A mixed-methods study of relationship stigma and well-being among sexual and gender minority couples

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Abstract

Research has documented associations between relationship stigma, relationship quality and adverse health outcomes among sexual and gender minority couples. However, this work focused primarily on one aspect of an individual's or a couple's identity rather than understanding the intersections of multiple, stigmatized social identities. As part of a larger project focused on testing the efficacy of a couples-based intervention to improve HIV medication adherence, 144 couples completed measures of relationship stigma, relationship quality, mental health, and substance use. A subset of 25 participants completed in-depth

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interviews to better understand the phenomenon of relationship stigma and its impact on their relationships. Quantitative results demonstrated that greater relationship stigma was associated with reduced relationship satisfaction and commitment, as well as greater closeness discrepancy and depressive symptoms. Qualitative findings provided nuanced insights into forms of relationship stigma that often intersected with other types of stigma and related forces of social and structural violence. Results also demonstrated the differential impact that relationship stigma had on couples and the ways in which individuals make adjustments to cope with or actively combat societal stigma. Findings illustrate the importance of attending to intersecting forms of stigma in addressing the well-being of sexual and gender minority couples.

Keywords: stigma, couples, LGBTQ, relationship quality, mental health

Introduction

A body of empirical evidence supports the premise that primary intimate relationships can be fundamental in maintaining physical health and emotional well-being (Revenson & DeLongis, 2011). Individuals who are in intimate and committed relationships tend to suffer from fewer diseases, have improved immune functioning (Robles & Kiecolt-Glaser, 2003), heal faster (Kiecolt-Glaser et al., 2005), and report less psychological distress (Seeman, 2001) than their counterparts who are not in intimate and committed relationships. The historical literature on this topic often narrowly focused on married, heterosexual, cisgender partnerships, but a burgeoning body of literature has begun to focus on the committed and intimate relationships of sexual and gender minority people – which encompass, but are not limited to, individuals who identify as lesbian, gay, bisexual, asexual, transgender, Two-Spirit, queer, and/or intersex, often referred to as LGBTQ+ (Gamarel, Darbes, Hightow-Weidman, Sullivan, & Stephenson, 2019; Gamarel, Reisner, Laurenceau, Nemoto, & Operario, 2014; Kurdek, 2005; Whitton, Dyar, Newcomb, & Mustanski, 2018). However, sexual and gender minority people experience stigma due to their sexual and/or gender minority status, which can result in adverse relationship and health outcomes (Doyle &

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Molix, 2015a; Gamarel et al., 2014; LeBlanc, Frost, & Wight, 2015; Lehmiller & Agnew, 2006; Lewis, Winstead, Lau-Barraco, & Mason, 2017; Neilands et al., 2020; Newcomb, 2020; Rosenthal & Starks, 2015).

Building on Goffman's (1959, 1963) classic theorizing on stigma, the minority stress theory developed for sexual minority individuals (Brooks, 1981; Meyer, 1995) and its adaptation for transgender individuals (Hendricks & Testa, 2012) posits that sexual and gender minority people are vulnerable to unique stressors due to their stigmatized status. According to these conceptual frameworks, sexual and gender minority individuals may experience chronic exposure to unique stressors in the form of discrimination and mistreatment, which in turn may lead to negative self-appraisals, concealment of one's stigmatized status, and expectations for future rejection, resulting in adverse health outcomes (Brooks, 1981; Hendricks & Testa, 2012; Meyer, 1995).

A substantial body of theorizing and scientific inquiry has focused on understanding the ways in which stigma may be shared by intimate partners (Bolger, DeLongis, Kessler, & Wethington, 1989; Doyle & Barreto, in press; LeBlanc et al., 2015). For example, sexual and gender minority people in intimate relationships may be ignored or rejected by their own or their partners' parents, relatives, friends, employers, coworkers, and the larger society rather than be validated, celebrated, and supported (Herek, 2007; Otis, Rostosky, Riggle, & Hamrin, 2006; Rosenthal & Starks, 2015). Sexual and gender minority people may also internalize negative messages about their romantic affiliations, leading to instances of relationship concealment from family, friends, and the general public (Frost & Meyer, 2009; Gamarel et al., 2014; LeBlanc et al., 2015). Extending stigma to intimate relationship contexts draws roots in Goffman's theorizing on associative stigma or courtesy stigma, as well as dyadic stress, minority stress proliferation, and interdependence theories (Bolger et al., 1989;

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Goffman, 1963; LeBlanc et al., 2015; Randall & Bodenmann, 2009; Thibaut & Kelley, 2017), which conceptualize stigma as a shared stressor that can negatively impact all members of intimate relationships (Bolger et al., 1989; LeBlanc et al., 2015; Randall & Bodenmann, 2009).

The unique forms of minority stress experienced by intimate partners have been termed couple-level minority stress and relationship stigma (Gamarel et al., 2014; LeBlanc et al., 2015; Rosenthal & Starks, 2015). Couple-level minority stress and relationship stigma are defined as the experiences or anticipated feelings of violence, discrimination, or rejection from family, friends, and others as a result of one's intimate relationship due to heteronormative and cis-normative models of relationships that pervade societies (Gamarel et al., 2014; Goldberg, 2013; LeBlanc & Frost, 2020; LeBlanc et al., 2015). Indeed, research has demonstrated associations between couple-level minority stressors and relationship stigma and reports of lower relationship quality, psychological distress, and substance use among sexual and gender minority couples (Doyle & Molix, 2015b; Frost et al., 2017; Gamarel et al., 2014; Gamarel et al., 2020; LeBlanc & Frost, 2020). The basic premise across these empirical studies suggests that sexual and gender minority people experience added stressors due to one's stigmatized relationship status or being in a relationship with a person who has a stigmatized identity (Doyle & Molix, 2015b; LeBlanc et al., 2015; Neilands et al., 2020).

Expansions of minority stress theory to intimate relationships have tended to only include samples of sexual minority individuals (Frost et al., 2017; LeBlanc & Frost, 2020) or transgender women and their cisgender male partner (Gamarel et al., 2014; Reisner, Gamarel, Nemoto, & Operario, 2014) while making claims about all sexual and gender minority couples (Chan & Erby, 2018). Further, these studies have primarily focused on one aspect of an individual's identity (i.e., sexual orientation or gender identity) rather than understanding

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how the intersections of multiple, stigmatized social identities and the interlocking systems of social, economic, and political power shape people's lives and their intimate relationships (Bauer, 2014; Bowleg, 2008; Chan & Erby, 2018; Crenshaw, 1990; Doyle & Molix, 2014). Although it has long been recognized that sexual and gender minority people also experience other forms of stigma, such as HIV stigma, racism, and classism, a focus on intersectionality has largely been omitted within empirical studies (Addison & Coolhart, 2015; Chan & Erby, 2018; Grzanka & Miles, 2016). Applying an intersectionality lens to understanding stigma processes among sexual and gender minority couples postulates that social, cultural, political, and historical factors influence experiences of oppression among sexual and gender minority couples and allows for an understanding of power imbalances within couples and their experiences of stigma (Chan & Erby, 2018; Crenshaw, 1990).

The aims of this mixed-methods study are two-fold (Creswell & Miller, 2000). First, this study seeks to quantitatively examine associations between relationship stigma and relationship quality, psychological distress, and substance use using dyadic data from 144 sexual and gender minority couples in which one or both partners are living with HIV. Based on prior studies (Gamarel et al., 2014; Gamarel et al., 2020), we hypothesize that greater reports of relationship stigma would be associated with lower relationship quality and greater reports of psychological distress and substance use at the individual level regardless of sexual or gender identity. In accordance with dyadic stress and minority stress proliferation theories (LeBlanc et al., 2015; Randall & Bodenmann, 2009), we also hypothesize that individuals' reports of relationship stigma would negatively influence partner outcomes- namely, that greater relationship stigma would have a dyadic cross-over effect such that individuals' reports of relationship stigma would be associated with partners' reports of lower relationship quality as well as greater psychological distress and substance use. Second, guided by an

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intersectionality lens (Bowleg, 2008; Chan & Erby, 2018; Crenshaw, 1990), this study seeks to qualitatively explore how stigma in intimate relationship contexts was experienced by sexual and gender minority couples and how different and interlocking forms of stigma directed at intimate relationships are experienced by sexual and gender minority individuals.

Methods

Participants and Procedures

Participants were enrolled in a larger study entitled "DuoPACT" that seeks to test the efficacy of a couples-based intervention to improve engagement in HIV care and medication adherence. Details of the study objectives and procedures have been published previously (Tabrisky, Coffin, Olem, Neilands, & Johnson, 2021). The intervention and control condition did not include content on ways to cope with or manage stigma. The current mixed-methods study was designed to include a secondary analysis of baseline data from 144 couples (N = 288 individuals) from the larger DuoPACT study and qualitative interviews with 25 individuals after their study completion. Qualitative interviews were conducted to better understand the nuanced domains of stigma in intimate relationship contexts and whether and how different forms of stigma manifest in and impact participants' relationships.

For the larger DuoPACT study, recruitment began on August 14, 2017 and ended on May 28, 2021. Flyers were posted in venues in the San Francisco Bay Area (LGBTQ resource centers, bars, coffee shops, etc.), community-based organizations (CBOs), clinics, pharmacies and community bulletin boards. Study advertisements were posted online on Craigslist, Facebook, Instagram and through dating/hook-up applications such as Growlr, Jack'd, and Grindr. During COVID-19 all recruitment transpired online or via provider referrals. Due to this remote pivot, the study also opened recruitment to the state of California rather than being restricted to the San Francisco Bay Area. The eligibility criteria for couples

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included at least one partner identifying as a sexual or gender minority person; both were age 18 or older, and the 'couple' was one where partners considered each other as someone "to whom they feel committed above anyone else and with whom they have had a sexual relationship." At least one partner needed to be living with HIV and report suboptimal engagement in HIV care, defined as one or more of the following: less than excellent medication adherence (i.e., very poor to good), having not seen an HIV primary care provider in at least the past 8 months, having a detectable or unknown viral load, or not currently (i.e., for the past 30 days) on antiretroviral therapy.

To determine eligibility, callers underwent a phone screening procedure, in which staff relayed background about the study and asked a series of questions to determine eligibility. Eligible and interested couples were scheduled for an enrollment visit, requiring that both members of the couple present together. To minimize one partner's pressuring the other to participate, partners were consented in separate rooms (in person or Zoom). At the baseline visit, participants completed their own computer-assisted personal interviewing survey using Qualtrics (Provo, Utah, USA). All study procedures were reviewed and approved by the Institutional Review Board (IRB) at the University of California, San Francisco.

Quantitative Methods

Procedures

Each partner completed a self-administered survey in-person prior the COVID-19 pandemic (March 16, 2021) and then remotely during the pandemic through the end of enrollment. Participants were asked about their relationship, stigma, and health in surveys that took approximately 90-120 minutes to complete. Each partner of the couple was compensated US $40 for completing the survey.

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Measures

Demographics. Participants were asked about age, relationship length, race/ethnicity, actor HIV status, partner HIV status, gender identity, sexual orientation identity, education, and income. *Relationship length* (continuous) was calculated as the mean of the length of time each couple member reported, in years. *Age* was re-parameterized into quartiles due to the non-linear relationship of continuous age with the outcomes. *HIV status* of participants was confirmed with documentation of a valid photo ID with the naming matching either an antiretroviral therapy (ART) medication bottle(s) or a positive HIV test from a provider. *Race and Latinx ethnicity* were combined into the following categories: non-Latinx Black, non-Latinx White, Latinx, and non-Latinx other. Categorical *education* had 5 levels: less than high school, high school graduate, some college, college graduate, and post doc. Due to the overwhelming prevalence of participants identifying as gay, *sexual orientation* was categorized as gay vs. other sexual orientation in multivariable analyses. *Gender identity* was assessed using the two-step method in which participants were asked their sex assigned on their original birth certification (male or female) and their current gender identity (man, woman, transgender, gender queer or another gender identity) (Reisner, Conron, et al., 2014). Similar to sexual orientation, gender identity had limited variability in responses and was dichotomized as cisgender man vs. other in multivariable analyses.

Relationship Stigma. Participants completed a relationship stigma scale that assesses the anticipation of rejection due to being in a sexual or gender minority couple from friends, family, and the general public. The relationship stigma scale has been shown to have strong validity and reliability in prior studies with transgender women and their cisgender partners (Gamarel et al., 2014) and demonstrated adequate internal reliability in this sample (α = 0.68). Response options range from 0 = “Never” to 4 = “Always.” For these items,

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participants reported how often they felt relationship stigma (e.g., "how often do you feel uncomfortable holding hands in public", "how often do you feel there is something wrong about being in a relationship with your partner"). We took the mean responses of the items such that higher scores indicate greater relationship stigma.

Relationship Quality. Participants completed three measures of relationship quality, including relationship satisfaction, commitment, and closeness discrepancy. *Relationship satisfaction* was measured using the 4-item Couples Satisfaction Index (Funk & Rogge, 2007), which has demonstrated good psychometric properties in prior studies with same-gender male couples (Starks, Gamarel, & Johnson, 2014). Participants were asked their level agreement with statements such as "I have a warm and comfortable relationship with my partner" and response options ranging from 0 (Not at all True) to 5 (Completely True). Items were summed, and higher scores were interpreted as indicating greater relationship satisfaction ($\alpha = 0.92$). *Commitment* was assessed with a 4-item scale (Kurdek, 2005), which has demonstrated good psychometric properties in prior studies with same-gender male couples (Starks et al., 2014). Participants indicated their level agreement by responding to statements such as "I am committed to maintaining my relationship with my partner" with response options ranging from 1 (Not at all true) to 9 (Extremely True). Items were summed, and higher scores were interpreted as indicating greater commitment to the relationship ($\alpha = 0.92$). *Closeness discrepancy* was assessed using the Inclusion of Other in Self (IOS) Scale, which measures how individuals conceptualize their own perceptions of relationship closeness (Aron, Aron, & Smollan, 1992). Consistent with Frost and LeBlanc (in press) in this special issue, the IOS comprises seven separate Venn diagrams with circles representing varying degrees of self and partner overlap. Participants were asked to select the diagram that best represents their current relationship, and a second version of the IOS asked participants

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to select the diagram that best describes their ideal relationship with their partner (Frost & Forrester, 2013; Gamarel & Golub, 2019). We then created a discrepancy score by taking the absolute difference between current and ideal levels of their IOS score (Frost & Forrester, 2013). The absolute discrepancy score ranged from 0 to 6 (M = 1.24, SD = 1.33), where higher scores were read as indicating more closeness discrepancies (i.e., greater differences in closeness reported by the two members of the dyad).

Psychological Distress. Participants completed the 20-item Center for Epidemiologic Studies Depression Scale (Radloff, 1977), which has demonstrated good reliability in diverse samples of sexual and gender minority individuals (Gamarel et al., 2014; Riggle, Rostosky, Black, & Rosenkrantz, 2017). This scale assesses depressive symptoms in the past week. Items were summed such that higher scores indicated greater depressive symptoms (α = 0.86).

Substance Use. Participants were asked about their alcohol use and non-marijuana illicit drug use. *Alcohol use* was assessed with the 10-item Alcohol Use Disorders Identification Test (AUDIT), which assesses whether individuals are at risk for the development of an alcohol use disorder (Saunders, Aasland, Babor, De la Fuente, & Grant, 1993). The AUDIT has been used across of range of populations, including sexual and gender minority individuals (Newcomb et al., 2020; Weber, 2008). Items were summed, and participants were then categorized into three groups: 1) "abstainers" (AUDIT = 0); 2) "nonhazardous drinkers" (AUDIT score = 1–7); or 3) "hazardous drinkers" (AUDIT $\geq$ 8) (Babor, Biddle-Higgins, Saunders, & Monteiro, 2001). Non-marijuana illicit drug use was assessed by asking participants to rate how often they used analgesics, cocaine, crack, heroin, stimulants/methamphetamine, erectile dysfunction drugs while high/drunk, or club drugs (e.g., ecstasy, ketamine) in the past three months. Participants were also asked to report

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frequency of "other" illicit drug use where they then reported what substance they used. Responses ranged from 0 (Not at All) to 7 (Daily). Participants who reported any recent non-marijuana illicit drug use (1) were compared to those who did not report any use (0).

Quantitative Analyses

Descriptive statistics such as frequencies, means, and standard deviations summarized demographic characteristics, relationship stigma, relationship quality, psychological distress, and substance use. Bivariate analyses using methods for comparing clustered means and proportions (e.g., Rao-Scott-based *F*-tests) compared participants in the qualitative subsample to those not in the qualitative subsample. Quantitative multivariable analyses followed procedures for dyadic data (Kenny, Kashy, & Cook, 2006). We used Actor-Partner Interdependence (APIM) models to examine associations between relationship stigma and psychological distress and relationship quality. APIM models allowed us to create two types of effects: *A*ctor effects, which are an individual's own value on explanatory variables (e.g., the relationship stigma scale) to predict their own score on outcomes (i.e., relationship quality, psychological distress, substance use), and partner effects, which are an individual's score on a predictor that is used to predict their partner's score on the outcome. Additionally, we included covariates (e.g., age, HIV status, relationship length, socioeconomic status, sexual identity) that have been shown to be associated with relationship quality and psychological wellbeing (Gamarel et al., 2019; Gamarel et al., 2014).

All analyses were completed in SAS 9.4 (SAS Institute, 2013). Following the recommendations of Loeys and Molenberghs (Loeys & Molenberghs, 2013) for the analysis of dyadic data with categorical outcomes, generalized estimating equations (GEE) clustered on couple ID were used in all analyses to account for the non-independence of dyadic data. GEEs with the exchangeable correlation structure were utilized with (1) the binomial

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distribution and logit link for the binary outcome: any non-marijuana illicit drug use; and (2) the normal distribution with the identity link for the continuous outcomes: psychological distress, relationship satisfaction, commitment, and closeness discrepancy. GEEs were used with the independent correlation structure and the multinomial distribution and the cumulative logit link for the ordered categorical outcome: AUDIT. Multivariable analyses were performed for the actor and partner relationship stigma independent variables, controlling for both actor and partner HIV status, actor age, race/ethnicity, sexual orientation, gender identity, income, education. The assumption of a linear relationship between the continuous independent variables, relationship stigma and income, with respect to the outcomes was assessed by reviewing plots and associated statistics based on aggregates of residuals. Missing data was trivial (n = 4, 1%) and ignored in these analyses.

Qualitative Methods

Procedures

After participants completed the larger DuoPACT study, a purposively-selected subset of study participants were invited to complete qualitative in-depth individual interviews. We had not completed the quantitative analysis of the survey data prior to conducting the qualitative interviews. Thus, the bridge between the two forms of data had not been established at the time the interviews took place. Rather, the main purpose of the in-depth interviews was to draw on the larger study to derive the subsample and to explore the phenomenological experience of relationship stigma. We planned to integrate and re-interpret our respective results of each analysis after sharing preliminary results from both data sets with the entire team.

Eligibility criteria for the qualitative sample included completing the larger DuoPACT study within the prior 6 months, at which time they had indicated that they were interested in being

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contacted for future research and were able to complete a remote session (had technology, privacy, and Wi-Fi access). Participants were excluded if they had moved out of state, were deceased, or lost to follow-up. Seventy-four participants were identified as eligible, and a study staff member (WF) attempted to contact all eligible participants to assess their interest in participating in the sub-study, prioritizing those who scored high and low on the relationship stigma scale (Median = 0.60, IQR = 0.20 - 1.20) and those in which at least one partner identified as a gender minority, to assess their interest in participating in the sub-study. The staff member spoke to or left a message for 44 participants, of whom 25 completed the qualitative interview. If the couple members were no longer in a relationship with each other, the interviewer used a modified interview guide that took the break-up into consideration. Twenty-five in-depth interviews were conducted over the HIPPA-compliant Zoom platform. Individual interviews were chosen rather than interviewing both members of the couple jointly because of the sensitive nature of the topic and because couples may have differing perceptions of stigma (Chan & Erby, 2018). The interview guide included open-ended questions along with suggested follow-up prompts to elicit participants' conceptions of and experiences of stigma in their lives and within their relationship, as well as how individuals coped with and managed adversity. Example questions included: "What, if any experiences have you had with stigma in your relationships?," "Walk me through your most recent experience of worrying about or dealing with a stigmatizing event in your relationship?," In what ways have you experienced stigma related to your relationship?" Interviews lasted between one and two hours, were audio-recorded, and professionally transcribed verbatim. The interviewer wrote a fieldnote following each interview to capture non-verbal communication, an overview of the interview content, potential changes to the interview guide, and emergent themes. Of note, the interviewer shared certain commonalities

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with some of the study participants in that they identify as a person with a sexual and gender minority status as well as identifying as a person of color. These identities allowed the interviewer to establish rapport with certain types of study participants who may have otherwise been less open had a White-identified, cisgender, heterosexual male or female member of the team conducted the interviews. This interviewer brought the same identities to bear on the analysis and interpretation of the data. Because our interviewer was an 'insider' and shared similar experiences with study participants, they were uniquely situated to shed light on issues of intersectionality. They picked up on nuances that other members of the team may have overlooked because they had less familiarity with the population under study. Their presence as a data collector and interpreter lent tremendous insight into the analytic process.

Analyses

The central questions we sought to answer during the analytic stage included: how is stigma in intimate relationship contexts experienced by sexual and gender minority couples, and how are different and interlocking forms of stigma manifesting within these relationships? An interdisciplinary team of four researchers (KG, WF, LV, KK) with a range of experience in qualitative data analysis (beginner-expert) as well as diversity in life experiences (e.g., sexual identity, race/ethnicity, gender identity, age) conducted a directed content analysis (Hsieh & Shannon, 2005). The steps involved in carrying out this analysis included: 1) immersion and familiarization with the dataset; 2) index coding whereby large chunks of text were deductively labeled with domains taken from the interview guide; 3) summarizing of code reports on 'experiences with stigma and discrimination', 'relationship stigma', 'impacts of stigma' and 'adjustments' made in response to general or relationship stigma; 4) drafting of analytic memos on the aforementioned codes; and 5) cross-case

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comparison to identify and describe commonalities related to relationship stigma experiences as well as identification and explication of disconfirming cases. The intent of the qualitative component was to understand the phenomenological or lived experience of relationship stigma. Our line of inquiry was driven by this key question. As such, our analytic approach was primarily deductive in that we interrogated participant narratives with an a priori assumption that relationship stigma would be present; in our analysis we specifically searched for the ways in which relationship stigma manifested and/or was contested.

Data Integration

In this study, we applied the definition of data triangulation as the process of using distinct methods to study a phenomenon for the express purpose of developing a comprehensive understanding of the phenomenon (O'Cathain, Murphy, & Nicholl, 2010). This is more than simply triangulating two sets of findings to corroborate one or the other. In this project, the quantitative results were available at a stage when the qualitative analysis was well underway. Lead author KG brought the results to the qualitative team for discussion. Initially, the team conferred about the extent to which the qualitative data supported the quantitative results. As we proceeded to read, re-read, and interpret the qualitative narratives, we held the quantitative data in mind. We read our data through this lens, seeking to provide context around the topics that were determined to be significant. In addition, we asked ourselves: *what are the other dimensions of relationship stigma that come through in the qualitative data?* This question helped us to put the distinct data sets into conversation with one another to offer an explanation about how and why couples experienced reduced relationship satisfaction, commitment, and closeness in the face of relationship stigma.

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We used several criteria to evaluate the trustworthiness and credibility of our interpretations (Lincoln & Guba, 1985). Several of our analysts are sexual and gender minority individuals and have had first-hand experience of relationship stigma. All members of the team were familiar with the various neighborhoods or regions in the Bay Area as well as the social-cultural climates in which many of our study participants lived. We believe that these findings will be highly transferable or applicable to other contexts and enhance the trustworthiness of our interpretations.

Results

Quantitative Results

The quantitative survey sample comprised 144 couples (39.9% sero-different and 60.1% sero-concordant) with 231 participants living with HIV and 57 not living with HIV. The demographics are shown in Table 1. Participants ranged in age from 19.90 to 73.50 years old ($M = 46.09$, $SD = 11.95$). The majority of participants identified as a cisgender man (92.4%), non-Latinx White racial identity (43.4%) and a gay sexual identity (81.4%). Approximately half of the sample earned less than $20,000 annually (52.5%), 65% reported that they could barely or could not get by on the money that they had, and 49% had been homeless in their lifetime. Couples' relationship duration at baseline ranged from 3 months to 49.29 years ($M = 8.28$ years, $SD = 8.43$), 12.5% had children, and 74.3% were living with their partner at the time of the baseline survey. The majority of couples included partners in which both members of the dyad identified as a cisgender man (88.6%) and a sexual minority identity (95.1%) and one or both members of the dyad identified as a person of color (74.9%).

Table 2 presents the multivariable models examining relationship stigma and its association with indicators of relationship quality, mental health, and substance use. For

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indicators of relationship quality, there were significant relationship stigma actor effects on each outcome. Specifically, relationship stigma was negatively associated with relationship satisfaction, $B = -2.99$, 95% CI 95%: -3.73, -2.26, $p < 0.001$, and commitment, $B = -3.67$, 95% CI: -4.88, -2.47, $p < 0.001$, and positively associated with the magnitude of discrepancies in closeness scores, $B = 0.36$, 95% CI: 0.11, 0.60, $p < 0.004$. There was a significant relationship stigma partner effect on relationship satisfaction, $B = -0.89$, 95% CI: -1.56, -0.21, $p = 0.01$, indicating that the greater relationship stigma reported by one partner was associated with lower levels of relationship satisfaction reported by the other partner. Greater relationship stigma scores were positively associated with depressive symptoms, $B = 2.42$, 95% CI: 1.23, 3.60, $p < 0.001$; however, there were not statistically significant associations between relationship stigma and alcohol use or non-marijuana illicit drug use.

Qualitative Results

The subset of 25 individuals who completed the qualitative interviews had a mean age of 47.92 years ($SD = 12.79$) and the majority were living with HIV (87.5%). In total, 83.3% identified as a cisgender man, 44% identified as non-Latinx White, and 75% self-identified as gay. The majority of participants had less than a college degree (70.9%), earned less than $20,000 annually (56%), and could barely or could not get by on the money that they had (80%). Of the 20 participants (83.3%) who were still in a relationship with their partner at the interview, 4% had children, relationship length at the time of the qualitative interview ranged from 1.52 to 22.51 years ($M = .98$, $SD = 6.15$), and 75% were living with their partner. Over three-quarters of couples in the qualitative sub-study included partners in which both members of the dyad identified as a cisgender men (87%), 95% of both partners identified as a sexual minority, and one or both members of the dyad identified as a person of color (75%). There were no significant differences between the participants in the qualitative sub-study

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and those in the larger quantitative sample (all *p*s > .18) with the exception of gender such that a greater proportion of participants in the qualitative sub-study included couples in which one partner identified as a gender minority compared to the larger quantitative-only sample ($p = 0.003$) and a greater proportion of participants identified as a cisgender male in the quantitative-only sample compared to other gender identity groups ($p = 0.008$). There was also a marginally significant result indicating a longer relationship length in the quantitative-only sample (p=.06).

Relationship stigma occurs when couples or individuals experience or anticipate experiencing rejection or discrimination based on their romantic affiliation due to the dominance of heteronormative and cis-normative models of relationships. However, participants in the qualitative subsample also described experiencing stigma- directed at the relationship and themselves as individuals on the basis of other intersecting social identities, life experiences, and circumstances, such as race, age discrepancies, body image, HIV status, incarceration history, drug use, and mental illness, among others. Many participants reported being subjected to indirect or direct forms of relationship stigma as a couple or experienced stigma directed at them due to their relationship affiliations.

Relationship Stigma Experiences

The narratives related to relationship stigma followed a discussion about stigma more generally. Most participants were familiar with the term and conversant about the concept of "stigma." Not surprisingly, most were unfamiliar with the formal or even informal concept of relationship stigma after the interviewer provided some examples. Some stated that they did not experience relationship stigma and there was variability in whether participants provided their own examples of relationship stigma. Many participants' narratives of relationship stigma experiences required further prompts and different framings by the interviewer and/or

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free-association during their own responses, which ultimately led to the unfolding of a more nuanced story of stigma experience. Despite a lack of ease and familiarity with the concept, participants often relayed instances of anticipating and experiencing discrimination directed at them and of contending with stigma as a couple. Table 3 presents pseudonym for 16 of the participant in the qualitative study.

For example, Bri, a 54-year-old, Black, heterosexual, transgender woman in a relationship with Benji, a 69-year-old, Black, heterosexual, cisgender man, initially responded that "no one stigmatizes our relationship" but then went on to describe how she and Benji experience discrimination directed at them as a couple in their everyday life. Benji described contending with "haters" and a "lifetime of stigma" primarily around his status as a Black man enduring racism on a continual basis. Once he started dating Bri, he experienced a new version of discrimination in the form of relationship stigma due to his romantic affiliation with her.

> I've experienced some, uh, some negativity from people that I've known and done business with. And - and - and it's funny because when they found out I was with somebody transgender, their whole persona toward me changed…..Like they - like they mad at me. That's funny. Why are they mad at me? I haven't done nothing to them. . . . But it's funny how people have stupid hatred in their head. And it's nothing - it's nothing you could tell them to get it out of their head.

For Benji, while he was accustomed to facing racism, his position as a heterosexual, cisgender man did not incite any discrimination on the basis of his romantic partners until he began dating a transgender woman. In numerous areas of his life, he was contending with changed attitudes towards him – from his business contacts, from the women in the grocery store he frequented, and especially from his former, cisgender ex-girlfriends. Benji was forced to cope with what became constant, mainly indirect, insidious, and hurtful forms of relationship stigma in his community and home environment. He drove this point home when he stated:

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> …this is what I want to tell you. Nobody - and there's four units in this building - nobody in this building speak to me. Okay. I want you to understand that.

Both Benji and Bri relayed stories of constantly running the risk of being the target of stigma and violence on the basis of their relationship.

Several participants were more direct in their descriptions of experiences of relationship stigma. For example, Ken, a 57-year-old, White, gay, cisgender man in a relationship with Ron, a 39-year-old, multi-racial, gay, cisgender man, provided an example of an event that typifies the definition of relationship stigma leveled directed at the couple. In response to a question asked of all participants about their history of experiencing stigma related to romantic relationships, Ken explained:

> ….we had stopped to speak with this woman who was, uh, uh, uh, who was there on the sidewalk. And we were having a pleasant conversation with her. …Uh, when this, uh, this other guy comes walking and walks right in the middle of the conversation. And, uh, as he's passing by uh, and calls us faggots. Um, uh, my reaction was pretty immediate and not pleasant. Uh, you know, just verbally. Uh, you know, I, uh, I yelled after him some - some, uh, choice words. ….I'm sure I could come up with m-dozens of others examples. You know? Every – every gay man - every gay man can come up with those.

Ken's reporting that "we were merely walking down the sidewalk" speaks to the crucial element of their simple physical presentation alone – two adult men on a sidewalk—being enough to create a hostile verbal assault.

Some participants also reported the ways that relationship stigma directly and indirectly impacted their healthcare. Riley, a 51-year-old, White, nonbinary individual, and Ray, a 57-year-old, multi-racial, gay, cisgender man, both relayed multiple instances in which they were not permitted to accompany one another to a doctor or emergency visit, including one incident at the emergency room that caused Riley to leave mid-treatment to mitigate the emotional pain of the stigmatizing situation. Jed, a 29-year-old, White, gay, cisgender man, provided an indirect example of how relationship stigma impacted his healthcare. He

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described an incident where he was denied pre-exposure prophylaxis (PrEP) from his long-term healthcare provider and said that she did not seem to want to have anything to do with him after they discussed his sexual practices and intimate partnerships. He relayed how she discontinued his care and canceled all his other existing prescriptions after this encounter.

These examples highlight the ways in which stigma can manifest itself in intimate relationships and how individuals' positionality and history of different forms of stigma can shape their experiences of relationship stigma.

Impacts of Relationship Stigma

In many interviews, the most common proxy for relationship stigma was the degree to which participants felt comfortable holding hands in public. While we explicitly probed for attitudes about public display of affection (PDA) or acts of intimacy that are seen by others, participants often spontaneously shared their perspectives on the topic. Many participants shared a similar attitude with their partner about PDA and the potential threat of stigma that it exposed them to. Often, couples were PDA averse as depicted by Brian, a 54-year-old, Black, cisgender man, who stated:

> …me and my partner, we never like did public displays of affection….we never gave anyone the chance to say don't be doing that, don't be hugged up in front of that. Don't be kissing in front of these kids or these people…. I don't need to be doing all that in public.

These couples described feeling uncomfortable with PDA regardless of situations or contexts. Some explained that avoiding PDA had nothing to do with their sexual orientation or fear of relationship stigma; rather, they spoke of PDA aversion as a personal preference for privacy.

Some participants were misaligned with their partners when it came to holding hands and other forms of PDA – that is, one member had greater PDA aversion than the other. For example, Jamie, a 47-year-old White, cisgender, gay man, depicted his partner, John, a 50-year-old, White gay, cisgender man, as being both "more cavalier" about PDA and "a bigger

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dude" than Jamie was, implying that John might be better positioned to discourage and/or successfully defend them in the face of discrimination. Whereas Nero, a 40-year-old Latino, gay, cisgender man, reported that he was much more comfortable with PDA than his partner:

> …my partner was always thinking about it [threat of stigma] and there would be no, we wouldn't hold hands in public, no PDA or nothing like that, he would always be hesitant to do so. Uh, even around the city. Or, you know, somewhere else like that. Or Gay Pride, he still wouldn't be willing to do that. ... I-I didn't care. I was like we're together. I mean we're in San Francisco of all places, I mean Gay Pride, I mean it should be okay here….You know, but he didn't think it was okay.

In several instances, relationship stigma placed strain on their relationships, although not all participants were necessarily connecting strain in their relationship to their experience of relationship stigma. We also observed the ways in which experiences with relationship stigma could invigorate feelings of connectedness in relationships and ultimately have a generative or positive impact on couples.

Straining Impact. Anton, a 36-year-old Asian, gay, cisgender man in a relationship with Jed, spoke of the impact of experiencing stigma due to his intimate relationship and provided us with a window into the subtle, but negative, consequential effects on their relationship. He reported that dealing with stigma made him feel fatigued, which created distance between him and his partner. He described the impact of stigma as something that "just makes you shut down" and "kills the vibe I guess you could say." He indicated that he struggled with the impacts of stigma and discriminations more so than his partner, Jed.

> It might impact me by, um, feeling, you know, like hurt or like I'm gonna hide things from people more. Or it might make me angry and, you know, wanna rub it in peoples' faces. Or, you know, I might feel ashamed of myself or ...? Because I'm gay or because of the argument?

Similarly, Ron described how relationship stigma made both him and his partner, Ken, distrustful of one another, causing them to second-guess their relationship. These impacts of

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relationship stigma were tied to an incident when he felt “attacked” by a friend who disapproved of his relationship with Ken because of their age discrepancy. Below he describes the consequences of that particular incident on his relationship with his partner:

> I'm not sure what the direct consequences of that was. But I think that it just, it doomed us from the gate. That's how I was feeling. I, you know, I was doubting our relationship. Um, I wasn't giving us the opportunity to be together. … Um, so I would find myself being very defensive, not trusting, and he would do the same.

Other couples described how they did not feel validation from their families; when asked about the impact this type of reaction from families had on their relationship Nero explained that his family did not respect him or his relationship:

> Um, it kinda put a little bit of a strain on it 'cause I would go to family functions and he'd be mad 'cause I was going but he couldn't go and he wanted to go but, 'cause he wanted to be with there with me.”

This “strain” ultimately resulted in the couple avoiding communicating with one another about their feelings as Nero reported - “we just wouldn't talk about it.”

Generative Impact: In some instances, couples interviewed described feeling empowered as a unit in the face of relationship stigma directed at them. Oftentimes, partners discussed standing up for the other, emotionally supporting their partner through a stigmatizing event, or being able to brush things off as unimportant with the support of their partner. A few participants described how experiences of relationship stigma brought them closer together. For example, Bri and Benji independently talked about the intimacy and safety they experienced as a result of their relationship. Benji explicitly stated that the negative attitudes directed at his relationship with Bri made him double-down on his efforts to be a good partner to her.

> …. all the people that tried to keep us apart. That didn't do anything, but make me - make us come together more. It made me more dedicated to make it work, you know? I feel more dedicated the more people try to - to keep us apart, I feel more stronger being with her because I'm gonna be with who I want.

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In this example, experiencing relationship stigma seemed to reinforce the commitment to one another. Similarly, Jed also reported that after experiencing some hostility while in public, the impact left him with the impression that the situation "probably made us [he and his partner, Anton] stronger since we're experiencing that together."

In contrast to stories relayed above, some couples described using public displays of affection like holding hands or expressing intimacy in public to intentionally confront or challenge stigma. Lon, a 20-year-old White, gay, cisgender man, explained:

> Another bystander that was in the store. She was like …kind of staring us down the entire time. And like even when we were talking with like the salesperson, like she was staring at us the whole time …and I mean I'm a little like confrontational a little bit. So, I just [looked her] dead in the eye and just started like making out with him, so, I mean …there's been like a few times like that.

Ray expressed how they hoped to set an example for other people to know that they can be in a loving relationship regardless of societal stigma related to his partner's weight. Ray stated:

> I'm also trying to let other slender people who are good looking know that they can date successfully heavyset people and not have that stigma … You know? Also, breaking that stigma is allowing both me and Riley to feel that much more comfortable being ourselves with each other in public without people being, oh my god, why is that guy with that guy, you know, kind of thing.

Adjustments

Participants often made adjustments to cope with the possibility and/or reality of contending with various forms of stigma and violence. We observed adjustments across all participants and classified them into two types of shifts: organizational and presentational. Notably, some narratives were linear in how participants viewed and talked about their shifts to avoid stigma, whereas others did not discuss their experience or current situation as being modified by any adjustment, even though their narrative painted a more intricate picture as to how violence rooted in stigmatization ultimately prompted a shift in these participants' present-day navigation of avoiding or contending with stigma. That is, the interviews

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revealed that some participants developed organizational or presentational shifts (sometimes unconsciously or automatically) to avoid stigma based on their sexuality, gender identity, race, ethnicity, and/or HIV status.

Organizational Adjustments. Organizational adjustments were instances in which participants described developing and actively engaging in thought processes which allowed them to move past or adaptively adjust for oppressive narratives and experiences. This included reframing negative stereotypes, or what Peter, a 25-year-old White, gay, cisgender man, referred to as "chemically shift[ing]" his self-perception:

> Um, I guess, it goes back to my own stigma of what being gay meant and m-m- that being gay was somehow lesser than a straight person in my mind, being - growing up Catholic and growing up needing to marry a woman and all this sort of stuff. Like it just was like - it was a - there was an aspect of like ... And that's where like I've read, um, *The Velvet Rage*, which is something where like gay people have to come into this authentic loving themselves and ... heal the part that says, "I'm not worthy," and because we are worthy - just as worthy as everyone else. And so I think that that was a big thing of like, okay, the me coming out - am I worthy enough to - for you to still love me, even though, now... you know that I'm gay kind of a thing. - And so just being able to like chemically shift my head, I think, helps maintain that, um, resilience. –

Other participants described various activities that helped distract them from the pain of stigmatizing experiences they encountered in their lives, such as 'tuning out' to some degree when moving through physical spaces where they might encounter stigma. A few participants said that they may not be aware of every instance where stigma against them is present. This was especially apparent among White cisgender men who eventually decided that they no longer cared about other people's opinions.

Other participants consciously pulled from their mental 'tool kit' to combat stigmatizing events, actively flipping the narrative back onto the persons or systems projecting stigma onto them. Rather than allowing the event to be experienced as a reflection of themselves and their partners, they understood and reaffirmed for themselves how

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stigmatizing events and sentiments had less to do with them and more to do with the person or institution enacting and perpetuating stigma. These participants reclaimed their own power, refusing to let the experience dehumanize them because of whom they had chosen to love and/or their HIV status.

Presentational Adjustments. We categorized presentational adjustments as strategies that encompassed shifts in personal physical mannerisms, physical locations (e.g., neighborhoods, states, localities), displays of affection with their partner while in public, and selective disclosure or omission of their stigmatized identity, condition, or relationship. Riley, a nonbinary person in a relationship with Ray spoke of the layers of stigma they faced as a couple, which they attributed to their HIV status, gender identity, and sexual identity. Riley discussed how Ray's support helped them release their fear of violence and/or being victimized due to their multiple stigmatized identities when they were together: "when my partner's with me I feel like I know that somebody's got my back… I hold my head up, you know, 'cause I know he's not ashamed of me." However, Riley described continuously experiencing stigma directed at their relationship in medical settings. For example, Riley shared an encounter in which Ray was denied access to visiting them in the hospital. Riley interpreted this denial as a clear example of stigma due to his relationship and as a result, Riley left the hospital without receiving medical treatment. Ray shared: "We feel like, you know. . .we don't understand why we're being discriminated like that. Like if I was his girlfriend, they wouldn't say anything about it, you know what I mean? But because I'm his boyfriend, um, there's still - like after all these years, and after we've come so far, we still-I still have to like make explanations for what I am doing there." Riley discussed the need to be assertive in expressing the need to have Ray accompany them to each of their doctors appointments:

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> Sometimes I'm like okay, I know that this appointment's going to go faster if I don't bring my partner with me. But we wanna be in on everything together. So, the idea of like not involving him [in] my doctor's appointments kind of is, you know, like they always look at me funny like when I'm like well, yeah, my appointment and my partner's coming too. Like I have to make that clear every time I make a doctor's appointment because that's, um, like a given that he has to be there with me.

Participants also described concealing their sexuality to avoid stigma, which often took the form of having to choose under what circumstances and environments it was safe to disclose. This is illustrated below by Jed where he described his experience of his partner asking him not to tell others that they were partners on the day of his partner's restaurant opening.

> You know, when Anton opened up his new restaurant, um, I was there the first day and, um, I don't know - people were just asking me do you work here, are you the owner, whatever. And I remember I said to someone, um, no this is my partner's restaurant. And then Anton told me not to say that, um, because he felt like he – I don't know – people might not want to eat at the restaurant because of that.

John, a 50-year-old, White, gay, cisgender man, also described deciding to hide his sexuality from his colleagues after being told that if he wanted to make it in his line of work, he would have to pretend to have a wife. He explained concealing his sexuality, allowed him to be more successful at work. He further described the constant vigilance required to manage the threat of others debunking his heterosexual narrative, such that at any moment, the presentational effort of passing (i.e., seen as a heterosexual man) could fail and ultimately affect his livelihood.

> Because I – I've always worked in an almost exclusively straight universe, and those social networks are social, and my assumption is that I would not ...be welcome. …I think it's probably pretty natural for people who have stigma but can pass, and if your passing is what you believe is making it work, it makes everybody else a threat because at any point the passing could fail.

The vigilance that John described at work was in contrast to other settings in which he described feeling comfortable showing affection to his partner. For example, John described

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how he showed PDA in settings outside of his workplace, “you know, I kiss him [his partner] good-bye every morning at 24th Street BART stop”.

Rae, a 47-year-old Latino Black, gay, cisgender man, described “code switching,” which allowed him to shift both his perception and mode of engagement with his surroundings.

> Do you know what code switching is? -Okay. As a Black, gay male, I live in a consistent place of code switching, depending on who I'm around, what environment I'm in. So I don't think of it, necessarily, as, "Oh, wow. Here I am. I'm about to deal with a place of stigma." It's just code switch, based upon the environment that you're in, to take care of what you need to take care of. Um, I'm coming to a place where I want to do less of it. I know it's still important. [laughs] It's - it's very important for me to be able to do that.

In his interview, Rae spoke to the intersecting stigmatized identities he holds: i.e. being Black, being gay, and living with HIV. He spoke to the ways each made itself present in his everyday life, and further described his navigation and embodiment of each identity in accordance with his surroundings. As he described his journey to self-acceptance, Rae elucidated the struggle to be affectionate with his partner while in public,

> So there may be times when my partner and I are together and I want to kiss. Well, some of the dynamics are still there for him. So he's less likely to give me a kiss in public. Um, I get it. I'm not always that open either… Everybody has different places where they are in that regards. So I think it may be a little bit harder of a process for him. Um, I'm not super PDA. But it's something that I realize I need. So, in those regards, yeah, it can get a little hairy at times.

For Rae, while some presentational adjustments were seen as strategic choices for the preservation of his own internal peace, other ajdustments like the selective public displays of affection between his partner and himself were more difficult.

Multiple participants described their adjustment of behaviors as contingent on their physical location, i.e., what state, city, or specific neighborhood they were. One couple developed a code to use when they felt it was unsafe to be seen as a gay couple while in

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public. The code helped the other partner know that their sexuality may be met with stigma or physical violence. Ultimately, this code facilitated a bit of peace while traveling together. Jamie explains:

> [My partner] and I have a code. If either one of us is feeling like this is a weird or unsafe environment, or it's problematic to display affection… It just means that we just do not have to appear obviously as a couple.

Similarly, other participants described having physically moved to a new state, city, or neighborhood to experience less stigma. The San Francisco Bay Area was described as a safe haven for LGBTQ+ individuals. John described the city as a "gilded cage"- a sort of safe haven for him and his cisgender male partner. Jamie (John's partner) explained that he moved to San Francisco because of its greater LGBTQ+ presence and community of people living with HIV. However, he also detailed how his relationship buffered him from the HIV stigma that he felt he would encounter if he was looking for partners in the city.

> And of course, I think I'd be subjected to a lot more stigma if I were trying to be dating. I decided fairly early on in my adulthood that I was only going to date other HIV positive men. Again, another reason why I moved to San Francisco was the population. … I don't have to deal with all the potential rejection or trouble being labeled a thing. So yeah, I think I would be subjected to a lot more stigma without a partner.

Many participants understood that being able to relocate was a privilege; some described not having the ability to choose their neighborhood and further explained, even if they could, they would still experience stigma. For example, Benji described how he and Bri knew that they would encounter stigma and even violence in neighborhoods in the San Francisco Bay Area because of their relationship and the intersections of their race, class, and gender presentation. When asked about any adjustments that he had made to experience less stigma, he stated:

> I haven't. I haven't. And this is what I told Bri okay, we live in a very, very ghetto-type neighborhood. There's candles down the streets on both sides of the street. When they have lit candles, you know what that represents? -People are getting killed here

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> every week. And we live right down the street from it. Okay. If we move somewhere else, we probably won't be in this sort of crime ridden neighborhood. But we still gonna encounter haters. Because wherever you go there's gonna be a hater. Wherever you go is gonna be somebody who dislike you. Okay. Those are things that you can't avoid. So you have to deal with it. And you have to live with it. … You know, so, I mean we just - we just - we focus on our relationship and what we have to do.

Other participants had experienced so much early life trauma (often due to racism and cissexism), in response to which they continuously made shifts over time (e.g., mannerisms), resulting in a narrative where any adjustments they made were not viewed as a chosen shift, but rather a matter of fact. For example, Dale, a 57-year-old, Black, gay, cisgender man, expressed not allowing stigma to affect him or his relationship and yet also later described how early life experiences of physical violence and its implicit threat led him to develop stealth behaviors to avoid stigma and violence.

> As I got older though, I, you know, I can, I can profess to the world that I love somebody. I can. But does that mean holding your hand or giving you a kiss in public? Absolutely not. And I think that all had a lot to do, again, like the era that I grew up in. I grew up in the '60s and '70s. You know, people would be surprised, all the stuff that you might see about free love and all that - it wasn't that free. You know what I mean? It, it, it came with a price. Um, um, you know, being called fags and sissies and shit - stuff like that. You know what I mean? And then in my head, I'm being called this by White men that I can't hit because if I hit them, I know I'm going to jail. […] I'm just saying it was happening with the Blacks too, but the, the, the White ones were a little more brash with it. They were a little more in the open with it and to say what they wanted because they thought they could, but at that time they could, you know? So, um, so that just came as part of my mold. And it's not really something that I'm really worried about breaking because I feel like I can show you just how much I care about you. It doesn't matter that we're in public and I'm - it doesn't matter.

Like many of the participants we interviewed, Dale's narrative demonstrated how societal stigma and notably the implicit threat of violence results in presentational adjustments made by individuals and their partners to avoid the threat of verbal assaults and physical violence. As a Black and gay man, Dale's narrative brings into focus how his intersecting identities shape his experience of stigma and adjustments, which were rooted in both systemic racism

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and heterosexism in contrast to the experiences of White gay cisgender men who do not experience the added layer of violence and pressures of white-supremacist racism.

Discussion

This mixed-methods study provides further evidence that stigmatizing social conditions can have a detrimental impact on the relationship quality and mental health of sexual and gender minority couples (Doyle & Molix, 2015a; Gamarel et al., 2014; LeBlanc et al., 2015; Lehmiller & Agnew, 2006; Lewis et al., 2017; Neilands et al., 2020; Newcomb, 2020; Rosenthal & Starks, 2015). Our results supported and extended findings from prior quantitative studies in demonstrating that relationship stigma – the anticipation of violence, discrimination, or rejection from others due to one's intimate relationship as a sexual or gender minority couple – was associated with reduced relationship quality and mental health but not substance use (Gamarel et al., 2014; Gamarel et al., 2020). The qualitative findings provided insights into nuanced direct and indirect forms of relationship stigma that often occurred in combination with other intersecting forms of stigma and violence (Bowleg, 2008). The qualitative findings also demonstrated the differential impact that relationship stigma had on couples and the ways in which individuals and couples made adjustments to avoid, cope with, or actively combat societal stigma. Importantly, our analysis revealed the detrimental aspects of relationship stigma that were often embedded in narratives of individual-level experiences of stigma and adjustments to cope with, combat, or minimize the harmful effects of societal stigma.

Consistent with our hypotheses and expanding upon Frost and LeBlanc (in press) in this special issue, our quantitative analyses demonstrated that greater relationship stigma was associated with reduced relationship satisfaction, commitment, and increased closeness discrepancies, as well as with greater psychological distress. We also observed a partner

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effect or dyadic-cross over effect whereby greater relationship stigma scores were associated with partners' reports of lower relationship satisfaction. These findings were observed in a sample of sexual and gender minority couples. The qualitative analyses elucidated the potential ways in which this phenomenon may operate for both sexual and gender minority couples such that relationship stigma has the potential to create distrust, distance, and inhibit communication between partners. Thus, the experiences and/or anticipation of stigma due to one's relationship, especially in combination with limited supportive social networks, can result in relationship strain, which has the potential to result in isolation and lower relationship quality (Rostosky, Riggle, Gray, & Hatton, 2007). Although relationship stigma was at times described as anticipatory in nature, participants in the qualitative sub-study also described instances of enacted forms of stigma such as verbal assaults and physical violence directed at their relationship. These instances of enacted stigma were often intersectional in nature such that experiences of discrimination and violence were embedded in interlocking and cyclic, sociopolitical systems of racism, HIV stigma, and classism that are currently structurally present and operationally and historically normalized. Although challenging to quantitatively measure (Bauer & Scheim, 2019; Rosengren-Hovee, Lelutiu-Weinberger, Woodhouse, Sandanapitchai, & Hightow-Weidman, 2021), future research is needed to develop and evaluate relationship stigma or couple-level minority stress scales that assess intersectional stigma directed at relationships (Chan & Erby, 2018). These should include considerations of the specific burdens and demand that each stigma carries as well as the implications for availability and accessibility for support available to those living under the pressures and systemic violence of that stigma. It should also include consideration of the ways that each stigma limits available coping strategies due to bodily/medical, social, relational, political, and/or economic repercussions that would follow as well as the ways that

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these channels for action and potential resource are already systemically limited under the influence of that given stigma.

Our qualitative findings suggest that understanding relationship stigma experienced by sexual and gender minority couples may be incomplete without recognizing ‘individual-level’ experiences of stigma. Notably, many (if not most) participants did not make strong distinctions between stigma targeted at their relationships and those directed at themselves as a sexual and/or gender minority person. However, many of these instances of stigma directed at the individual-level were focused on that individual’s intimate relationships. That is, participants relayed stories about stigma in the form of discrimination due to their relationship affiliations even when their partner was not physically present. For example, Jed’s experience of discrimination from his medical provider due to his intimate relationship affiliation can be viewed as intertwined with the stigma he has faced as a gay man and the adjustments he has had to make to cope with stigma both individually and with his partners. Similarly, Dale’s aversion to PDA must be contextualized in the trauma that he endured throughout his life as a Black gay man; that is, the real threat of legal punishment for him as a Black man compared to White gay men if he were to protest stigma. These findings suggest that relationship stigma or couple-level minority stress may be a product of the aggregate of anticipatory and/or enacted stigma and violence directed at the relationship as well as individual experiences of stigma that are often relational in nature. Future research is warranted to explore experiences of stigma directed at intimate relationships and how these experiences overlap with or relate to relationship stigma and couple-level minority stress: how these experiences may operate similarly, differently, or in a distinct kind of relationship to one another.

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Although the quantitative results may suggest a linear association between relationship stigma and adverse outcomes, the qualitative results demonstrated that relationship stigma did not always tell this simple story. For example, we observed partners engaging in resistance strategies (Neilands et al., 2020), where partners used PDA as a form of activism, stood up for one another, provided emotional support, and reported feeling closer and more intimate with their partner after navigating a stigmatizing event together (Frost, 2013a, 2013b, 2014). It is plausible that sample size limitations precluded us from observing differences in resistance strategies by different social identities or positions; therefore, future research is warranted with more diverse samples to better understand the different resistance strategies employed by sexual and gender minority couples. This is particularly important given that participants' narratives revealed a number of ways in which their experiences with different forms of stigma throughout their life came to bear in a specific ways in creating stress and placing strain on their relationships.

Although the findings showcased the damaging and sometimes generative or positive effects of relationship stigma and other intersecting forms of stigma in participants' lives, we observed that participants in the qualitative sub-study made adjustments to cope with the possibility and/or reality of contending with the different forms of stigma and violence. Consistent with prior research (Frost, 2011), some participants made organizational adjustments and employed different types of meaning-making strategies as a form of resistance to stigma directed at their relationships. For example, several of the White participants described finding strength and self-worth by shifting their thought processes around the stigma and violence they were forced to endure due to their sexuality, which oftentimes required actively challenging dominant heterosexist narratives. Others engaged in presentational strategies, which included adopting changes to their physical appearances

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and/or mannerisms, displays of affection, and disclosure depending on the context, including geographic location. These presentational adjustments were more salient when described in connection to relationship stigma that existed at the intersections of other marginalized social identities, such as race, gender, and HIV status.

Although the current analyses only began to touch the surface on intersectionality (Bowleg, 2008; Chan & Erby, 2018), we found that participants' accounts of relationship stigma, other forms of stigma and violence (and implicit threat), and adjustments were embedded in interlocking systems of power. Notably, qualitative narratives of presentational adjustments to relationship stigma often occurred at the backdrop of violence that is embedded within racist, heterosexist, and cissexist structures and institutions, such as the real threat of incarceration and differential access to material resources (e.g., neighborhoods, health care) that individuals had endured throughout their lives. Importantly, organizational adjustments such as the ability or lack thereof to choose to disclose, the differential experience of safety surrounding options to respond to stigma, the particular range of options for adjusting to or confronting stigma, and the availability or lack thereof to frequent specific locations - including different neighborhoods in the San Francisco Bay Area - cannot be disentangled from specific affordances rooted in systems of power and privilege. Specifically, many of the Black participants in the qualitative sub-study described less choice and personal agency in these types of adjustments, including the awareness that any negative reaction to address stigma could result in harm, including incarceration.

Surprisingly few participants spoke about HIV stigma directed at their relationship. Instead, participants spoke of individual-level experiences of HIV stigma. A few participants noted that they anticipated that they would experience more HIV stigma if they were not in a relationship. Thus, it is plausible that intimate relationships may serve as buffer from the

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insidious nature of HIV stigma that exists, even in the San Francisco Bay Area, by allowing people to avoid exposure to HIV stigma by reducing their need to seek intimate partners and thus disclose a stigmatized identity. However, future research is warranted with a more diverse sample in other geographical locales to understand how HIV stigma may be experienced at the couple-level.

Limitations and Strengths

This study has a number of limitations related to our methods and our application of intersectionality as a theoretical approach. First, this study relies on self-report data, which may be subject to social desirability. Second, there may be measurement concerns with the relationship stigma scale used in the quantitative study. The relationship stigma scale demonstrated adequate reliability (α = 0.68); however, the relationship stigma scale was designed with transgender women and their cisgender male partners (Gamarel et al., 2014). Therefore, future research is warranted to evaluate the psychometric properties of relationship stigma and couple-level minority stress scales with diverse samples of sexual and gender minority couples. Third, participants were recruited primarily from the San Francisco Bay Area with a history of social and legal protections against LGBTQ+ discrimination. As such, these findings may not be generalizable to sexual and gender minority couples in other geographic regions and settings and reports of stigma and violence may be more robust among individuals who do not live in this geographical locale. Fourth, several participants in the qualitative sub-study relayed prior experiences with substance use and linked those periods of heavy use to early experiences of stigma and trauma. The interview guide did not specifically inquire about substance use to be able to generate an understanding of the null quantitative findings. Fifth, an individual interview approach was explicitly chosen to due to the sensitive nature of the topic; however, focus groups may have allowed participants to

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share their experiences and generate more insight, common understandings, and shared language around relationship stigma. There was only one interviewer so that they could probe areas for further exploration due to their familiarity across the interviews; however, this may have also resulted in presentation bias such that participants may have described experiences in a particular way due to the named and inferred social identities of the interviewer. While the parent project did not focus on stigma, the intervention arm did include content on relationship dynamics and communications. Follow-up assessments are still ongoing, which precludes us from exploring whether the intervention had any impact on the responses of the participants in the qualitative sub-study. Additionally, causal inferences are limited in the current study design such that it is plausible that indicators relationship quality and psychological distress may result in greater reports of relationship stigma. Thus, future research such as Frost and LeBlanc (in press) in this special issue that utilize longitudinal designs is warranted.

Our application of intersectionality is also limited in several ways. Although efforts were made to recruit a diverse sample, participants predominantly identified as White, gay, cisgender men, which limited the breadth and scope of our analyses. For instance, due to small numbers of cisgender and gender minority participants of color, quantitative analyses were unable to incorporate distinguishing characteristics based on intersectional dyadic characteristics such as couple configurations of race/ethnicity, sexual identity, and gender identity; future studies should be designed with this goal in mind. Intersectionality has also been critiqued as being essentializing, which occurs when one form of difference of one individual or group is collapsed as being representative of an entire group (Dhamoon & Hankivsky, 2011). Thus, future research is needed with more diverse samples to attend to the

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ways in which race, sexuality, gender, and other identities and conditions intersect with one another and impact indicators of relationship quality and psychological wellbeing.

A major strength of this study was the mixed-methods design to better understand how relationship stigma impacts the lives of sexual and gender minority couples. Specifically, our mixed-methods approach helped us triangulate findings to enhance credibility (Creswell & Miller, 2000). Additionally, the positionality of our interdisciplinary team was taken into account in the decision to have four qualitative analysts who brought diversity in their life experiences (e.g., sexual identity, race/ethnicity, gender identity, age) during the interpretation process.

Conclusions

These findings point to the continued importance of understanding the ways in which stigma manifests itself in the intimate and committed relationships of persons from LGBTQ+ communities. Our quantitative and qualitative findings demonstrated that relationship stigma may confer adverse relationship and mental health outcomes for sexual and gender minority couples. LGBTQ+ communities must continuously contend with stigma at the societal level as many states do not include protections in nondiscrimination statues in the United States (Movement Advancement Project, 2019). The qualitative findings highlighted how verbal assaults and physical violence, as well as implied threats, are also important aspects of people's experiences of relationship stigma and may be more pronounced in geographical locations with fewer legal protections. The qualitative findings also suggest that a narrow lens that exclusively focuses on one form of stigma may obscure empirical claims about experiences of stigma in relationship contexts (Bowleg, 2008; Chan & Erby, 2018). For example, understanding "relationship stigma" and individual-level stigma around one's intimate relationship affiliations may produce important findings such that the combination

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may prove more important than the sum of its parts. That is, the qualitative findings support that wider views (additionally guided by an intersectionality lens) can shed light on the nuanced forms of stigma and range of available adjustments given a person's social identities at axes of systems of social, economic, and political power.

Thus, our findings support the need for multilevel interventions. Our qualitative findings demonstrated the nuanced ways that the workings of relationship stigma are more complicated than has been described by the literature up to this point; specifically, greater complexity is revealed when viewing cases through an intersectionality lens and how various systems of oppression interweave and place differential burdens on sexual and gender minority couples of various sociopolitical identities and positionalities (Chan & Erby, 2018). That is, our findings suggest that a narrow focus on one form of stigma may obscure and render invisible other interlocking forms of stigma that impact couples' wellbeing. For example, couple-level interventions can assist partners in recognizing different forms of stigma in order to help foster a positive sense of self-worth and encourage optimal dyadic coping strategies. However, such intervention efforts must recognize that the same underlying forces that contribute to relationship stigma or couple-level minority stress may also impact and/or be informed by individual-level stigma around one's intimate relationship affiliations that can occur in health care and employment settings. Simultaneously, there is an urgent need for organizational- and policy-level interventions such as structural competency trainings in healthcare, employment, education, and legal systems (Bailey et al., 2017), as well as community-led structural demands such as poverty elimination and ending mass incarceration (Spade, 2015) to dismantle interlocking systems of oppression that perpetuate stigma and violence. Indeed, recent evidence has highlighted the determinantal impact of structural racism and anti-LGBTQ+ policies on the health of Black sexual minority men

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(English et al., 2021) and underscores the importance of policies that invest in reparations to promote access to quality education, repealing stop-and-frisk policing, and decriminalization of drug laws that only fuel mass incarceration and resultant inequities experienced by LGBTQ+ people of color (Spade, 2015).

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Author Biographies

Kristi E. Gamarel is a social psychologist with mental health counseling training. She has over 15 years of experience working with sexual and gender minority communities.

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willi Farrales has a Masters of Arts in counseling psychology and 5 years of experience counseling individuals and couples.

Luz Fernanda Venegas' concentration in public health addresses health inequities and intersectional barriers marginalized communities face in taking an active role in their health care.

Samantha E. Dilworth holds a Masters of Science in statistics and serves as a data manager and statistician on multiple studies at UCSF.

Lara S. Coffin has a Masters in Public Health and has worked as Project Director at UCSF on multiple NIH-funded HIV community intervention studies.

Torsten B. Neilands is a Professor and Director of the Methods Core at UCSF. He holds a Ph.D. in Psychology (Quantitative Methods and Psychometrics and Social Psychology).

Mallory O. Johnson is a Professor of Medicine, Co-Director of the Center for AIDS Prevention Studies (CAPS), and Co-Director of the Center for AIDS Research (CFAR) at UCSF. He is the PI of the DuoPACT study.

Kimberly A. Koester has extensive experience as a qualitative health researcher. Currently, her work is focused on PrEP implementation and HIV health services research.

Table 1.
Characteristics of Study Sample

	Qualitative Sample N = 25	Quantitative Only Sample N = 263	Full Sample (Qual + Quant) N = 288
Individual-level characteristics	N (%)	N (%)	N (%)
Gender			
Cisgender man	20 (83.3)	246 (93.5)	266 (92.4)
Cisgender woman	1 (4.0)	1 (0.4)	2 (0.7)
Transgender woman	0	1 (0.4)	1 (0.4)

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Transgender/queer/other gender identity (AMAB)	4 (16.7)	13 (4.9)	17 (5.9)
Transgender/queer/other gender identity (AFAB)	0	2 (0.8)	2 (0.7)
Race/ethnicity			
Non-Latinx Black	7 (28.0)	44 (16.7)	51 (17.7)
Non-Latinx white	11 (44.0)	114 (43.4)	125 (43.4)
Latinx	2 (8.0)	67 (25.5)	69 (24.0)
Non-Latinx other	5 (20.0)	38 (14.5)	43 (14.9)
Sexual orientation			
Heterosexual	3 (12.5)	9 (3.5)	12 (4.2)
Gay	18 (75.0)	214 (82.0)	232 (81.4)
Bisexual	2 (8.3)	21 (8.1)	23 (8.1)
Queer	0	16 (6.1)	16 (5.6)
Other	1 (4.2)	1 (4.2)	2 (0.7)
Education			
Less than high school	4 (16.7)	16 (6.1)	20 (7.0)
High school graduate	7 (29.2)	78 (29.7)	85 (29.6)
Some college/trade school	6 (25.0)	89 (33.8)	95 (33.1)
College graduate	4 (16.7)	53 (20.2)	57 (19.9)
Post graduate degree	3 (12.5)	27 (10.3)	30 (10.5)
Income			
Less than $10,000	8 (32.0)	74 (28.1)	82 (28.5)
$10,000-19,999	6 (24.0)	63 (24.0)	69 (24.0)
$20,000-29,999	5 (20.0)	42 (16.0)	47 (16.3)
$30,000-39,999	3 (12.0)	18 (6.8)	21 (7.3)
$40,000-49,999	0	9 (3.4)	9 (3.1)
$50,000-59,999	0	10 (3.8)	10 (3.5)
$60,000-69,999	0	10 (3.8)	10 (3.5)
$70,000-79,999	0	7 (2.7)	7 (2.4)

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$80,000-89,999	1 (4.0)	4 (1.5)	5 (1.7)
$90,000-99,999	0	8 (3.0)	8 (2.8)
$100,000 or more	2 (8.0)	18 (6.8)	20 (6.9)
Financial situation			
I have enough to live comfortably	7 (28.0)	94 (35.7)	101 (35.1)
I can barely get by on the money I have	13 (52.0)	128 (48.7)	141 (49.0)
I cannot get by on the money I have	5 (20.0)	41 (15.6)	46 (16.0)
Broken up at time of interview	4 (16.7)	n/a	n/a
HIV status			
Positive	21 (87.5)	231 (80.2)	231 (80.2)
Negative	3 (12.5)	57 (19.8)	57 (19.8)
	Mean (SD)	Mean (SD)	Mean (SD)
Age (years)	47.6 (12.8)	46.0 (11.9)	46.1 (12.0)
Relationship length (years)	5.3 (5.9)	8.6 (8.6)	8.28 (8.42)
Number of children	0.6 (1.5)	0.2 (0.7)	0.2 (0.8)
Couple-level characteristics			
Living with partner	19 (76.0)	195 (74.1)	214 (74.3)
Married or in domestic partnership	6 (24.0)	78 (29.7)	84 (29.2)
Couple HIV status			
Sero-concordant positive	16 (64.0)	158 (60.1)	174 (60.4)
Sero-different	9 (36.0)	105 (39.9)	114 (39.6)
Gender			
Cisgender male couple	17 (68.0)	233 (88.6)	250 (86.8)
Cisgender female couple	1 (4.0)	1 (0.4)	2 (0.7)
One partner is a is gender minority	7 (28.0)	25 (9.5)	32 (11.1)
Both partners are gender minorities	0 (0)	4 (1.5)	4 (1.2)
Sexual orientation			
Both partners are straight/heterosexual	2 (8.0)	6 (2.3)	8 (2.8)

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One partner is a sexual minority	1 (4.0)	7 (2.7)	8 (2.8)
Both partners are sexual minorities	22 (88.0)	250 (95.1)	272 (94.4)
Race/ethnicity			
Neither partner is a racial/ethnic minority	6 (24.0)	66 (25.1)	72 (25.0)
Only one partner is racial/ethnic minority	11 (44.0)	95 (36.1)	106 (36.8)
Both partners are racial/ethnic minorities	8 (32.0)	102 (38.8)	110 (38.2)

Note: In the full sample, there were 3 missing sexual orientation, 1 missing education, and 1 missing any children. In the qualitative sample, there was 1 missing sexual orientation, 1 missing education, and 1 missing children data. AMAB=assigned male on one's original birth certificate; AFAB=assigned female on one's original birth certificate.

Table 2. *Associations between relationship stigma and relationship quality, psychological distress, and substance use*

	Relationship Satisfaction		Commitment		Closeness Discrepancy		Psychological Distress		Alcohol Use		Non-marijuana Illicit Drug Use	
	B	95% CI	B	95% CI	B	95% CI	B	95% CI	OR	95% CI	OR	95% CI
Relationship Stigma *(Actor Effect)*	**-2.99**	**(-3.73, -2.26)**	**-3.67**	**(-4.88, -2.47)**	**0.36**	**(0.11, 0.60)**	**2.42**	**(1.23, 3.60)**	1.24	(0.87, 1.78)	1.23	(0.80, 1.9)
Relationship Stigma *(Partner Effect)*	**-0.89**	**(-1.56, -0.21)**	-0.81	(-1.92, 0.31)	0.23	(-0.05, 0.50)	0.17	(-0.94, 1.28)	0.95	(0.68, 1.33)	0.96	(0.64, 1.44)
Covariates												
Relationship length	-0.01	(-0.07, 0.05)	0.10	(0.03, 0.17)	**-0.02**	**(-0.03, -0.004)**	0.02	(-0.08, 0.11)	1.00	(0.98, 1.03)	0.99	(0.96, 1.02)
Race /Ethnici												

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ty												
Black	*Ref*	--	*Ref*	--	*Ref*	--	*Ref*	--	*Ref*	--	*Ref*	--
White	0.43	(-1.10, 1.96)	1.39	(-0.60, 3.39)	-0.32	(-0.88, 0.23)	**2.52**	**(0.26, 4.77)**	0.49	(0.24, 1.02)	**3.22**	**(1.57, 6.58)**
Latinx	-0.09	(-1.78, 1.60)	-0.08	(-2.32, 2.16)	-0.26	(-0.90, 0.39)	0.88	(-1.32, 3.09)	**0.44**	**(0.20, 0.95)**	**2.32**	**(1.05, 5.13)**
Other	-0.63	(-2.61, 1.35)	0.53	(-2.16, 3.23)	-0.37	(-1.04, 0.30)	1.71	(-0.92, 4.33)	**0.26**	**(0.11, 0.61)**	1.60	(0.67, 3.82)
Cisgender Male Gender	-0.02	(-0.73, 0.69)	0.59	(-0.46, 1.63)	0.12	(-0.21, 0.45)	**1.43**	**(0.09, 2.78)**	1.03	(0.58, 1.84)	1.44	(0.78, 2.64)
Gay Sexual Identity	0.02	(-0.54, 0.58)	-0.46	(-1.35, 0.44)	-0.03	(-0.26, 0.19)	-0.34	(-1.35, 0.67)	1.33	(0.90, 1.96)	1.19	(0.82, 1.75)
Education												
Less than high school	*Ref*	--	*Ref*	--	*Ref*	--	*Ref*	--	*Ref*	--	*Ref*	--
High school graduate	1.79	(-0.33, 3.92)	1.77	(-1.46, 4.99)	-0.62	(-1.49, 0.25)	-0.65	(-3.55, 2.25)	0.83	(0.26, 2.61)	0.64	(0.22, 1.83)
Some college	0.45	(-1.62, 2.52)	1.46	(-1.83, 4.75)	-0.45	(-1.30, 0.41)	-0.09	(-2.81, 2.62)	0.86	(0.29, 2.48)	0.56	(0.19, 1.64)
College graduate	0.67	(-1.53, 2.87)	0.85	(-2.75, 4.45)	-0.82	(-1.73, 0.08)	0.30	(-3.03, 3.63)	1.12	(0.35, 3.59)	0.61	(0.19, 1.98)

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Post doctorate	1.51	(-0.78, 3.80)	2.15	(-1.32, 5.61)	-0.65	(-1.54, 0.23)	-0.69	(-3.95, 2.57)	2.38	(0.69, 8.21)	0.59	(0.17, 2.06)
Age												
1st quad. (< 36.1 yrs)	*Ref*	--	*Ref*	--	*Ref*	--	*Ref*	--	*Ref*	--	*Ref*	--
2nd quad. (< 46.7 yrs)	-0.19	(-1.55, 1.17)	0.02	(-2.03, 2.06)	-0.23	(-0.65, 0.19)	-0.98	(-3.11, 1.14)	0.73	(0.34, 1.54)	1.30	(0.60, 2.82)
3rd quad. (< 54.6 yrs)	0.14	(-1.40, 1.67)	0.52	(-1.51, 2.55)	-0.30	(-0.78, 0.19)	**-3.15**	**(-5.46, -0.83)**	0.57	(0.24, 1.35)	0.76	(0.31, 1.84)
4th quad. (≥ 54.6 yrs)	0.36	(-1.26, 1.97)	-0.43	(-2.67, 1.81)	-0.41	(-0.92, 0.10)	-2.24	(-4.59, 0.12)	**0.37**	**(0.15, 0.90)**	0.44	(0.18, 1.05)
Income	-0.01	(-0.18, 0.16)	0.07	(-0.18, 0.31)	-0.01	(-0.05, 0.04)	**-0.42**	**(-0.66, -0.19)**	**1.14**	**(1.04, 1.26)**	0.94	(0.85, 1.03)
HIV positive status	**-1.12**	**(-1.99, -0.24)**	**-1.68**	**(-3.10, -0.26)**	**0.32**	**(0.01, 0.63)**	1.64	(-0.35, 3.63)	1.29	(0.72, 2.31)	**1.89**	**(1.03, 3.47)**

Note: N = 283 for AUDIT; N = 284 for Relationship Satisfaction, Commitment, Closeness Discrepancy, Psychological Distress, and any Non-Marijuana Illicit Drug Use. The analysis represents data from 288 rows for 144 couples (one row for each couple member). All models were estimated via generalized estimating equations (GEE) with an exchangeable correlation structure to account for correlations of responses for individuals within dyads. Odds ratios (OR) are reported for the ordinal (AUDIT) and binary logistic (any drug use) regression models and unstandardized betas (B) are reported for the linear regression models (relationship satisfaction, commitment, closeness discrepancy, and psychological distress). Bolded text indicates effects that are statistically significant at $p < 0.05$.

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Table 3.

Qualitative Sample Characteristics

Participant Pseudonym	Romantic Partner Pseudonym	Gender	Sexual Orientation	Race/Ethnicity	Age
Bri	Benji	Transgender woman	Straight	Black, non-Hispanic	54
Benji	Bri	Cisgender man	Straight	Black, non-Hispanic	69
Ken	Ron	Cisgender man	Gay	White, non-Hispanic	57
Ron	Ken	Cisgender man	Gay	Multi-racial, non-Hispanic	39
Riley	Ray	Gender nonbinary	Gay	White, non-Hispanic	51
Ray	Riley	Cisgender man	Gay	Multi-racial, non-Hispanic	57
Jed	Anton	Cisgender man	Gay	White, non-Hispanic	29
Brian	N/A	Cisgender man	Gay	Black, non-Hispanic	54
Jamie	John	Cisgender man	Gay	White, non-Hispanic	47
John	Jamie	Cisgender man	Gay	White, non-Hispanic	50
Nero	N/A	Cisgender man	Gay	White, Hispanic	40
Anton	Jed	Cisgender man	Gay	Asian, non-Hispanic	36
Lon	N/A	Cisgender man	Gay	White, non-Hispanic	20

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Peter	N/A	Cisgender man	Gay	White, non-Hispanic	25
Rae	Dale	Cisgender man	Gay	Black, Hispanic	47
Dale	Rae	Cisgender man	Gay	Black, non-Hispanic	57

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