in same-sex couples, therapists would also benefit from examining their views of relationships that may stem from heterosexual bias. For instance, a heterosexual practitioner may believe that monogamy is a key ingredient for a functional relationship; however, that is not necessarily the case for gay male couples (Bonello & Cross, 2010). Similarly, some

lesbian couples may appear to be enmeshed, while in fact they are satisfied and functioning well with their degree of closeness (Schreurs & Buunk, 1996).

In addition to research and practice, there are implications for training. There continues to be a need for training programs to provide opportunities for developing competence in working with sexual minority clients (Schneider, Brown, & Glassgold, 2002). Numerous scholars have argued that the generalist training model provided by most programs inadequately prepares students for work with LG clients (Buhrke & Douce, 1991; Clark & Serovich, 1997; Dworkin, 1992; Murphy, Rawlings, & Howe, 2002). Such generalist models tend to be rooted in heterosexual bias that can actually result in harm to LG clients (Phillips & Fischer, 1998). Consequently, training programs must provide students with the chance to face and sort out homophobia and heterosexist biases. Part of this process involves teaching trainees about the unique challenges and stressors faced by lesbian and gay individuals as well as educating them about how the lesbian and gay culture is both similar to and different from the dominant culture.

Even more striking than the inadequate training in LG individual issues is the near omission of LG couple training in graduate programs. Researchers have indicated that although trainees will have some experience serving LG individuals and couples in their clinical training practicum, it is rare that graduate-level training coursework includes a focus on the unique needs of LG couples (Israel, Ketz, Detrie, Burke, & Shulman, 2003; Rutter, Estrada, Ferguson, & Diggs, 2008). Israel and colleagues (2003) suggested highlighting these unique needs in couples counseling courses by including LG couple scenarios in training protocols. Findings from the present study can inform such protocols. Specifically, it is worthwhile for trainees and clinicians to be aware of the

important role of emotional intimacy in the relationships of LG couples. Emotional intimacy can lessen the impact of internalized homonegativity and sexual orientation concealment on relationship satisfaction. Considering that sexual minority clients may exhibit high-risk behaviors due to stress stemming from their marginalized status (American Psychological Association, 2000), it is vital for training to include knowledge of variables that positively affect their well-being. Readers interested in gaining knowledge in counseling sexual minority clients may refer to *The Handbook of Counseling and Psychotherapy With Lesbian, Gay, and Bisexual Clients* (Perez, DeBord, & Bieschke, 2000). Additionally, *Lesbian, Gay, Bisexual, Trans, and Queer Psychology: An Introduction* (Clarke, Ellis, Peel, & Riggs, 2010) offers an overview of many different aspects of the lives of lesbian, gay, bisexual, trans, and queer people.

Summary and Conclusions

The purpose of the present study was to examine the relationship between minority stress, emotional intimacy, relationship satisfaction, and health. The results suggested that emotional intimacy mediates the relationship between internalized homonegativity and relationship satisfaction, health symptoms, and alcohol use as well as the effect of sexual orientation concealment on relationship satisfaction. These findings add support to research suggesting that internalized homonegativity and sexual orientation concealment negatively affect relationship satisfaction and that minority stress negatively affects health among LG individuals. The results are also consistent with literature highlighting the importance of emotional intimacy in same-sex couples. Future research should continue to explore minority stress among individuals in LG couples, with particular attention paid to intimacy and health outcomes. Research on emotional

intimacy in this population is relatively new and is a valuable focus, given that it may serve as a protective factor against societal oppression. Continued examination of minority stress in same-sex couples will increase our understanding of both the challenges as well as sources of strength within a couple. The knowledge gained from the present study and future inquiries can be useful to practitioners for guiding the treatment of lesbian and gay couples seeking therapy.

The most significant finding in the current study is the mediated pathway leading from internalized homonegativity to relationship satisfaction through reduced emotional intimacy, while controlling for general stress. Although all couples must contend with general stress, same-sex couples must contend with additional stress—minority stress—stemming from societal stigma. The current findings demonstrate that it is not just stress that negatively impacts relationship satisfaction among individuals in same-sex couples; rather, minority stress has an effect on relationship satisfaction over and above general stress. By further demonstrating the deleterious impact of sexual minority stress on relationship satisfaction, it can be argued that a more egalitarian society would ameliorate the overall well-being of partners in same-sex couples. Considering that universal rights are not yet a reality for sexual minority people, findings may be used as incentive in the fight for equality.

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Appendix A: Study Advertisement

McGill

Minority stress, intimacy, relationship satisfaction, and health in same-sex couples

ARE YOU CURRENTLY IN AN INTIMATE RELATIONSHIP WITH A SAME-SEX PARTNER THAT HAS LASTED AT SIX MONTHS?

Lesbian and gay individuals aged 18 years or older who are currently in a same-sex relationship of at least six months and who can answer questions about intimacy and relationship satisfaction are wanted for a doctoral dissertation study conducted by Andrea Gusclbauer under the supervision of Dr. Nathan Grant Smith.

The goal of the study is to learn more about how individuals in same-sex couples are affected by minority stress, with special attention on intimacy, relationship satisfaction, and health.

If you are willing to participate in a 15 to 45 minute online questionnaire, please go to https://www.surveymonkey.com/s/8ZM22PS.

Only one member of the couple can participate in the study.

For more information (including information for completeing the questionnaire over the phone or having the questionnaire mailed to you), please contact:

Andrea Guschlbauer, Ph.D. Candidate, Dept. of Educatonal and Counselling Psychology, McGill University
andrea.guschlbauer@mail.mcgill.ca

Supervisor: Nathan Grant Smith, Ph.D., Dept. of Educational and Counselling Psychology, McGill University
nathan.smith@mcgill.ca

Please note that the Ethics Review Board of McGill University has approved this study.

*By completing the online questionnaire, you have a 3/150 chance to win a $50 Amazon.com gift card.

Appendix B: Demographic Information Form

Demographic Form

1. How do you identify?
   - Lesbian
   - Gay
   - Bisexual
   - Queer
   - Homosexual
   - Heterosexual

   - Other (please specify): _____

2. How do you identify?
- Man
- Woman
- Transgender
- Female-To-Male
- Male-To-Female
- Other (please specify): _____

3. What is your age? _____

4. What province/state do you currently live in? _____

5. This question is about your **racial, ethnic or cultural identity**/identities. The list below contains categories developed by the US Census Bureau. We recognize that this list is not perfect and presents some problems, but it will allow us to compare participants with others in your area. With which, if any, of these categories do you identify? Please check all that apply

- Black/African American
- White/European American
- Latino/Latina
- Asian/Asian American/Pacific Islander
- Native American/American Indian/Aboriginal
- You don't have an option that applies to me. I am (*Please specify*)_____

5. This question is about your **racial, ethnic or cultural identity**/identities. The list below contains categories developed by Statistics Canada. We recognize that this list is not perfect and presents some problems, but it will allow us to compare participants with others in your area. With which, if any, of these categories do you identify? Please check all that apply.

- Aboriginal/First Nations
- Arab
- Black – African
- Black – Caribbean
- Chinese
- Filipino
- Japanese
- Korean
- Latin American
- Southeast Asian (e.g. Vietnamese, Cambodian, Malaysian, Laotian, etc)
- South Asian (e.g. East Indian, Pakistani, Sri Lankan, etc)
- West Asian (e.g. Iranian, Afghan, etc)
- White (e.g. Canadian or European background)
- You don't have an option that applies to me. I am (*Please specify*)_____

6. This question is about your HIV status. Part of this study looks at general health, including HIV/AIDS.
   What is your HIV status?

- HIV-positive
- HIV-negative/status unknown

7. What is your income?

- Below $10,000
- $10,001-$20,000
- $20,001-$30,000
- $30,001-$40,000
- $40,001-$50,000
- $50,001-$60,000
- $60,001-$70,000
- $70,001-$80,000
- $80,001-$90,000
- $90,001-$100,000
- $100,001-$110,000
- $110,001-$120,000
- $120,001-$130,000
- $130,001-$140,000
- $140,001-$150,000
- $150,001-$160,000
- Over $160,000

8. What is your occupation? _____

9. What is your highest level of education?

- Less than High School
- High School or Equivalent
- Some College
- Associate's Degree
- Bachelor's Degree
- Master's Degree
- Doctoral Degree

10. What is your relationship status?

- In a relationship, living apart
- In a relationship, living together
- Married, civil union, domestic partnership, or equivalent (whether or not recognized where you live)

11. What is your religion?

- Agnostic
- Atheist
- Buddhist
- Catholic
- Greek Orthodox
- Hindu
- Islamic
- Jewish
- Protestant
- Wiccan
- Other (please specify): _____

12. How long have you been in a relationship with your current partner (# of months or years)? _____

13. This question is about your partner's **racial, ethnic or cultural identity**/identities. The list below contains categories developed by the US Census Bureau. We recognize that this list is not perfect and presents some problems, but it will allow us to compare participants with others in your area. With which, if any, of these categories does your partner identify? Please check all that apply

- Black/African American
- White/European American
- Latino/Latina
- Asian/Asian American/Pacific Islander
- Native American/American Indian/Aboriginal

- You don't have an option that applies to my partner. He/she is (*Please specify*)_____

14. This question is about your partner's **racial, ethnic or cultural identity**/identities. The list below contains categories developed by Statistics Canada. We recognize that this list is not perfect and presents some problems, but it will allow us to compare participants with others in your area. With which, if any, of these categories does your partner identify? Please check all that apply.

- Aboriginal/First Nations
- Arab
- Black – African
- Black – Caribbean
- Chinese
- Filipino
- Japanese
- Korean
- Latin American
- Southeast Asian (e.g. Vietnamese, Cambodian, Malaysian, Laotian, etc)
- South Asian (e.g. East Indian, Pakistani, Sri Lankan, etc)
- West Asian (e.g. Iranian, Afghan, etc)
- White (e.g. Canadian or European background)
- You don't have an option that applies to my partner. He/she is (*Please specify*)_____

15. How old is your partner? _____

16. Do you have children? _____

If you have children, please specify how many _____

Appendix C: Informed Consent Form

INFORMED CONSENT TO PARTICIPATE IN RESEARCH

Stress, intimacy, relationship satisfaction and health among individuals in lesbian and gay couples.

Principal Investigator:
Andrea Guschlbauer, PhD Candidate, McGill University, Montreal, QC, Canada

Purpose of the Study

This research project is being carried out by the above researcher, a graduate student at McGill University, as part of her dissertation for the requirements of her doctoral degree in Counselling Psychology. You are being asked to participate in a study to better understand the impact of discrimination on same-sex couples, particularly as it relates to intimacy.

Procedure of the Study

Should you agree to participate in this study, you will be directed to the online survey. It is estimated that the study will take approximately 45 minutes of your time. You will be asked to provide some general demographic information. In addition, you will be asked to complete a series of short questionnaires. The questionnaires will assess various aspects of your intimate relationship, your mood, your health, and your experiences of discrimination as it relates to being lesbian or gay.

Should you choose the option of including your email address, you will be entered in a lottery for the chance to win one of three prizes of $50.

Risks and Benefits

Your participation in this study poses no more than minimal risk. However, it is possible that you might become uncomfortable while answering the questions. If the topic brings about negative reactions (e.g., discomfort or anxiety) at any point, you may stop answering the questions and exit the survey without penalty. Should you experience distress following participation in the study, you can find a detailed listing of mental health professionals and treatment centers throughout the United States and Canada at the following link:
http://therapists.psychologytoday.com/rms/?utm_source=PT_Psych_Today&utm_medium=House_Link&utm_campaign=PT_TopNav_Find_Therapist
Alternatively, you can visit your local health care center for further assistance (e.g., counselling services).
Please note that your identity and all information obtained from this study will be kept confidential.

Although there may not be a direct benefit to you, participation may provide you with the opportunity to better understand your own experiences.

Participant Rights

You are free to exit the survey at any time without any repercussion or prejudice. You can either select the icon to "Exit survey/withdraw participation", present at the top right of each survey page, or you can choose "Exit survey/withdraw participation" at the end of the survey rather than selecting "Done". Both methods will ensure that your answers are not recorded. In addition, you are under no obligation to reveal identifying information in the survey.

Confidentiality

Your identity and all information obtained from this study will be kept confidential. If you choose to be entered in the draw for the prize, you will be directed to a separate online survey where you can provide your email address, not linked to your survey responses in order to maintain anonymity. All data obtained during this study will be kept strictly confidential and will be identified only by an assigned code number. Data will be kept in a secure digital data storage device in the office of the principal investigator. Only the principal investigator, Andrea Guschlbauer, her faculty advisor for the study (Dr. Nathan Grant Smith), and several student research assistants will have access to the data and email addresses. The researchers will at all times comply with the Tri-Council ethical guidelines for research with human subjects.

Contacts

If you have any questions If you have any questions prior to, during, or following the completion of your participation in this study you may contact Andrea Guschlabuer at andrea.guschlbauer@mail.mcgill.ca, who would be glad to answer any questions or address any concerns. For information about your rights as a participant in a study, or concerns about risks, you may contact the Ethics Review Board of McGill University at 514-398-6831 or lynda.mcneil@mcgill.ca. If you wish to complete the questionnaire over the phone or have it mailed to you, please contact Andrea Guschlbauer at the above address.

Participant's Consent (LINKED)

By clicking the link below, I affirm the following:
This research project has been explained to me. I have carefully read the above information and clearly understand it. I freely consent and voluntarily agree to participate in this research project. I can print a copy of this participant consent form as a record of my involvement.
_____ I consent to participate
_____ I do not consent to participate