

Dyadic effects of enacted stigma, internalized homophobia, and communal coping on depressive symptoms among cisgender sexual minority male couples

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Abstract

The present study investigated the dyadic direct and indirect effects of enacted stigma on depressive symptoms via internalized homophobia and whether communal coping moderated the effects of enacted stigma on internalized homophobia and depressive symptoms. Hypotheses were tested using actor–partner interdependence models with a sample of 543 cisgender sexual minority male couples. Results showed both partners' enacted stigma experiences were associated with elevated levels of internalized homophobia via actor and partner effects. Internalized homophobia was only associated with elevated depressive symptoms via actor effects. Indirect effects analysis suggested that internalized homophobia mediated the actor and partner influence of enacted stigma on depressive symptoms. Communal coping moderated the direct effects of enacted stigma on internalized homophobia and attenuated the conditional indirect actor and partner effects of enacted stigma on depressive symptoms. Findings underscore the role of intimate relationship processes in understanding the impacts of enacted stigma on depressive symptoms.

KEY WORDS

APIM, couple, depression, discrimination, gay, internalized homophobia

INTRODUCTION

Depression is a pervasive mental health problem that affects approximately 1 in 10 US adults (Villaruel & Terlizzi, 2019). Previous research suggests sexual minorities are at an elevated risk of experiencing depressive symptoms (Bybee et al., 2009; Feinstein & Dyar, 2017). Compared to heterosexual men, cisgender sexual minority men experience a greater lifetime incidence of mood disorders and are more likely to attempt suicide with more severe injuries from such attempts (Li et al., 2016; Meyer et al., 2011). These findings underscore the need to investigate the risk and protective processes associated with cisgender sexual minority men's disproportionately high rates of depressive symptoms.

Considerable evidence implicates *enacted stigma* as a salient predictor of depressive symptoms among cisgender sexual minority men (Hall, 2018; Seaton et al., 2014). Enacted stigma refers to overt acts of discrimination and humiliation directed at a person because of their stigmatized status, such as businesses refusing to sell products to certain clients due to the clients' known or perceived sexual orientation (Huebner et al., 2004; Lea et al., 2014). Several studies have documented linkages between greater rates of enacted stigma and increased depression and depressive symptoms among cisgender sexual minority men (Feinstein et al., 2012; Walch et al., 2016). Although there is considerable research linking experiences of enacted stigma to depressive symptoms, the mechanisms underlying this association are unclear and warrant further investigation.

Internalized homophobia may be a potential mechanism through which enacted stigma affects depressive symptoms. Internalized homophobia is the personal endorsement of sexual stigma as part of an individual's value system and self-concept characterized by an intrapsychic conflict between same-sex attraction experiences and feeling a need to be heterosexual (Walch et al., 2016). Internalized homophobia can also lead to the rejection of one's sexual orientation (Frost & Meyer, 2009). Theoretically, our investigation of internalized homophobia as a potential mediator of the association between enacted stigma and depressive symptoms is informed by Meyer's (2003) sexual minority stress theory. According to Meyer (2003), the societal policing of gender- and sexuality-based norms is facilitated through acts of enacted stigma. Enacted stigma cultivates discriminatory environments wherein sexual minorities may internalize shame and conceal their sexual identity as a coping strategy for dealing with discrimination and the realities of violent victimization of cisgender sexual minority men (Frost & Meyer, 2009; Herek et al., 2007). Internalized homophobia, however, can be psychologically taxing, increasing men's vulnerability to depressive symptoms and emotional distress (Cohen et al., 2016; Walch et al., 2016). Despite prior theory and research, few studies have investigated if internalized homophobia operates as a mediator linking enacted stigma to depressive symptoms among cisgender sexual minority men (e.g., Szymanski & Ikizler, 2013).

Romantic relationships are essential to understanding enacted stigma and internalized homophobia because partners may jointly experience and cope with stressful experiences. Recent research suggests interactions with supportive partners may help reduce the harmful effects of discrimination (McNeil et al., 2014; Smith et al., 2020), therefore acting as a buffering mechanism. Communal coping may significantly protect individuals from the adverse mental health effects of enacted stigma and internalized homophobia. Communal coping refers to couples engaging in a cooperative decision-making and problem-solving process salient in coping with individual and collective stressors (Afifi et al., 2012). When confronted with stressors, couples who use communal coping (a) have a communal coping orientation, that is, they perceive working together (i.e., joint effort) as beneficial or necessary, (b) communicate openly about the stressor or experience, and (c) problem-solve solutions to a situation conjointly (Salazar et al., 2013). That is, partners address stressful situations as a "we" problem—rather than as

an “I” problem—and in this context, they try to cope with stress together as a couple (Mitchell et al., 2019). Lewis et al. (2006) posit that communal coping supports couples in addressing the negative effects of contextual stressors by eliciting transformations in thoughts, feelings, and behaviors in the form of coping strategies to reduce stress. For example, Partner 1 may share with Partner 2 a recent experience of work-related discrimination. Together they may appraise the incident as a shared issue and collaboratively craft an incident report to supply to Partner 1’s human resources department. Prior research indicates that patterns of communal coping are consistent across different domains of social functioning, processes, and outcomes (Lyons et al., 1998).

Communal coping differs from other forms of dyadic coping as it involves the presence of a shared appraisal process in which partners view a problem or stressful situation interdependently regardless of its origins (Falconier & Kuhn, 2019). For example, problem-focused dyadic coping may involve collaborative action in which partners work together to address a problem, but communal coping occurs when partners view the problem as shared (Bodenmann et al., 2016). Recent research indicates that communal coping may be a generalizable interpersonal coping skill (Afifi et al., 2020; Mickelson et al., 2001). According to Afifi et al. (2020), demonstrations of communal coping in one area indicate skill competence in other topical areas. For example, communal coping is associated with reductions in depressive symptoms even when focused on the topics of diabetes (Zajdel et al., 2018), breast cancer (Robbins et al., 2013), and multiple role strain (Wells et al., 1997). Although research on communal coping among cisgender sexual minority men is scarce, extant evidence suggests that men with a greater orientation toward communal coping reported reduced levels of internalized homophobia (Stachowski & Stephenson, 2015). Stachowski and Stephenson’s (2015) study of 447 cisgender sexual minority men indicated that increased levels of internalized homophobia were associated with decreased levels of couples’ communal coping ability regarding HIV risk management. Despite prior theoretical and empirical research indicating that communal coping enables couples to develop collaborative strategies that reduce the negative impact of contextual stressors and address the demands of stressful situations, the potential for communal coping to protect men from the effects of sexual discrimination has yet to be investigated. In this study, we extend prior research in this area by investigating the generalizability of communal coping. We examine how demonstrations of communal coping in one topical area (e.g., sexual health decision-making) may influence couples’ ability to effectively cope with other areas of stress (i.e., enacted stigma, internalized homophobia).

Enacted stigma and internalized homophobia in a couples context

Recent research suggests enacted stigma experiences affect individuals and their romantic partners (Cao et al., 2017; Trail et al., 2012). According to LeBlanc et al.’s (2015) theoretical model of relational stress proliferation, the negative effects of enacted stigma can be experienced by both partners via *stress spillover* (e.g., through intrapersonal processes such as abruptly withdrawing from interactions) and *stress crossover* (e.g., through interpersonal processes such as disproportionate displays of aggression when faced with relational conflict). When one partner (i.e., “Partner 1”) encounters a stressful experience, such as being the victim of enacted stigma, the effects of this stress may impact the relationship, affecting the quality of interactions with their partner (Partner 2; Buck & Neff, 2012). As such, Partner 1’s stressors become a shared stressor, affecting Partner 2’s stress level and mood (Randall & Bodenmann, 2017). To date, several studies have provided evidence that partners in an intimate relationship may influence one another’s psychosocial well-being (Buck & Neff, 2012; Neff & Broady, 2011); yet, research that examines the dyadic effects of enacted stigma on internalized homophobia or depressive symptoms is lacking.

Prior research indicates that the psychological stress associated with internalized homophobia may also affect an individual's romantic partner (Feinstein et al., 2012, 2018). For example, psychological stress is associated with partners' responding negatively to their partners' experiences of stress by withdrawing, responding sarcastically, and providing support unwillingly, or insincerely, or minimizing the significance of the experience (Bodenmann et al., 2006). Individuals with higher levels of internalized homophobia are more likely to feel as though they, and others like them, are deserving of mistreatment and discrimination (Puckett et al., 2018). Taken together, this suggests that internalized homophobia may be a significant dyadic stressor that negatively impacts individuals and their partners. In this study, we use LeBlanc et al.'s (2015) theoretical model of relational stress proliferation to extend prior research concerning sexual minority stress processes, as Meyer (2003) articulated, by investigating the dyadic effects of enacted stigma and internalized homophobia on depressive symptoms.

Communal coping may help individuals manage stress, including relating to their partners' experiences of enacted stigma. Communal coping may support the facilitation of couples' sense of togetherness, which, in turn, could help buffer the development of internalized homophobia and attenuate the indirect effects of experiences of enacted stigma on partners' depressive symptoms. Afifi et al. (2012) demonstrated that the attenuating effects of partners' communal coping behaviors are interdependent and, thus, couples who view uncertainty about challenging topics as issues that can be addressed as a unit ("we") have better outcomes among 402 individuals who had recently experienced a natural disaster. Dyadic communal coping might be helpful because it directly signifies to members of the relationship that each partner is actively involved in managing the stress associated with their experiences of enacted stigma, which adds to each partner's psychosocial coping resources.

Current study

Informed by Meyer's (2003) sexual minority stress theory and LeBlanc et al.'s (2015) research on relational stress proliferation, we investigate the direct and indirect effects of enacted stigma on depressive symptoms via internalized homophobia in the context of cisgender sexual minority male relationships. We expected partners' experiences of enacted stigma to be associated with elevated levels of depressive symptoms for both partners via elevated levels of internalized homophobia. Furthermore, we investigated the moderating influence of communal coping on the following associations: (a) enacted stigma and depressive symptoms, (b) enacted stigma and internalized homophobia, and (c) internalized homophobia and depressive symptoms. We expected high levels of communal coping to attenuate each of these associations. We extend previous research in this area by (a) investigating the dyadic mediating role of internalized homophobia in the association between enacted stigma and depressive symptoms and (b) investigating the moderating influence of communal coping as a generalizable interpersonal coping skill.

METHOD

Participants

Hypotheses were tested using data from Project Couples Health and Attitudes toward Preexposure Prophylaxis (CHAPS), a cross-sectional mixed method Web-based study consisting of 543 cisgender male couples ($n = 1086$) examining attitudes toward pre-exposure prophylaxis (PrEP) use and patterns of PrEP use among concordant seronegative and serodiscordant cisgender male couples in the USA (see Mitchell et al., 2020). Men were mostly non-Hispanic

White (811, 74.7%) and between 25 and 34 years of age (637, 58.7%). 1006 (92.6%) participants identified as homosexual/gay, 59 (5.4%) identified as bisexual, and 21 (1.9%) identified as queer. Most participants had graduate degrees (382, 35.2%) or were college graduates (378, 34.8%) and worked full time (863, 79.5%). In addition, 38.3% (416) of participants identified as being boyfriends, whereas 37.2% (404) identified as being married. Most couples reported their relationship lengths being between 1 and 3 years (174, 32.0%) or between 5 and 10 years (130, 23.9%) and were currently living together (447, 82.3%). One hundred and eighty-six (34.3%) couples reported being in an interracial relationship (additional demographic information is provided in Table S1).

Recruitment and procedure

Participants were recruited through targeted, Web-based advertisements and postings on commonly used social media websites and dating websites and mobile apps such as Facebook, Instagram, Scruff, and Grindr. The advertisements included a link that led interested individuals to a landing page with detailed information about the study and a Web-based eligibility screener with consent.

Individual eligibility criteria for the original study included (a) being a cisgender male (i.e., assigned male at birth and currently identifies as male), (b) being in a relationship with another cisgender male for 3 or more months, (c) having an HIV seronegative or unknown status or known HIV seropositive status, and (d) having had condomless anal sex with their primary relationship partner within the last 3 months. Once deemed eligible, individuals proceeded to the consent Web page, which outlined the study's content and process. Once consent was provided, the individual (Partner 1) was directed to the partner referral system, where he provided contact information (email and telephone number) and a name or nickname for his partner (Partner 2). Partner 2 would then receive an email informing him that his partner (Partner 1) had signed up for the study and had provided his contact information, along with a link to the landing page to access the same screener and consent process. The link provided to Partner 2 was connected to Partner 1's metadata, such that they both were assigned the same random study ID number as a hidden data field (as a couple). Once Partner 2 completed the same eligibility screener and consent process, Partner 2 was then asked to provide contact information for his partner (Partner 1) to enable cross-matching of partner contact details.

After enrollment, individual emails were sent to each partner, asking them to independently complete a Web-based survey (hosted on Qualtrics) via a link. Each partner was compensated \$50 for their participation. Additional details have previously been reported about the recruitment and enrollment procedures (see Mitchell et al., 2020). The study protocol was approved by the University's Human Subjects Review Board (HUM00125711).

Measures

Enacted stigma

Participants completed the Heterosexist Harassment, Rejection, and Discrimination Scale (HHRDS; Szymanski, 2006). The scale includes 13 items to reflect the frequency with which participants experienced heterosexist harassment, rejection, and discrimination within the past year. Each HHRDS 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*). Example items include "how many times have you been rejected by friends because you are a

sexual minority” and “how many times have you been verbally assaulted because of your sexual minority.” Items were summed to create a total enacted stigma score, where higher scores indicated elevated experiences of heterosexist harassment, rejection, and discrimination in the past year; Cronbach's α was .91.

Internalized homophobia

Internalized homophobia was assessed via an eight-item measure that indexed intrapsychic conflict between experiences of same-sex affection or desire and feeling a need to be heterosexual (Smolenski et al., 2010). Participants' responses to the items ranged from 1 (*strongly agree*) to 5 (*strongly disagree*). Example items include “I feel comfortable being seen in public with an obviously gay person” and “I feel comfortable discussing homosexuality in a public situation.” Items were summed to create a total internalized homophobia score, where higher scores indicated elevated levels of internalized homophobia; Cronbach's α was .79.

Communal coping

Communal coping was assessed using a seven-item measure of couples' engagement in joint efforts to make decisions concerning their sexual health behavior (Salazar et al., 2013). Each item began with the stem, “To what extent do you and your partner make decisions together about...” and was followed by a behavior (e.g., being sexually faithful to each other, either of you having sex “outside” your relationship, etc.). Participants responded to the items on a five-point Likert scale that ranged from 1 (*not at any extent*) to 5 (*to a great extent*). Items were summed to create a total communal coping score, where a higher score indicated greater frequency in engaging in communal coping strategies; Cronbach α was .81.

Depressive symptoms

Depressive symptoms were assessed using a 10-item version of the Center for Epidemiologic Studies–Depression scale (Björgvinsson et al., 2013). Items on this measure began with the stem question, “How often did you feel the following ways in the past week?” and were followed by a behavior (e.g., I felt depressed, I felt everything I did was an effort, etc.). Men responded to the items on a scale ranging from 0 (*rarely*) to 3 (*most of the time*). Items were summed to create a total depressive symptoms score, where higher scores indicated more depressive symptoms; Cronbach α was .80.

Data analysis

Hypotheses were tested using an extended version of the actor–partner interdependence model (APIM) framework suitable for the analysis of indistinguishable dyadic data and investigations of mediation (e.g., Ledermann et al., 2011) and moderation (e.g., Garcia et al., 2015) in Mplus 8.3. An indistinguishable dyad is composed of two individuals who cannot be meaningfully distinguished by a variable that has been shown to empirically differentiate the two members, as in the case of cisgender sexual minority male couples (Fitzpatrick et al., 2016; Kenny et al., 2006). The APIM allows for simultaneously estimating the effects of an individual's and his partner's predictors on both couple members' outcomes while considering interdependencies.

The effects of an individual's independent variable on their dependent variables are called *actor effects*, whereas effects on the partner's dependent variables are called *partner effects*. Within indistinguishable dyadic models, each partner's respective actor and partner effects are constrained to be equal as partners are randomly assigned the positions of Partner 1 or Partner 2. For instance, the association between Partner 1's enacted stigma and Partner 1's internalized homophobia is constrained to be the same as the association between Partner 2's enacted stigma and Partner 2's internalized homophobia.

Within our sample, there was 1.4% missing data. Little's missing completely At random (MCAR) test, $\chi^2(18) = 26.16, p = .10$, suggested that missing values were MCAR and were unrelated to the study variables (Li, 2013). Accordingly, missing data were managed with full information maximum likelihood estimation (Little & Rubin, 2019). Full information maximum likelihood tests hypotheses with all available data; no cases were dropped due to missing data (Little & Rubin, 2019). A post hoc power analysis was conducted using the software package pwrSEM, which utilizes the Monte Carlo approach to post-hoc structural equation modeling power analysis (Muthén & Muthén, 2002; Wang & Rhemtulla, 2021). Using our sample size of 543 and 1000 simulations set at the alpha level of $p < .05$, we observed 95–96% power to detect direct associations, 85% power to identify the indirect mediation associations, and 82% power to identify interactive associations.

Model fit was evaluated with the comparative fit index (CFI; values greater than or equal to .90), root mean square error of approximation (RMSEA; values less than or equal to .08), and standardized root mean residual (SRMR; values less than or equal to .08; Awang, 2012; Kline, 2015). The Chi-square test of model fit (χ^2) estimates was also reported for completeness. The significance of indirect effects was evaluated with bootstrapping analyses with 5000 bootstrapping resamples to produce 95% confidence intervals as these intervals consider possible non-symmetry in the distribution of estimates, which can bias p -values (Hayes & Scharkow, 2013; Shrout & Bolger, 2002). Moderating effects were evaluated by simultaneously introducing four interaction terms to the APIM mediation model (Garcia et al., 2015). The first moderation model included the following interactions: (a) P1 enacted stigma \times P1 communal coping, (b) P1 enacted stigma \times P2 communal coping, (c) P2 enacted stigma homophobia \times P2 communal coping, and (d) P2 enacted stigma \times P1 communal coping. The second moderation model included a similar set of interactions but with internalized homophobia replacing enacted stigma as the primary predictor. For each moderation model, predictors, moderators, and confounding variables were standardized prior to creating interaction product terms, as suggested by Frazier et al. (2004). Product terms were calculated by multiplying these standardized variables to facilitate the interpretation of slopes. Significant interactions were probed using simple slope analysis at ± 1 standard deviation of communal coping. We used Cohen's f^2 to compute the magnitude of change in effect size from Model 1 to Model 2 due to the inclusion of the interaction terms (Cohen, 2013). It should be noted that average effect sizes for moderation tend to be low, around .009 (Aguinis et al., 2005). Therefore, Kenny (2018) recommends using .005 (small), .01 (medium), and .025 (large) as effect size cutoffs for moderation.

Previous research suggests that certain individual and interpersonal-level sociodemographic factors may influence rates of depressive symptoms among gay and bisexual men (Bauermeister et al., 2010; Hall, 2018). As a result, several covariates were included in each model (Ledermann et al., 2011). Participants' age, relationship length, cohabitation status, employment status, education level, and interracial relationship status (yes/no) were controlled for all models. In addition to the direct paths linking the variables, covariation between all predictor variables was permitted. Residuals of all dependent variables were correlated with the model's shared unexplained variance and were individually constrained to be equal for both partners (Kenny et al., 2006).

RESULTS

Preliminary analysis

First, we tested for non-independence using intraclass correlations (ICCs) to investigate associations between partners' reports of the same variable (Kenny et al., 2006). In dyadic data analysis, ICCs are interpreted similarly as Pearson correlations (Kenny et al., 2006). They represent the degree to which scores of dyad members are interrelated and may assume any value between -1.0 and 1.0 , wherein an ICC of 1.0 suggests that members of the dyad had identical responses (Kenny et al., 2006). Our ICCs indicated that couple members' scores were sufficiently similar to one another to support the use of indistinguishable dyadic analysis. Associations between study variables were assessed using individual-level two-tailed Pearson's r correlations due to the indistinguishability of the data. Individual-level correlations, means, standard deviations, and ICCs are presented in [Table 1](#).

Dyadic mediation model

The dyadic mediation APIM fit the data as follows: $\chi^2(52) = 75.42, p < .05, \chi^2/df = 1.45$; CFI = .94, RMSEA = .03 90% CI [0.01, 0.04], and SRMR = .05 (see [Figure 1](#)). Significant positive actor and partner effects in the paths linking enacted stigma and internalized homophobia were found, suggesting that more experiences of actor enacted stigma were associated with elevated levels of (a) actor internalized homophobia ($\beta = .16, p < .001$) and (b) partner internalized homophobia ($\beta = .10, p < .001$). Significant positive actor effects between enacted stigma and depressive symptoms ($\beta = .30, p < .001$) and between internalized homophobia and depressive symptoms were also found ($\beta = .13, p < .001$), suggesting that more experiences of actor enacted stigma were associated with elevated levels of actor depressive symptoms and that elevated levels of actor internalized homophobia were associated with elevated levels of actor depressive symptoms, respectively.

Significant indirect actor effects emerged linking actor's experiences of enacted stigma to actor's level of depressive symptoms via actor's levels of internalized homophobia ($\beta_{\text{ind}} = .009, B_{\text{ind}} = .02, p < .01$). Significant indirect partner effects also emerged linking actor's experiences of enacted stigma to his partner's depressive symptoms via partner's level of internalized homophobia were found ($\beta_{\text{ind}} = .006, B_{\text{ind}} = .014, p < .01$; [Table 2](#)). That is, an actor's experiences of enacted stigma were indirectly related to elevated levels of their partner's depressive symptoms via elevations in his partner's level of internalized homophobia. Explained variance in depressive symptoms for Partner 1 and Partner 2 was similar (partner 1: $R^2 = .18$; partner 2: $R^2 = .17$).

Buffering effects of communal coping

A second model examined whether communal coping moderated the dyadic associations between enacted stigma and depressive symptoms and between enacted stigma and internalized homophobia. The model fit the data as follows: $\chi^2(82) = 144.30, p < .001; \chi^2/df = 1.69$; CFI = .87; RMSEA = .04, 90% CI [.03, .05]; and SRMR = .04. Direct significant negative actor effects between communal coping and internalized homophobia ($\beta = -.17, p < .001$) were evidenced, indicating that higher levels of communal coping were associated with reductions in actor's levels of internalized homophobia. Partner communal coping significantly moderated the association between actor enacted stigma and actor internalized homophobia (partner effects: $\beta = -.07, B = -.07, p < .05$), suggesting that higher levels of partner's communal coping buffered

TABLE 1 Means, standard deviations, intraclass correlations, and individual-level two-tailed Pearson's *r* correlations

	1	2	3	4
1. Enacted stigma	1			
2. Internalized homophobia	.20**	1		
3. Depressive symptoms	.35**	.22**	1	
4. Communal coping	-.10**	-.19**	-.14**	1
Mean	23.52	14.07	14.20	27.76
SD	7.96	5.06	3.38	6.15
ICC	.39**	.27**	.20**	.35**

Abbreviation: ICC, intraclass correlation.

p* < .05; *p* < .01.

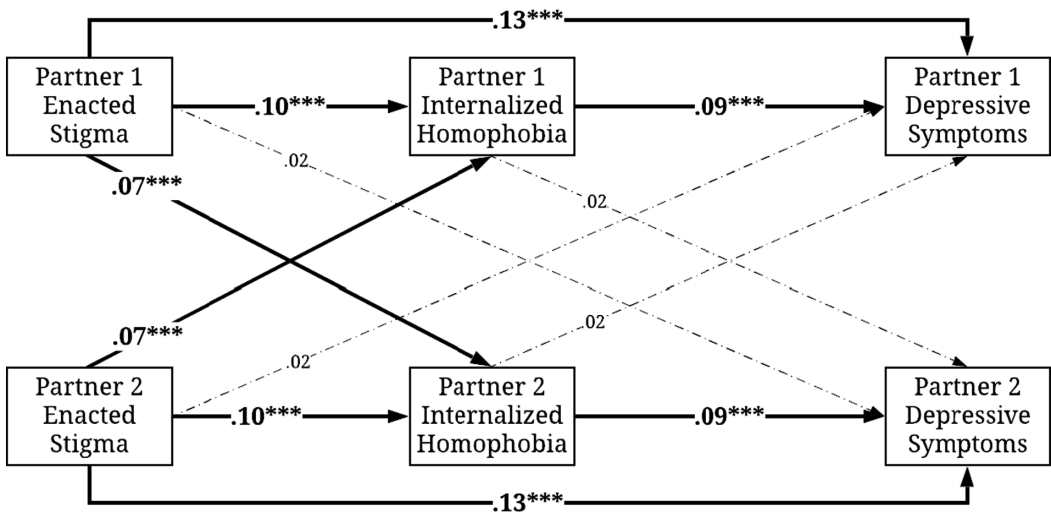


FIGURE 1 Unstandardized results of the APIM predicting depressive symptoms among same-sex male couples. Note. For sake of clarity, correlations are not depicted. All endogenous variables were regressed on control variables. **p* < .05; ***p* < .01; ****p* < .001

the effects of actor's experiences of enacted stigma on actor's internalized homophobia (see Figure 2). No other significant actor or partner interactions were observed. Furthermore, no conditioned indirect effects were found. The final model's explained variance in depressive symptoms for Partner 1 and Partner 2 was also similar (Partner 1: $R^2 = .17$; Partner 2: $R^2 = .19$). The inclusion of interaction terms significantly added to both actor's and partner's explained variance (partner's $f^2 = .02$; actor's $f^2 = .01$).

The third model examined whether communal coping moderated the dyadic associations between internalized homophobia and depressive symptoms. The model fit the data as follows: $\chi^2(136) = 184.16, p < .005; \chi^2/df = 1.35; CFI = .95; RMSEA = .03, 90\% CI [.02,.03];$ and $SRMR = .04$. Direct significant negative actor effects between enacted stigma and communal coping ($\beta = -.09, p < .001$) were evidenced, indicating that higher levels of enacted stigma were associated with lower levels of actor's communal coping. This model evidenced no significant interactions.

TABLE 2 Unstandardized indirect effects of the APIM predicting depressive symptoms among same-sex male couples

Pathway	Estimate	95% CI lower	95% CI upper
ES _{P1} → IH _{P1} → DS _{P1}	.009**	.002	.015
ES _{P1} → IH _{P1} → DS _{P2}	.002	-.003	.006
ES _{P1} → IH _{P2} → DS _{P1}	.001	-.002	.004
ES _{P1} → IH _{P2} → DS _{P2}	.006**	.001	.010
ES _{P2} → IH _{P2} → DS _{P2}	.009**	.002	.015
ES _{P2} → IH _{P2} → DS _{P1}	.002	-.003	.006
ES _{P2} → IH _{P1} → DS _{P2}	.001	-.002	.004
ES _{P2} → IH _{P1} → DS _{P1}	.006**	.001	.010

Abbreviations: ES, enacted stigma; IH, internalized homophobia; DS, depressive symptoms; P1, Partner 1; P2, Partner 2.

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

DISCUSSION

The present study investigated the dyadic effects of enacted stigma on depressive symptoms among same-gender couples. Specifically, APIM was used to investigate the direct and indirect dyadic impact of enacted stigma on depressive symptoms via internalized homophobia. The role of communal coping as a moderator of the effects of enacted stigma on depressive symptoms and internalized homophobia was also examined. Study findings revealed that enacted stigma experiences were associated with elevated levels of internalized homophobia via significant actor and partner effects. However, internalized homophobia was only associated with elevated depressive symptoms via actor effects. The results of our indirect effects analysis demonstrated that internalized homophobia mediated the effects of actor and partner exposure to enacted stigma on depressive symptoms. Furthermore, communal coping buffered the direct effects of enacted stigma on internalized homophobia but not of enacted stigma on depressive symptoms or internalized homophobia on depressive symptoms.

We observed significant direct actor associations between enacted stigma and depressive symptoms. These results are consistent with previous studies, which demonstrated that personal experiences of discrimination were associated with greater psychological distress, psychiatric diagnoses, and mental health care utilization among sexual minorities (Burgess et al., 2007). Marti-Pastor et al. (2020) found that cisgender sexual minority men who reported enacted stigma experiences presented a higher prevalence of clinically relevant depressive symptoms than those who reported not having any enacted stigma experiences. Findings from our study provide further evidence demonstrating that enacted stigma undermines the mental health and well-being of cisgender men in same-gender partnerships.

The finding of significant actor effects between enacted stigma and internalized homophobia is consistent with prior theorizing regarding sexual-minority-related stress (Meyer, 2015). Growing up in a heterosexist social environment may place cisgender sexual minority men at heightened risk for exposure to various forms of enacted stigma, including rejection, discrimination, and violence, which may occur before they become aware of their sexual minority status (Meyer, 2015). As a result of these experiences, some cisgender sexual minority men may internalize negative attitudes about their sexual orientation. This internalization process may serve as a form of contextual adaptation that sexual minorities adopt to thrive within inhospitable homonormative social contexts (Meyer, 2015). Russell and Bohan (2006) further support this line of research noting that internalized homophobia may originate from the internalization of social interactions, stemming from prevailing heterosexism and sexual prejudice, and

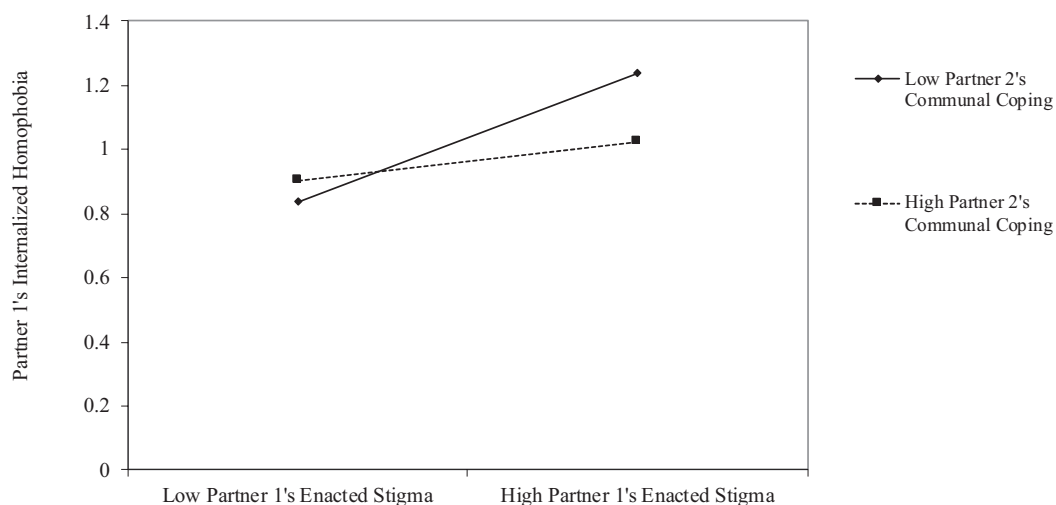


FIGURE 2 Actor association of enacted stigma and internalized homophobia moderated by communal coping of the partner

not from internal pathology or a personality trait. Consistent with emerging evidence, our findings suggest that partnered cisgender sexual minority men may internalize negative beliefs and attitudes toward their sexual orientation partly due to their enacted stigma experiences.

We also found significant, direct, actor associations between internalized homophobia and depressive symptoms. Past research suggests that individuals with higher internalized homophobia experience more depressive symptoms. For example, Newcomb and Mustanski's (2010) meta-analysis of internalized homophobia and mental health problems found a small to moderate correlation between internalized homophobia and depressive symptoms. Consistent with these studies, our findings also document the detrimental effect of internalized homophobia on cisgender sexual minority men's mental health, demonstrating direct associations between internalized homophobia and depressive symptoms.

We further found significant partner effects between enacted stigma and internalized homophobia. These results corroborate the findings of a nascent line of research indicating individual experiences of enacted stigma may affect one's partner's psychological health and well-being (LeBlanc et al., 2015). For example, Wofford et al. (2019) demonstrated that more frequent discrimination experiences for both actors and partners were associated with poorer self-rated health, higher depressive symptoms, and more relationship strain for both actors and partners. A possible explanation for this association may be that partners are experiencing significant vicarious traumatization. Vicarious traumatization refers to the indirect psychological stress that can occur when individuals are exposed to difficult or disturbing images and stories second-hand (Nelson et al., 2002). Additional psychological stress could lead to profound shifts in individuals' understanding of their environment (Nelson et al., 2002). For example, Partner 2 may notice that their fundamental beliefs regarding their (or relationships) environment's safety may be altered by repeatedly hearing about Partner 1's experiences of enacted stigma. Partner 2 may become more fearful of their (or relationships) environment and endorse aspects of internalized homophobia to cope with living in an inhospitable, heteronormative context. Our results contribute to extant literature documenting the dyadic effects of enacted stigma in the context of sexual minority relationships.

We found no significant direct partner effects associated with enacted stigma and depressive symptoms. Our finding is inconsistent with an expanding body of research documenting the crossover effects of discrimination on a partner's mental health and well-being. For example,

Gamarel et al.'s (2014) investigation regarding how experiences of transgender-related enacted stigma among transgender women and their cisgender male partners were associated with both partners' mental health found that transgender-related enacted stigma was associated with increased odds of depressive distress among transgender women and their male partners. This discrepancy may be attributed to differences in individuals' qualitative experiences of enacted stigma. Couples who share similar marginalized identities may have a deeper qualitative understanding and connectivity regarding their experiences of enacted stigma. As such, they may be more open to sharing their experiences or querying about their partner's experiences of enacted stigma. This discrepancy indicates the need for further research examining the cross-over effects of sexual minority-related enacted stigma in the context of intimate relationships.

Notably, internalized homophobia served as a significant indirect actor and partner mediator through which experiences of enacted stigma were associated with increases in depressive symptoms for individuals and their partners. Consistent with the theoretical work of LeBlanc et al. (2015) and Meyer (2015), our findings underscore the importance of internalized homophobia in examining the systemic effects of enacted stigma on depressive symptoms. The intrapsychic conflict associated with internalized homophobia may create relational distress that, in turn, provokes feelings of anger and elicits externalizing responses to partners such as arguing, yelling, throwing things, and fighting (Hansen & Sassenberg, 2006). The resulting stress and relational isolation contribute to depressive symptoms and issues related to self-esteem, self-worthiness, and social competence (Trail et al., 2012). The results of this study indicate that experiences of enacted stigma may have a detrimental effect on cisgender sexual minority men's mental health by compromising their relationship with themselves, their sexual orientation, and their intimate partners.

Our findings suggest that communal coping can buffer the effects of enacted stigma on internalized homophobia at both individual and dyadic levels, but not the effects of internalized homophobia on depressive symptoms. These findings are consistent with existing research underscoring the importance of communal coping in minority stress management concerning external stressors (Meyer, 2015; Rostosky & Riggle, 2017). Prior research suggests that communal coping might promote environmental resilience and reduce stress levels among romantic relationships. For instance, Stachowski and Stephenson's (2015) research found higher levels of communal coping helped partners deal more effectively with stressful events, despite exposure to discrimination and other pressures. Prominent theories of adaptive coping suggest that people show resilience in the face of external stressors when they have adequate resources to allow for positive adaptation to and recovery from adversity (Alvaro et al., 2010; Hobfoll, 1989). Communal coping thus represents a pattern of relating that can help partners within an intimate relationship process and absorb stress associated with external discrimination without feeling overwhelmed or engaging in maladaptive behaviors. In addition to these promising results, there is abundant room for further progress in identifying protective factors against both external and internal forms of sexual discrimination within the context of romantic relationships.

Our findings indicated that communal coping attenuated the indirect actor and partner effects of enacted stigma on depressive symptoms via internalized homophobia, such that in the context of higher levels of communal coping, there were no indirect associations between enacted stigma and depressive symptoms. A possible explanation for this might be that communal coping may not support sexual minority men's ability to thrive (i.e., the ability to grow and be better off after an experience of adversity) in the face of sexual discrimination. A recent qualitative study with young Black gay and bisexual men found that individuals who discussed thriving in the face of both racial and sexual discrimination also reported having supportive relationships with people who helped them to develop a strong sense of identity, provided them with opportunities to give back to their communities, and promoted positive norms about health (Reed & Miller, 2016). This study did not list communal coping

or romantic relationships as significant contributors to men's thriving (Reed & Miller, 2016). However, the nascency of this line of research prohibits our ability to draw clearly defined conclusions. Present results, paired with previous nascent evidence, suggest the need for further exploratory research investigating the potential associations between enacted stigma, communal coping, and cisgender sexual minority men's ability to thrive when confronted with enacted stigma.

Implications for clinical practice and future interventions

Our findings suggest that to understand the effects of enacted stigma, prevention scientists and clinicians must consider how its influence affects both individuals and their romantic partners. By doing so, clinicians and prevention scientists may be able to (a) gain a more thorough understanding of the effects of enacted stigma and internalized homophobia on cisgender sexual minority men's health and well-being, (b) develop more efficacious and contextually responsive clinical practices, interventions, and treatment plans, and (c) consider communal coping as a salient interpersonal-level protective factor against sexual-minority related discrimination for treatment planning. For example, emotionally focused couples therapy (EFCT) explicitly targets communal coping by enhancing the couple's process of sharing and responding to distressing experiences together (Johnson & Whiffen, 1999). In EFCT, increased communal coping has been associated with greater relationship satisfaction and linked to couple therapy's long-term benefits (Dalglish et al., 2015; Wiebe et al., 2017). Additionally, interventions aimed at increasing communal coping may support cisgender sexual minority male couples in counteracting the effects of various forms of enacted stigma. For instance, couples-based voluntary HIV counseling and testing (CVCT) is a public health intervention that utilizes communal coping to reduce HIV transmission, reduce sexual risk-taking, and increase condom usage (Stephenson et al., 2013). Within CVCT, couples participate in HIV counseling and testing together (Stephenson et al., 2013). Among cisgender sexual minority male couples, CVCT's emphasis on communal coping has been demonstrated to (a) reduce the burden of sharing one's HIV-positive status by ensuring provider-assisted mutual disclosure, (b) create an opportunity for couples to discuss, establish, or revise sexual agreements for their relationship, and (c) allow couples to prepare a risk-reduction plan based on the HIV status of both partners (Purcell et al., 2014).

Strengths and limitations

The present study results should be considered in the context of its limitations. First, our analysis of cross-sectional data and the relatively low effect sizes evidenced in this study prevent us from clarifying the examined associations' directionality and strength and limit causal conclusions; prospective examinations of these pathways are needed. Second, our measure of communal coping focused on sexual health. Although prior research indicates that patterns of communal coping are consistent across different domains of social functions, processes, and outcomes, future studies may benefit from a more robust assessment of couples' level of communal coping across a variety of topics and behaviors. Third, self-report measures are subject to social desirability and recall biases. Future studies would benefit from utilizing multi-method designs to adequately capture the study constructs and the associations. Fourth, despite relationship well-being being a salient factor in understanding the mechanisms linking enacted stigma to depressive symptoms, it was not assessed in the initial study, so we were unable to include it in this secondary data analysis. Future prospective studies would benefit from the inclusion of this confounding factor.

Finally, the study focused on cisgender sexual minority male couples; findings may not generalize to other sexual minority couples. Despite its limitations, the current study contributes significantly to emerging literature documenting risk and protective processes associated with the consequences of enacted stigma on cisgender sexual minority men's mental health.

CONCLUSION

The purpose of this study was to investigate the dyadic effects of enacted stigma, internalized homophobia, and communal coping on sexual minority male couples' depressive symptoms. To our knowledge, this study represents among the first empirical studies to dyadically investigate how (a) individual's experiences of enacted stigma may help illicit internalized homophobia in their partners, (b) internalized homophobia serves as a potential explanatory mechanism in the dyadic association between enacted stigma and depressive symptoms, and (c) the role of adaptive interpersonal-level communal coping processes as a protective factor against sexual minority-related discrimination. Experiences of enacted stigma were associated with increases in both actors' and partners' internalized homophobia, which were then associated with increases in actors' and partners' levels of depressive symptoms. Further, communal coping emerged as a significant attenuator of the direct effects of enacted stigma on internalized homophobia and the indirect effects of internalized homophobia on the association between enacted stigma and depressive symptoms. Prevention scientists and clinicians may use the insights provided by these results to enhance intervention programs aimed at addressing the disproportionately high rates of depressive symptoms prevalent among sexual minority cisgender men and cisgender sexual minority male couples.

CONFLICT OF INTEREST

We have no conflicts of interest to disclose.

AUTHOR CONTRIBUTIONS

Mr. Curtis wrote the first draft of the manuscript, conceived of the study, and conducted statistical analyses. Dr. Kogan assisted with the conceptualization of the study and commented on drafts of the manuscript. Dr. Mitchell and Dr. Stephenson provided the data and contributed to the writing in addition to commenting on drafts.

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SUPPORTING INFORMATION

Additional supporting information may be found in the online version of the article at the publisher's website.

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