

Couple and Family Psychology: Research and Practice

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Online First Publication, October 25, 2021. <http://dx.doi.org/10.1037/cfp0000199>

CITATION

Meuwly, N., & Davila, J. (2021, October 25). Associations Between Internalized Heterosexism and Perceived and Observed Support in Same-Gender Couples. *Couple and Family Psychology: Research and Practice* Advance online publication. <http://dx.doi.org/10.1037/cfp0000199>

Associations Between Internalized Heterosexism and Perceived and Observed Support in Same-Gender Couples

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The aim of the present study was to examine associations between internalized heterosexism and support processes among same-gender couples. Individuals who belong to a sexual minority group and report negative representations of their sexual identity (what we term internalized heterosexism) are known to report poorer individual well-being (Meyer, 2003) as well as lower relationship satisfaction (Cao et al., 2017). We expected that internalized heterosexism would be negatively associated with the evaluation and provision of support in same-gender couples. We used a multimethod approach including daily self-report measures of support over 14 days and observed support interactions between partners to examine the associations of internalized heterosexism with (a) perceptions of partner support and relationship satisfaction and (b) observed partner support provision behavior. Data of 68 same-gender couples were analyzed with Actor–Partner–Interdependence–Models (APIM; Kenny & Cook, 1999). Relationship satisfaction as well as partners’ general levels of perceived support at baseline were unrelated to one’s own and partners’ reports of internalized heterosexism (no significant actor and partner effects). Individuals who reported more internalized heterosexism, however, evaluated their partner’s daily support as more negative compared to individuals with lower internalized heterosexism. Moreover, we found a trend that internalized heterosexism is negatively associated with the quality of observed support behavior. Couple interventions should, therefore, target internalized heterosexism to enhance support processes between partners.

Keywords: same-gender couples, internalized heterosexism, relationship satisfaction, support, dyadic coping

According to the Vulnerability–Stress–Adaption model of romantic relationship functioning (VSA; Karney & Bradbury, 1995), support processes are one of the key “adaptive processes” in which couples engage, in the face of stress, that are directly linked to important relationship outcomes, such as satisfaction. Indeed, there is a large body of research that examines how support processes function in relationships when partners are coping with stress. For example, effective support from a

partner helps people to cope with stress (e.g., Dehle et al., 2001; Meuwly et al., 2012). Moreover, support between partners is related to higher relationship satisfaction, better conflict resolution, increased trust in the relationship, and greater relationship stability (Bodenmann, 2005; Cutrona et al., 2005; Lavner & Bradbury, 2012; Sullivan et al., 2010).

However, the vast majority of research in this area comes from studies of mixed-gender

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We have no conflict of interest to disclose. Funding for this study was provided by the Swiss National Science Foundation awarded to the first author (PZ00P1_154921).

Authors would like to thank all couples who participated in the study and students who helped collecting data.

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couples. Studies comparing different types of couples do show that same-gender and mixed-gender couples are more similar than different regarding relationship quality and communication (e.g., Julien et al., 2003; Kurdek, 2008; Peplau & Fingerhut, 2007; Roisman et al., 2008). For example, romantic partners serve as a primary source of support irrespective of couple type (Coyne & DeLongis, 1986; Graham & Barnow, 2013; Kurdek, 1988), and individuals who receive more support from their partners are more satisfied with their relationships (e.g., Graham & Barnow, 2013; Julien et al., 2003). Nonetheless, we should not assume that all aspects of support processes function in the same manner in same-gender couples. This is particularly true, because, in contrast to mixed-gender couples, same-gender couples are faced with unique stressors. Specifically, those which are linked to their minority status related to societal acceptance of their relationships. Therefore, in this study, we examined how internalized heterosexism (i.e., internalized negativity about one's sexual minority identity) might interfere with support processes of same-gender couples.

Minority Stressors

Despite growing acceptance and increasing legal rights for same-gender couples in many Western societies, sexual minority individuals are exposed to social stressors which are uniquely related to their minority status. As such, in addition to typical life and normative stressors (e.g., starting a new job) as well as everyday stressors (e.g., doing household chores and commuting to the job), sexual minority individuals are faced with repetitive stressors, such as institutional and social discrimination, prejudice, or even physical harassment. There is strong empirical evidence that individuals who are facing high levels of minority stressors are at risk for elevated levels of psychopathology (e.g., Meyer, 2003).

As Hatzenbuehler (2009) has noted, this ongoing exposure to societal stigma “gets under the skin” (p. 707) and negative societal attitudes may be internalized. Thus, distal minority stressors (e.g., discrimination by others) might lead to proximal minority stressors, particularly internalized negative representations of one's sexual identity,¹ which we term internalized heterosexism going forward (to be inclusive). Indeed, sexual minority individuals who report internalized heterosexism

also report poorer mental health and well-being (e.g., Hatzenbuehler, 2009; Meyer, 2003). A meta-analysis with approximately 6,000 sexual minority individuals in 31 studies showed a small-to-moderate association between internalized heterosexism and internalizing mental health problems (Newcomb & Mustanski, 2010). Thus, internalized heterosexism might explain heightened levels of psychological problems.

In addition, because internalized heterosexism may include not only views about the self, but also wider societal views about the relationships of sexual minority individuals (Meyer, 1995; Newcomb & Mustanski, 2010), internalized heterosexism can affect relationships with others, such as comfort with disclosing one's sexual identity to others, being connected to other sexual minority individuals, or enjoying same-sex sexual activity (e.g., Currie et al., 2004; Davidson et al., 2017; Totenhagen et al., 2018). The same is true for romantic relationships.

Impact on Romantic Relationships

High levels of internalized heterosexism in one or both partners in same-gender relationships are an additional stressor on the relationship and it impairs the quality of relationships (Frost & Meyer, 2009; LeBlanc et al., 2015). For example, individuals with higher levels of internalized heterosexism report more romantic relationship problems (Frost & Meyer, 2009), and internalized heterosexism is negatively related to relationship quality and satisfaction (e.g., Pepping et al., 2019; Thies et al., 2016; for a meta-analysis, see Cao et al., 2017, and Doyle & Molix, 2015). However, we know very little about the mechanisms of this association. One possibility is the internalized heterosexism, because it is an internal stressor that makes people vulnerable to negative views of the self and reduced well-being, might impair support processes, and might do so particularly in the face of external stress. For example, if one is feeling bad about the self and/or they are emotionally compromised, their coping resources may be limited, particularly in the face of additional stress. Indeed, this is consistent with the VSA Model of relationship

¹ These representations have been labeled in various ways, including internalized homophobia, internalized homonegativity, internalized biphobia, internalized binegativity, internalized sexual stigma, and internalized self-stigma.

functioning (Karney & Bradbury, 1995), which suggests that both external stressors and individual vulnerabilities impair the ability to engage in adaptive support processes (which subsequently affects relationship satisfaction).

Furthermore, according to Lazarus's transactional model of stress, individuals' subjective evaluations of the demands of a situation and available resources play a central role in the experience of stress (Lazarus, 1991). An individual experiences stress when subjectively perceived demands of a current situation outweigh the resources available to manage those demands (Lazarus & Folkman, 1984). In the face of external stressors, internalized heterosexism might affect (consciously or nonconsciously) individuals' evaluations of demands and resources in the situation, thereby reducing their ability to act in an adaptive manner in response to external stressors. Indeed, negative representations of the self can amplify perceptions of external stress (Lazarus, 1991), which may lead to poorer functioning.

The idea that internalized heterosexism might affect adaptive functioning in the face of external stress is in line with findings of a daily diary study by Totenhagen et al. (2018). The authors found that internalized heterosexism and daily extradyadic stress interacted to predict relational well-being. Greater stress was associated with greater perceived conflict and lower relationship quality among individuals with greater internalized heterosexism (there was no association for individuals who reported lower internalized heterosexism).

With regard to support processes among same-gender couples, there is very little research, but what does exist points to an association with internalized heterosexism. Higher levels of internalized heterosexism in gay male individuals have been found to be related to lower levels of perceived partner support (Kamen et al., 2011) as well as lower self-reported common dyadic coping (i.e., coping skills when both partners are stressed at the same time; Feinstein et al., 2018). However, to better understand the negative impact of internalized heterosexism on partner support processes, not only is more research needed, but research employing methods that capture the experience of stress in real time (Laurenceau & Bolger, 2005), as well as actual support behavior, is needed (cf. Julien et al., 2003; Kuhn et al., 2018; Pasch et al., 1997), as is research that includes both members of the couple.

The Present Study

As such, in this study, we examined how internalized heterosexism might interfere with support processes of same-gender couples, using a multimethod approach including daily self-reported measures of support over 14 days and observed support interactions between partners. This allowed us to examine perceptions of daily support processes in day-to-day life, as well as objectively coded, observed support behavior in actual couple interactions. We assessed internalized heterosexism broadly, including three identity domains (internalized homonegativity, acceptance concerns, and difficulty with the identity development process) described by Mohr and Kendra (2011; details are provided in the method section). Research has shown that these three aspects of identity are positively related to each other and they are all related to negative affectivity (e.g., Frei et al., 2013; Mohr & Kendra, 2011; Pepping et al., 2019).

In line with the VSA model (Karney & Bradbury, 1995) and research indicating that internalized heterosexism was negatively associated with coping and relationship satisfaction (e.g., Cao et al., 2017; Doyle & Molix, 2015; Feinstein et al., 2018; Kamen et al., 2011; Totenhagen et al., 2018), we expected that internalized heterosexism (an individual vulnerability) would be negatively associated with the evaluation and provision of support (an adaptive process) in same-gender couples. We tested the following hypotheses regarding actor effects (i.e., partner A's own reports of internalized heterosexism on partner A's outcome) and partner effects of internalized heterosexism (i.e., effect of partner B's internalized heterosexism on partner A's outcome) on perceptions of relationship functioning, in line with existing research:

Hypothesis 1: One's own internalized heterosexism (Hypothesis 1a actor effect) as well as partner's internalized heterosexism (Hypothesis 1b partner effect) would be negatively related to relationship satisfaction.

Hypothesis 2: One's own internalized heterosexism (Hypothesis 2a actor effect) as well as partner's internalized heterosexism (Hypothesis 2b partner effect) would be negatively related to perceived partner support at baseline.

Hypothesis 3: One's own internalized heterosexism (Hypothesis 3a actor effect) as well as partner's internalized heterosexism (Hypothesis 3b partner effect) would be negatively related to daily perceived partner support.

Research on the effect of internalized heterosexism on support provision does not exist, but there is reason to think that they may be related. First, because external stress may activate (or interact with) internalized heterosexism, the ability to provide support to one's partner may be impaired. In addition, because one's own internalized heterosexism can also be directed toward a partner who is also a member of the stigmatized group (Herek et al., 2009), one might be less motivated to provide support to their partner. We, therefore, formulate the following hypothesis.

Hypothesis 4: Internalized heterosexism would be related to quality of support provision. We expect a negative actor effect of internalized heterosexism for positive dyadic coping and a positive actor effect of internalized heterosexism for negative dyadic coping (partner effects were examined in an exploratory manner).

Because we are interested in the unique effects of internalized heterosexism on relationship functioning, and given data consistently showing associations of individual well-being with both internalized heterosexism and relationship functioning (e.g., Bodenmann et al., 2004; Davila et al., 1997; Doyle & Molix, 2015; Frost & Meyer, 2009), we controlled for individual well-being in all analyses and expected the effect of internalized heterosexism to be significant over and above the effect of well-being. To clarify, for actor effects, we are examining whether one's own internalized heterosexism is associated with one's own outcomes, over and above one's own and partner's general stress. For partner effects, we are interested in whether partner's internalized heterosexism is associated with one's own outcomes, over and above one's own and partner's general stress. We further controlled for age, as it was associated with internalized stigma in previous studies (e.g., Ross et al., 2013).

Method

Author Positionality

Authors are both relationship researchers, psychologists, and licensed psychotherapists. The first author is a cis-gender White European female, living with her female partner. The second author is a cis-gender female who identifies as bisexual and is currently single. She is a White/Puerto Rican American.

Sample

To participate in the study, couples needed to be in a relationship of at least 6 months (currently cohabitating or seeing each other at least four times a week), both partners aged at least 20 years, and speaking German as their common language (because of coding interaction data). The present study focused on a sample of 68 same-gender couples (26 male and 42 female couples) living in Switzerland (see Table 1). Most couples (78%) were cohabitating and relationship length ranged from 6 months to 30 years ($M = 5.5$ years; $SD = 5.3$). Approximately one-third of the couples (32%) were married or in a civil union (there was no gay marriage in Switzerland at the time of data collection), most of them (94%) without children. Of the 136 individuals, 80 were cis-women, 50 cis-men, and 6 gender minority individuals (two individuals identified as trans-woman, two identified as trans-man, and two as gender fluid; the latter two also identified as a female lesbian couple). All of them were aged between 20 and 68 years ($M = 34.9$; $SD = 11.3$). The majority of the samples identified as gay or lesbian (83.1%), 14.7% as bisexual, and 2.2% reported another sexual identity. Most of the individuals were Swiss (84.3%), a minority was German (8.6%), or reported other nationalities (7.1%).

Couples were recruited using electronic resources (e.g., Facebook and websites) and emails to members of national and regional networks of gay, lesbian, and bisexual individuals in Switzerland (e.g., pinkcross, LOS, and LGBT* student groups) as well as other organizations for the larger public (e.g., political associations and student organizations). We also advertised the study in a commercial gay magazine. One hundred and seven persons contacted the study team, but 10

Table 1
Sample Characteristics

Variable	<i>n</i>	(%)	<i>M</i>	(<i>SD</i>)	κ
Gender					.87***
Cis-woman	80	(58.8)			
Cis-men	50	(36.8)			
Other	6	(4.4)			
Married/civil union ^a	44	(32.4)			
Cohabiting with partner ^a	107	(78.7)			
Children ^a	9	(6.6)			.17*
Relationship length (years)			5.47	(5.26)	
Age (years)			34.90	(11.33)	.83***
Sexual orientation					.55***
Lesbian or gay	113	(83.1)			
Bisexual	20	(14.7)			
Other	3	(2.2)			
Nationality					.15**
Swiss	115	(84.3)			
German	12	(8.6)			
Other	9	(7.1)			
Employment					.20***
Unemployed	10	(7.4)			
Student	30	(22.1)			
Employed	79	(58.1)			
Self-employment	13	(9.6)			
Retired	4	(2.9)			
Income					.34***
Less than 40,000 Chf/year	42	(30.9)			
40,000–60,000 Chf/year	32	(23.5)			
60,000–80,000 Chf/year	24	(17.6)			
More than 80,000/year	38	(28.0)			

Note. κ = Cohen's Kappa, measure of partner similarity (presented only for variables which vary between partners; the measure for the metric variable age represents an intraclass correlation). Swiss francs (Chf) are about equal to U.S.-Dollars.

^a Reflects the number and percentage of participants answering "yes" to this question.

* $p < .05$. ** $p < .01$. *** $p < .001$.

did not respond after a first email contact. After the phone screening, 80 couples agreed to participate. Study protocol was completed by 72 couples. Four couples needed to be excluded for the following reasons: language problems ($n = 2$), poor compliance ($n = 1$), or problems with smartphones ($n = 1$). The study was given approval from the Human Research Ethics Committee of the Canton auf Vaud, Switzerland. Data were collected between 2015/8 and 2017/12.

Procedure

Couples who were interested in the study were first briefed on the study procedure on the phone. Both partners needed to agree on participation in the study. When agreeing for study participation and inclusion criteria were met, a date for a home visit at the couple's or one partner's home was arranged. The study included two parts:

(a) a home visit with the goal to observe and videotape the couple interaction and (b) a 14-day daily diary with repeated measures of both partners on communication processes and well-being.

After the phone screening, the study team visited the couple in their home to complete the first part of the study. The participants received information about the study procedures, and after agreeing, they were given the informed consent form to sign. Participants first had to complete, independently, a series of questionnaires. Then, to have a more objective view on dyadic interaction, couples were videotaped during different interaction tasks in line with previous studies on partner support (e.g., Julien et al., 2003; Kuhn et al., 2018; Pasch et al., 1997). In the first task, each partner was instructed to tell their partner about a recent stressful experience that they experienced outside their relationship (e.g., work-related stress, conflict with friends). The

couple was asked in a randomized order to discuss the topic identified by one partner for 7 min, followed by a discussion of a stressful topic identified by the other partner for another 7 min. The partner who talked about their stressful experience was instructed to disclose how they felt in the situation, whereas the other partner (support provider) was asked to be involved in the discussion, as they wished. This allowed us to observe support provision behavior in a spontaneous manner.

In the second part of the study, we used an ambulatory assessment approach to capture communication processes in daily life. Participants rated their current emotional states and reported on interactions with their partner four times a day (in the morning, noon, evening, and before going to bed) during 2 weeks. During the home visit, participants were introduced to the smartphones and a trial run was applied to discuss questions. A study hotline was also available and participants were instructed to call whenever they had questions or technical problems (only two participants used the study hotline). Upon completing the daily diary, a member of the study team picked up smartphones at couple's home. Participants were then paid an incentive of 200 CHF (approx. 200 U.S. Dollars) per couple.

Measures

Internalized Heterosexism

To assess internalized heterosexism, nine items of the Lesbian, Gay, and Bisexual Identity Scale by Mohr and Kendra (2011) were filled out by participants at baseline. Those items represent the three subscales *internalized homonegativity* (sample item: «If it were possible, I would choose to be straight.»), *acceptance concerns* (sample item: «I often wonder whether others judge me for my sexual orientation.») and *difficult process* (sample item: «Admitting to myself that I am an LGB person has been a very painful process»). Each item was rated on a 6 point-Likert scale (1 = *disagree strongly*, 2 = *disagree*, 3 = *disagree somewhat*, 4 = *agree somewhat*, 5 = *agree*, and 6 = *agree strongly*); thus, higher levels represent more internalized heterosexism. Items of the subscales internalized homonegativity and acceptance concerns were translated in German by Frei et al. (2013); the three items for the subscale difficult process were translated by

the first author. Internal consistency for the total scale internalized heterosexism with nine items was adequate ($\alpha = .79$).

Individual Well-Being

To assess individual well-being, participants had to fill out the Depression, Anxiety, and Stress Scale (DASS-21) by Lovibond and Lovibond (1995). The scale consists of 21 items, with seven items each assessing depressive symptoms (example item: "I couldn't seem to experience any positive feeling at all"), anxiety (e.g., "I experienced breathing difficulty"), or stress symptoms (e.g., "I found it hard to wind down"). Each item had to be evaluated on a 4-point scale ranging from 0 = *did not apply to me at all* to 3 = *applied to me very much, or most of the time* for the time period of the preceding 2 weeks. Lower levels represent a better individual well-being. Internal consistencies of the subscales were adequate (Cronbach's α ranging between .78 and .87).

Relationship Satisfaction

We used the Quality of Marriage Index (Norton, 1983), adapted for use with unmarried couples, to assess relationship satisfaction. Participants rated how much they agreed with statements on a 6-point scale (1 = *not at all*; 6 = *very much*). Example items are "My relationship with my partner makes me happy" or "We have a good relationship." The scale represents the mean of seven items; thus, higher values represent higher relationship satisfaction. Internal consistency of the scale was adequate ($\alpha = .89$).

Perceived Partner Support at Baseline

To assess partner support, we used the Dyadic Coping Inventory (DCI; Bodenmann, 2008). Because the research question was focused on the perception of partner support, we only administered 10 items of the DCI which included evaluation of the partner's dyadic coping, such as partner's supportive dyadic coping ("My partner shows empathy and understanding to me."), partner's delegated dyadic coping ("My partner takes on things that I normally do in order to help me out."), and partner's negative dyadic coping (recoded; "When I am stressed, my partner tends to withdraw"). Other items which focus on

partners' stress communication or own dyadic coping behavior were not considered. Items were rated on a 5-point scale from 1 = *very rarely* to 5 = *very often*. Thus, higher levels represent better partner support at baseline. Internal consistency of the scale was adequate ($\alpha = .83$).

Daily Support Received From Partner

During 14 days, couples participated in a daily diary where they filled out short questionnaires four times a day. At each timepoint, individuals were asked whether they experienced extradyadic stress and whether they were actively seeking support from their partner. If they reported they did, they had to rate the quality of support that they received (my partner: "was supportive and encouraging," "was affectionate, hugged me," "comprehensive, caring," "indifferent, insulting," and "helped me to reframe the situation") with an 8-point Likert scale (0 = *not at all*, 7 = *very much*). Participants were originally asked to complete seven items, but two had to be excluded, because internal consistency was not satisfactory. The final scale including five items showed an adequate Cronbach α of .76.

Observed Support Provision Quality

The videotaped interaction was coded with the revised System to Evaluate Dyadic Coping (SEDC) by Bodenmann (2012). As noted earlier, each individual (support seeker) was asked to discuss a stressful experience or topic with their partners (the support provider). Support providers were asked to engage in the conversation and to respond in whatever way they wanted. To ensure that couples did not discuss a conflictual topic, they were asked to discuss a topic that was unrelated to the romantic partner (extradyadic stress, such as work-related stress, conflicts with friends or family, etc.). The SEDC was developed to code support interactions in intimate relationships; it includes codes for stress communication of the support seeker and codes for dyadic coping for the support provider. The frequency of stress communication was included as a control variable in the study, because a partner can only provide support if stress is expressed. *Positive dyadic coping* included problem-focused dyadic coping (reactions to stressed partner asking for advice), emotion-focused dyadic coping (e.g., empathic understanding, showing solidarity with the partner), validating

partner, and nonverbal dyadic coping (e.g., holding, hugging, and kissing) as well as listening attentively to the partner and showing interest. *Negative dyadic coping* was coded if the provided support was insensitive, superficial, or hostile (e.g., ignoring partner's stress communication, making fun of partner's feeling, and diminishing partner's experience). Dyadic coping was coded at 10-s intervals (positive, negative, or no dyadic coping) by two independent and intensively trained coders (up to 60 hr). Coders were blind to the hypotheses of the study. Inter-rater reliability for dyadic coping was adequate (Cohen's $\kappa = .78$ for stress communication and .76 for dyadic coping). The variables represent relative frequencies of positive and negative dyadic coping as well as stress communication during the 7-min interaction videotaped at couples' homes. Correlation between relative frequencies of positive and negative dyadic coping was $r = .81$, $p < .001$.

Statistical Analyses

Data were analyzed with multilevel models to control for nonindependence of dyadic data. Data of individuals (Level 1) were nested within couples (Level 2). To estimate actor and partner effects simultaneously, we used the Actor-Partner-Interdependence-Model (APIM; Kenny & Cook, 1999). Because couples were treated as indistinguishable dyads, only one actor (i.e., own internalized heterosexism regressed on own outcome) and one partner effect (i.e., partner's internalized heterosexism regressed on own outcome) are estimated. Actor and partner's age and DASS scores were included as control variables.

To test the hypothesis that perceived daily support from the partner would be negatively associated with internalized heterosexism, we computed the aggregated mean of all timepoint participants rated received support as an outcome variable. This helped us to avoid adding a third level (repeated measures) to the model. Because the effect of internalized heterosexism on daily measures represents a cross-level interaction, one can only estimate between-subject effects. Thus, adding a third level to the model would only add complexity to the analysis without having advantages for estimation of effects.

To test a hypothesis that the quality of observed support provision (positive and negative dyadic coping) would be associated with internalized heterosexism, we included (relative frequency of)

partner's stress communication as a control variable, because the extent of support provision behavior depends on the degree of partner's support seeking behavior.

Results

Descriptive Results and Intraclass Correlations

Table 2 presents means and standard deviations for all study variables. Measures of internalized heterosexism between partners were significantly correlated ($ICC = .22, p = .006$). Intraclass correlations between partners for self-reported relationship measures were significant and moderate ranging between .45 and .56 ($p < .001$). Intraclass correlation between partners for positive and negative dyadic coping rated by independent coders was lower ($ICC = .11, p = .115$ for positive and $ICC = .23, p = .004$ for negative dyadic coping).

Before testing the hypotheses, we checked which of the suggested control variables were significantly correlated with our predictor internalized heterosexism. Age ($r = -.24$) was significantly related to internalized heterosexism ($p \leq .014$). Older participants reported lower levels of internalized heterosexism.² With regard to the subscales of the DASS, the only significant correlation that we found was between internalized heterosexism and self-reported stress symptoms: $r = .19, p = .030$. Internalized heterosexism was unrelated to depressive symptoms and anxiety in our sample ($p \geq .321$). We, therefore, controlled for stress symptoms only to test our hypotheses.

Hypothesis 1: Negative Association Between Internalized Heterosexism and Relationship Satisfaction

First, we estimated associations between internalized heterosexism and relationship satisfaction. We hypothesized that actor as well as partner's internalized heterosexism would be related to relationship satisfaction controlling for actor's and partner's age and DASS stress symptoms. As reported in Table 3, actor as well as partner effects of internalized heterosexism were not significant ($p \geq .731$). Thus, internalized heterosexism was unrelated to partners'

evaluations of relationship satisfaction. Hypothesis 1 was not confirmed.

Hypothesis 2: Negative Association Between Internalized Heterosexism and Perceived Partner Support at Baseline

Second, we estimated associations between internalized heterosexism and perceived partner support at baseline, again controlling for age and DASS stress symptoms. Actor as well as partner effects of internalized heterosexism were not significant ($p \geq .564$). Thus, own as well as partner reports of internalized heterosexism were unrelated to global evaluations of partner support at baseline. Hypothesis 2 was, therefore, not confirmed.

Hypothesis 3: Negative Association Between Internalized Heterosexism and Daily Partner Support

Third, we examined the association between internalized heterosexism and perceived partner support in daily reports of support quality when actively seeking support from the partner. Supporting our hypothesis, self-reported internalized heterosexism was negatively related to perceptions of partners' daily support: the actor effect was significant, $b = -.268, p = .021$. Thus, individuals who reported more internalized heterosexism evaluated their partners' daily support as of lower quality relative to individuals with lower internalized heterosexism. This effect was over and above the effect of actor and partner DASS stress symptoms and age. Partners' report of their internalized heterosexism, however, was not related to their partners' perceptions of daily support (partner effect: $p = .729$).

Hypothesis 4: Negative Association Between Internalized Heterosexism and Quality of Support Provision Behavior

Finally, we examined the association between internalized heterosexism and quality of support provision behavior. Again, we included age and

² We also collected data on relationship length. However, it was not added as a control variable because it was unrelated to internalized heterosexism ($p = .728$). Furthermore, age and relationship length were correlated ($r = .49, p < .001$).

Table 2*Mean, Standard Deviations, and Intraclass Correlations for Study Variables*

Variable	<i>M</i>	<i>SD</i>	Range	ICC
Internalized heterosexism	2.52	.76	1.25–5.17	.22**
Stress symptoms (DASS)	1.05	.58	.00–3.00	.30***
Anxiety (DASS)	.29	.40	.00–2.71	.26**
Depressive symptoms (DASS)	.39	.46	.00–3.00	.34***
Relationship satisfaction (QMI)	5.41	.61	3.14–6.00	.56***
Partner support baseline (DCI)	4.29	.52	2.40–5.00	.45***
Daily partner support	4.43	1.01	1.99–6.98	.54***
Stress communication partner	.94	.09	.57–1.00	–.02
Positive dyadic coping	.88	.14	.28–1.00	.11
Negative dyadic coping	.06	.11	.00–.62	.23**

Note. $N = 136$ partners in 68 couples. DASS = Depression, Anxiety and Stress Scale; DCI = Dyadic Coping Inventory.
 * $p < .05$. ** $p < .01$. *** $p < .001$.

DASS stress symptoms as control variables in the model. In addition, we controlled for partners' relative frequency of stress communication, because the amount of support provision behavior depends on the degree of partners' support seeking behavior. According to Hypothesis 4, own reports of internalized heterosexism should be related to lower support provision quality. To test this hypothesis, we estimated two models: one for positive and the other for negative dyadic coping. There was a trend that actor's internalized heterosexism was negatively related to positive dyadic coping ($b = -.023, p = .075$) as well as positively related to negative dyadic coping ($b = .025, p = .059$). Thus, there was a trend for higher levels of internalized heterosexism to be associated with poorer quality of support provision. Partner reports of internalized heterosexism were not significantly associated with dyadic coping ($p \geq .148$). Those effects were considered exploratory.³

Discussion

The aim of the present study was to examine associations between internalized heterosexism and support processes among same-gender couples. According to the Vulnerability–Stress–Adaption model of romantic relationship functioning (VSA; Karney & Bradbury, 1995), support processes are one of the key “adaptive processes” in which couples engage, in the face of stress, that are directly linked to key relationship outcomes. Because internalized stigma might have stronger effects on

relationship functioning, while individuals are stressed, we used a multimethod approach including daily self-reported measures of support over 14 days and observed support interactions between partners to examine the associations of internalized heterosexism with (a) perceptions of partner support and relationship satisfaction and (b) observed partner support provision behavior.

Negative Association Between Internalized Heterosexism and Perceived Partner Support and Relationship Satisfaction

Contrary to our expectations and to previous findings (e.g., Cao et al., 2017; Doyle & Molix, 2015), relationship satisfaction and perceived partner support at baseline were not related to internalized heterosexism. Although it is not clear why this was the case, internalized heterosexism was, on average, low, and perceived satisfaction and support were, on average, high in the sample. As such, restricted ranges might have contributed to the null findings.

However, when asking individuals repeatedly about the quality of support that they received immediately from their partners (in the diary

³ We have conducted post-hoc sensitivity analyses, for each hypothesis, estimating for each gender group a simple APIM (without including control variables). The direction of effects of actor internalized heterosexism was the same for females and males. The six gender minority individuals were coded as follows: two trans-men as male and two trans-women as well as the two gender fluid identified persons (who also identified as a female lesbian couple) as female.

Table 3
Internalized Heterosexism Predicting Relationship Satisfaction and Support Measures

Predictor	<i>b</i>	<i>SE</i>	<i>p</i>
DV: Relationship satisfaction (QMI)			
Intercept	6.221	.427	.000
Internalized heterosexism actor	-.023	.066	.731
Internalized heterosexism partner	-.008	.066	.900
DASS stress actor	-.246	.085	.005
DASS stress partner	-.272	.085	.002
Age actor	.006	.006	.295
Age partner	-.012	.006	.052
DV: Partner support baseline (DCI)			
Intercept	4.952	.367	.000
Internalized heterosexism actor	-.019	.059	.745
Internalized heterosexism partner	-.034	.059	.564
DASS stress actor	-.112	.078	.154
DASS stress partner	-.174	.078	.027
Age actor	-.006	.006	.322
Age partner	-.001	.006	.890
DV: Daily partner support (daily diary)			
Intercept	6.059	.753	.000
Internalized heterosexism actor	-.268	.114	.021
Internalized heterosexism partner	.040	.114	.729
DASS stress actor	.071	.148	.634
DASS stress partner	-.309	.149	.040
Age actor	-.021	.010	.044
Age partner	-.002	.010	.833
DV: Observed positive dyadic coping			
Intercept	.025	.113	.825
Internalized heterosexism actor	-.023	.013	.075
Internalized heterosexism partner	-.019	.013	.148
DASS stress actor	-.016	.017	.339
DASS stress partner	-.002	.017	.897
Age actor	-.001	.001	.528
Age partner	.000	.001	.900
Stress communication partner	1.066	.100	.000
DV: Observed negative dyadic coping			
Intercept	.058	.115	.616
Internalized heterosexism actor	.025	.013	.059
Internalized heterosexism partner	.018	.013	.162
DASS stress actor	.016	.017	.335
DASS stress partner	.003	.017	.868
Age actor	.001	.001	.529
Age partner	.000	.001	.951
Stress communication partner	-.158	.102	.124

Note. Estimates are unstandardized effects. DASS = Depression, Anxiety and Stress Scale; DCI = Dyadic Coping Inventory.

study), the quality of perceived daily support was negatively related to internalized heterosexism. Individuals who reported higher levels of internalized heterosexism reported lower quality of partners' daily support in the daily diary. This was in line with our expectations and with the findings of Kamen et al. (2011) who found a negative association between self-stigma and perceived

partner support (for gay male individuals). The fact that the association emerged only in the diary data may suggest that internalized heterosexism might specifically be triggered when stressed, but it is also possible that the findings are a consequence of increased validity of measurement of partner support for repeated measures relative to baseline questionnaire data (Laurenceau & Bolger, 2005). Ambulatory assessment allows repeated measures of specific behaviors and perceptions in a real-time manner which makes self-reported data less prone to self-bias relative to baseline questionnaires.

We also expected that partner reports of internalized heterosexism would be associated with relationship satisfaction and perceived partner support. These hypotheses were, however, not confirmed. Contrary to the finding of Otis et al. (2006), individuals with partners who reported more internalized heterosexism were not less satisfied with their relationship or the support that they received from their partner. Although it is not clear why this was the case in our study, partner effects are often found to be weaker than actor effects in couples research (Kenny et al., 2006). Thus, it is also possible that we did not have enough power to find partner effects for internalized heterosexism.

Negative Association Between Internalized Heterosexism and Quality of Support Provision Behavior

We also examined the hypothesis that one's own internalized heterosexism would be associated with lower quality of support provision behavior. Indeed, we found a trend that individuals who reported more internalized heterosexism were rated by independent coders to provide poorer quality of dyadic coping (more positive and less negative dyadic coping). Of course, further research, in larger samples, will be needed to see if this finding is reliable. That said, we offer two possible and nonexclusive speculative explanations for this finding, which might be used to assist with future theory and research in this area. First, it might be possible that for individuals with high internalized heterosexism, negative representations of the self and/or same-gender relationships might impair positive support provision. As an example, the internalized belief that "same-gender relationships are not going to last" might

interfere with positive partner support. Second, internalized stigma might also be directed to the partner who is a member of the stigmatized group (Herek et al., 2009). As a consequence, individuals with more internalized heterosexism might feel ambivalent to provide support to their partners (Mohr & Fassinger, 2006). As an example, the internalized belief “lesbian/gay individuals are weak,” might interfere with the motivation to provide positive support to the partner.

An important, related question is what is it about internalized heterosexism that is impairing? Given that internalized heterosexism is marked by negative self-views, one potential explanation could be self-esteem. Indeed, Herek et al. (2009) have suggested that sexual self-stigma could be understood as a feature of low self-esteem. In their study, self-esteem was a mediator for the relationship between internalized stigma and psychological distress. In the context of romantic relationships, one could take the risk regulation model into account which explains the negative effect of low self-esteem on relationship functioning (Murray et al., 2000, 2006). Individuals with low self-esteem perceive themselves to be of less relational value; and their behavior in romantic relationships is shaped by the motivation to protect the self from potential rejection. As a consequence, individuals who perceive the self as of less relational value tolerate less risk and, therefore, share less with their partner and/or are less motivated for providing support, as doing so might create a sense of interdependence (Murray et al., 2008). Self-protection behavior activates a vicious cycle, as individuals might in turn feel less close to their partners. Individuals with high levels of internalized heterosexism might also perceive themselves as of less relational value. This idea, however, was not empirically tested and it awaits further research.

We were able to rule out one possible explanation for our findings. We know from studies with mixed-gender couples that more stressed individuals perceive dyadic interactions more negatively (e.g., Neff & Karney, 2009). By controlling for actor and partner self-reported stress symptoms, we can rule out that our findings are explained by the fact that individuals who report more internalized heterosexism are in general more stressed and, therefore, perceive partner support more negatively and have less resources to provide positive support to their partners.

Limitations

In interpreting our results, one has to consider several limitations. Our sample was small and not representative of all sexual minority individuals. In particular, participating couples were characterized by relatively high levels of relationship satisfaction and high outness. We recruited our sample mainly through networks of the LGB community; thus, one cannot exclude a self-selection bias. It is possible that individuals with very high-internalized heterosexism might be less likely to participate in such a study as ours, and particularly in one including videotaped interactions at home. However, we expect that estimated associations are more likely to be underestimated than overestimated for a more distressed sample. Moreover, our sample was mostly based on White cis-gender couples. More research is needed for ethnic and gender diverse samples of same-gender couples to understand if these findings may be generalized to populations with intersecting identities. Indeed, among sexual minority individuals, some data suggest that racial/ethnic and gender minoritized individuals experience different types and levels of minority stressors than do White and cis-gender individuals (see Bauerband et al., 2019). Similarly, minority stress may be experienced differently and have different effects among people with different intersecting sexual, gender, and racial/ethnic identities (see Everett et al., 2019; Shangani et al., 2020; although cf. Velez et al., 2017). As such, stress may differentially impact diverse peoples' relationships, as well as their engagement in and experience with support processes in relationships.

Our sample size was too small to allow for adequate power to test for gender differences. As such, we cannot rule out that there are gender differences in the estimated associations. The literature has shown inconsistent findings about gender differences in relationship functioning among sexual minority individuals. One study found stronger effects of internalized heterosexism on relationship quality and intimacy for men relative to women (Thies et al., 2016), whereas a meta-analysis showed stronger effects of minority stressors among female relative to male same-sex couples. Although, this meta-analysis also included more distal minority stressors (Cao et al., 2017). Overall, sexual minority men are often more stigmatized than sexual minority women.

As a consequence, men often report higher levels of internalized heterosexism than women (e.g., Balsam & Mohr, 2007), as was also the case in our sample ($M = 2.72$, $SD = .69$ for males, $M = 2.40$, $SD = .77$ for females, $p = .014$). We have conducted post hoc sensitivity analyses and they show similar actor effects of internalized heterosexism for males and females, but this should be considered tentatively given the small sample size. The association between experiences of discrimination and internalized heterosexism has also been found to be stronger for men than women (e.g., Feinstein et al., 2012). As such, gender differences should be examined in larger samples and focusing more specifically on support processes in future research.

Implications, Applications, and Future Directions

Despite limitations, the findings suggest that, in line with the VSA model (Karney & Bradbury, 1995), aspects of internalized heterosexism are likely relevant for same-gender couples' support processes. More internalized heterosexism is related to more negative perceptions of daily support by the partner and lower quality of support provision (although the latter finding was only marginally significant). These findings have a number of important implications.

First, internalized heterosexism may be an important area to target for prevention/intervention efforts with regard to increasing adaptive support processes among same-gender couples. At present, relationship interventions for same-gender couples focus primarily on communication and conflict resolution, similar to existing couple interventions for mixed-gender couples (e.g., Whitton et al., 2016, 2017). Interventions for same-gender couples that focus on social support and/or dyadic coping, and how it is associated with internalized heterosexism, do not exist and are needed (see Scott et al., 2019). Of course, more research also is needed to identify specific mechanisms of how internalized heterosexism may have an impact on dyadic coping and social support allowing for the development of tailored approaches to enhance support processes between same-gender partners.

Next, in addition to prevention/intervention for couples, our findings continue to underscore the

importance of helping sexual minority individuals reduce negative self-stigma (or prevent it in the first place) and develop a positive identity (see, e.g., the work of Pachankis and colleagues; e.g., Burton et al., 2019). Indeed, a positive identity may benefit relationship functioning. For example, Pepping et al. (2019) found that identity affirmation (e.g., being proud of one's identity) was positively associated with couple relationship satisfaction among same-gender couples. As such, future research also should focus on whether and how positive aspects of sexual identity contribute to social support and dyadic coping among same-gender couples.

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Received September 16, 2020

Revision received July 26, 2021

Accepted August 6, 2021 ■