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Providing Relationship Interventions to Same-Sex Couples: Clinical Considerations, Program Adaptations, and Continuing Education

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Despite remarkable similarities to different-sex couples in terms of core relationship processes and outcomes, same-sex couples differ from different-sex couples in important ways, including relational strengths (e.g., more egalitarian) and challenges associated with their sexual minority identity (e.g., discrimination). Given that most cognitive-behavioral relationship interventions have been designed for and tested on different-sex couples, clinicians wishing to serve same-sex couples will need to make appropriate adaptations to these interventions in order to remove heterosexist bias and sensitively meet the unique needs of same-sex couples. Further, clinicians should strive to be culturally competent in serving this population by developing knowledge of same-sex couple dynamics and issues, and by building a sense of comfort working with these families, which may involve addressing personal biases. The current paper seeks to provide an introduction to same-sex couple relational processes, and offers clinical recommendations and intervention adaptations to better serve this population. Some examples will refer to the development of the Strengthening Same-Sex Relationships programs, culturally sensitive relationship education programs specifically designed for and successfully piloted with male and female same-sex couples.

Same-sex couples have enjoyed rapid societal advances over the past few decades, including a doubling in the number of Americans who support marriage equality in the past 25 years (McCarthy, 2015), the repeal of Don't Ask Don't Tell in 2010, and greater protections by federal and state laws (e.g., antidiscrimination employment laws towards sexual minorities in many states). Most notably, a mere 11 years after Massachusetts became the first state to legalize same-sex marriage in 2004, the Supreme Court guaranteed same-sex couples the nationwide right to marry in June 2015. Since then, the number of married same-sex couples in the United States has grown exponentially to over 547,000 in June 2017 (Romero, 2017).

However, these advances have been met with backlash (Signorile, 2015). In 2017, approximately 129 state and local anti-LGBT laws were proposed (Warbelow & Diaz, 2017). Violence towards LGBT individuals and communities has increased, including the LGBT Pulse Nightclub attack in 2016. It is therefore clear that, despite the many recent social and legal advances, heterosexism—defined as societal ideologies that conceptualize "human experience in strictly heterosexual terms, consequently ignoring, invalidating, or derogating lesbian, gay, and bisexual orientations, behaviors, relationships, and lifestyles" (Herek, Kimmel, Amaro, & Melton, 1991, p. 258)—continues to permeate all levels of society. As a result, individuals in same-sex relationships are subject to specific forms of psychological stress associated with their marginalized social status, hereafter referred to as *sexual minority stress* (Meyer, 2003).

Together, these conflicting social forces have important implications for relationship service providers (i.e., couple therapists, relationship education facilitators). For one, as more same-sex couples pursue marriage, an increasing number of these couples are likely to seek premarital relationship education or couple therapy to treat marital distress. Increased societal acceptance at large may also translate into all same-sex couples (including those who do not pursue marriage) feeling greater comfort disclosing sexual minority identity to providers, thereby reducing barriers to relationship interventions.

At the same time, there are several challenges to providing relationship services that are culturally appropriate, acceptable, and beneficial for same-sex couples. First, most relationship interventions were developed for monogamously partnered, different-sex couples and consequently use heteronormative language and images

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in their advertising and clinical materials. Sexual minorities report that this can send a message that services are exclusively intended for different-sex couples (Scott & Rhoades, 2014). Second, many interventions include heterosexist assumptions about couple processes, such as the presence of gender-role driven behavior and gender-based relationship inequality (Whitton & Buzzella, 2012). This is often perceived by sexual minorities as alienating and discourages engagement in treatment (Scott & Rhoades, 2014; Shelton & Delgado-Romero, 2011). Third, most interventions do not address unique challenges faced by same-sex couples, such as coping with discrimination, the absence of community-wide role models and social norms to guide relationship behaviors, and lower social support (Whitton & Buzzella, 2012). Finally, the majority of practicing clinicians report feeling unprepared to work with sexual minorities (American Psychological Association, 2012), with little to no clinical training with same-sex couples (Whitton & Buzzella, 2012). Unsurprisingly, sexual minority adults report that few clinicians are knowledgeable about same-sex couples and consequently make heterosexist assumptions about couple dynamics when providing relationship interventions to same-sex couples (Scott & Rhoades, 2014; Shelton & Delgado-Romero, 2011).

In this paper, we reference the American Psychological Association's (APA) guidelines for psychological practice with LGB individuals and families (APA, 2012) to guide our discussion of culturally sensitive relationship interventions for same-sex couples. These guidelines dictate that we consider the ways in which existing relationship interventions, originally developed for different-sex couples, need to be adapted in order to: (a) avoid unintended harm to sexual minorities due to differences in values, beliefs, or practices, and (b) ensure that program content is relevant and responsive to the needs of same-sex couples. Our recommendations will be tailored towards relationship interventions based in cognitive-behavioral principles—such as the Prevention and Relationship Enhancement Program (Markman, Stanley, & Blumberg, 2010), Integrative Behavioral Couple Therapy (Christensen, Atkins, Baucom, & Yi, 2010), and Cognitive Behavioral Couple Therapy (Epstein & Baucom, 2002)—as these interventions have been shown to have positive effects on couple satisfaction and relationship stability (Fischer, Baucom, & Cohen, 2016; Markman & Rhoades, 2012). Cognitive-behavioral relationship interventions generally focus on helping couples disrupt destructive relationship patterns through increased awareness of their negative interactions (e.g., thoughts, behaviors, and patterns), and by teaching acceptance- and change-based strategies to reduce conflict and increase positive interactions (e.g., distress tolerance, structured communication skills, prioritizing friendship, fun, and intimacy). Our recommendations will draw upon our experiences developing the Strengthening Same-Sex Relationships (SSSR) programs, culturally sensitive relationship education programs specifically designed for male (Buzzella, Whitton, & Tompson, 2012; Whitton et al., 2016) and female same-sex couples (Whitton, Scott, Dyar, et al., 2017; Whitton, Scott, & Weitbrecht, 2017).

Increasing the cultural sensitivity, quality, and accessibility of evidence-based relationship interventions for same-sex couples will require change at the micro-, mezzo-, and macro-levels of care. In this paper, we will primarily focus on micro-level changes, making recommendations for how clinicians can work toward competence in providing culturally sensitive relationship interventions to same-sex couples. Specifically, we propose that (a) providers must be knowledgeable about same-sex relationships, including the effects of stigma, and differences in relationship dynamics and issues compared to different-sex couples, (b) the interventions themselves must be free of heterosexist bias and adapted to meet the unique needs of same-sex couples, and (c) clinicians must be accepting of same-sex relationships, which may include addressing personal biases and engaging in continuing education. However, we will also provide some suggestions for mezzo-level changes aimed at reducing disparities in the environment of care and ideas for how clinicians and mental health organizations might advocate for macro-level change through legislative and institutional policies.

We start by providing a general overview of cultural competency in clinical work with sexual minorities and their families. Next, to enhance provider knowledge of same-sex relationships, we review the literature on same-sex couple processes, highlighting similarities and differences with different-sex couples and describing unique minority-based stressors. We then propose specific recommendations for adapting existing interventions and providing relationship services in culturally sensitive ways, followed by specific strategies practitioners can use to reduce their own explicit and implicit bias against sexual minorities and same-sex couples.

Clinician Cultural Competency With Sexual Minority Individuals and Families

Culturally competent care requires sensitively attending to the cultural experience of one's client (Bedoya & Safren, 2009; Lo & Fung, 2016; Sue, 1998). While most often discussed in relation to clients' ethnic or racial backgrounds, culturally competent psychotherapy with sexual minorities—often referred to as "gay affirmative" therapy—similarly involves attending to the unique cultural experiences, values, and beliefs of sexual minorities (Johnson, 2012). Although recommended skill sets vary slightly by source (Hook, Davis, Owen, Worthington, & Utsey, 2013), culturally competent care generally

requires attainment of knowledge about the common experiences of members of the cultural group in question, awareness of one's own belief systems as they may impact the delivery of psychological services to this group, and the ability to deliver appropriate therapeutic interventions.

LGB clients frequently report negative experiences with therapists who lack knowledge about sexual minority experiences, perpetuate heteronormativity, and commit microaggressions, defined as "communications of prejudice and discrimination expressed through seemingly meaningless and unharmful tactics" (APA, 2012; Shelton & Delgado-Romero, 2011, p. 210; Sue, 1998). For instance, LGB individuals have reported that clinicians can negatively impact therapy experiences by presuming that sexual orientation is the core cause of a client's psychological difficulties (Shelton & Delgado-Romero, 2011). Conversely, clinicians may minimize or ignore a client's sexual orientation or perpetuate heteronormativity through their language and therapy environment. For example, practitioners may only include pictures of different-sex couples on advertisements, use heteronormative language on therapy materials (e.g., having *man/husband* and *woman/wife* on intake forms), and lack LGB-specific signs of safety in their therapy offices (Scott & Rhoades, 2014; Shelton & Delgado-Romero, 2011).

Additionally, APA guidelines encourage clinicians to "strive to understand the effects of stigma (i.e., prejudice, discrimination, and violence) and its various contextual manifestations" (APA, 2012, p. 12). This includes understanding the impact of systemic and institutional forms of oppression on LGB romantic relationships (APA, 2012). For example, same-sex couples continue to face laws and policies that may directly affect their relationships, including inconsistent antidiscrimination employment and housing laws, health insurance policies, and parenting protections across the country (Warbelow & Diaz, 2017). Further, sexual minorities experience chronic stigma and discrimination towards their relationships, whether through slights, microaggressions, or the possibility of rejection and violence in their daily lives. As a result, partners face decisions and consequences related to relationship disclosure ("outness"), discrimination based on their sexual identity, and internalized heterosexism, all of which can have direct, adverse effects on their relationship quality (Frost & Meyer, 2009; Jordan & Deluty, 2000; Knoble & Linville, 2012; Meyer & Dean, 1998).

Other challenges are related to gaining acceptance and support from families-of-origin and religious organizations. Importantly, these challenges must be contextualized based on the intersection of multiple identity markers, including race, gender identity, age, socioeconomic status, and ability. Given the importance of providers developing knowledge of these common experiences, values, and challenges of same-sex couples, we now review the literature on same-sex relationship processes and unique issues.

An Overview of Same-Sex Couple Processes

In this section, we will largely focus on studies that compare same-sex couple processes to those observed in different-sex couples. We believe this can be quite helpful, as most practicing couple therapists are familiar with different-sex relationship dynamics and would benefit from learning how their clinical experience providing cognitive-behavioral relationship interventions may generalize to working with same-sex couples. Nevertheless, we note that comparison studies may include inherent heterosexist bias by presuming that different-sex relationships are the normative standard (Cabaj, 1988; Goodrich, Rampage, Ellman, & Halstead, 1988), and their findings are prone to be misused or misrepresented if differences are attributed to internal deficits among same-sex couples, rather than to experiences associated with their oppressed identity (e.g., discrimination; APA, 2012). Throughout this review, we encourage readers to be mindful of these possibilities as we seek to describe the research findings in a manner that will best enhance clinical knowledge.

Relationship Processes and Quality

Core relationship processes predictive of satisfaction and stability (i.e., relationship longevity) are remarkably similar between same- and different-sex couples (Gottman et al., 2003; Julien, Chartrand, Simard, Bouthillier, & Bégin, 2003; Khaddouma, Norona, & Whitton, 2015; Kurdek, 2004, 2005). Couples with more effective communication and conflict management, more perceived social support, and higher commitment generally report greater stability and relationship quality. Moreover, the magnitude of these associations is similar, suggesting that underlying mechanisms of couple dynamics are generally universal (Kurdek, 2004, 2005).

Relationship outcomes—such as relationship satisfaction, love, intimacy, sexual satisfaction, and commitment—are also comparable across same- and different-sex couples (Balsam, Beauchaine, Rothblum, & Solomon, 2008; Blair & Pukall, 2014; Kurdek, 2004, 2005). Additionally, relationship quality evidences a similar trajectory for both groups, starting high and declining with time (Kurdek, 1998). Evidence is more mixed regarding relationship stability. Some research suggests that cohabiting same-sex couples break up at higher rates than cohabiting and married different-sex couples e.g. (Lau, 2012). However, a nationally representative sample of U.S. couples found that, after controlling for marriage and commitment ceremonies, the dissolution rates of same- and different-sex couples are comparable (Rosenfeld, 2014). This suggests that greater instability of same-sex couples observed in earlier U.S.

samples may have been due to differences in access to marriage. Indeed, more recent reports in the U.S. suggest that married same-sex couples and those with civil unions may have *lower* dissolution rates compared to married different-sex couples. Across legally recognized marriages as of 2014, 1.1% of same-sex relationships dissolved their marriages compared to 2.0% of different-sex couples (U.S. Census Bureau, 2014). More research is needed to determine whether same-sex couples, including both those who marry and those who do not, are at elevated risk for relationship dissolution. It is nevertheless clear that many same-sex couples develop and maintain life-long relationships (Reczek, Elliott, & Umberson, 2009).

Communication

Relationship interventions most frequently address communication processes, particularly conflict management. Across couple-types, the frequency of arguing and topics of disagreement are comparable—specifically, all couples argue about finances, children, affection, and household tasks at similar rates (Kurdek, 2005)—with the exception that male same-sex couples argue about sex outside of their relationship more often (Solomon, Rothblum, & Balsam, 2005). Communication quality is also equally predictive of relationship quality across couple type (Julien et al., 2003). Some evidence suggests that same-sex couples argue more effectively, in which partners more equally share speaking turns, have more positive tones, propose more solutions and compromises, and engage in less demand-withdraw patterns, representing a particular strength among same-sex relationships (Gottman et al., 2003; Kurdek, 2004). These more effective communication skills have been theorized to result from the lack of societally prescribed gender roles for same-sex couples, allowing them to avoid certain dysfunctional communication patterns, such as men withdrawing and women demanding in the classic demand-withdraw pattern. At the same time, men are more likely to engage in withdrawing behaviors and women are more likely to pursue regardless of the gender of their partner (Baucom, McFarland, & Christensen, 2010), suggesting that clinicians should still assess for the presence of these behaviors and patterns among same-sex couples.

Relationship Roles

Same-sex couples establish relationship roles outside societally based gender roles that often influence the division of labor and financial responsibilities in different-sex couples. For example, despite increases in women entering the workforce in the past half century, men still tend to provide more financially and women perform the majority of household tasks and childrearing responsibilities in different-sex relationships (Greenstein, 2009; Gotta et al., 2011; Solomon et al., 2005). By contrast, same-sex couples tend to divide household tasks, financial responsibilities, and childrearing more equally (Gotta et al., 2011; Solomon et al., 2005; Spitalnick & McNair, 2005) and base these roles on partner preferences, skills, and availability. This may provide a particular advantage to same-sex couples by allowing them to determine relationship roles that best meet their unique needs. At the same time, the negotiation of roles and responsibilities may require additional communication and conflict management.

Sexuality

Across couple types, sexual satisfaction is consistently correlated with relationship satisfaction (Butzer & Campbell, 2008; Byers, 2005; Peplau, Fingerhut, & Beals, 2004; Scott, Ritchie, Knopp, Rhoades, & Markman, 2017). Despite some important differences in sexual practices, levels of sexual satisfaction are similar across same- and different-sex couples (Blair & Pukall, 2014). Female same-sex couples tend to report having sex less frequently than male same-sex or different-sex couples and tend to report a desire to increase this frequency (Peplau et al., 2004; Scott et al., 2017; Solomon et al., 2005). However, female same-sex couples indicate that the duration of their sexual encounters are typically longer than is reported by other groups (Blair & Pukall, 2014) and there is evidence to suggest the quality of their sexual encounters, such as rates of orgasm, may be higher compared to women in different-sex relationships (Bancroft, Loftus, & Long, 2003; Puts, Welling, Burriss, & Dawood, 2012; Scott et al., 2017). Women in same-sex relationships also tend to have broader conceptualizations of sex, in which manual stimulation, sex toys, and oral sex are more likely to be considered having sex in these relationships (Scott et al., 2017; Sewell, McGarrity, & Strassberg, 2016). Thus, although women in same-sex relationships may have sex less frequently, on average,compared to other groups, their levels of sexual satisfaction remain comparable. Male couples, by contrast, engage in sex at comparable rates to different-sex couples (Blair & Pukall, 2014), while having more narrowly defined conceptualizations of sex compared to other groups (e.g., penile-anal penetration; Sewell et al., 2016). Further, as aforementioned, men in same-sex relationships have demonstrated a tendency to argue about sex outside the relationship more frequently than other groups (Gotta et al., 2011), which may be related to their higher likelihood to engage in nonmonogamy agreements.

Monogamy

One area in which male same-sex couples differ from other couple types regards their expectations and agreements about sexual exclusivity. Within different-sex and female same-sex couples, sexual monogamy is nearly universally expected and considered crucial to a healthy relationship (e.g., Conley, Ziegler, Moors, Matsick, &

Valentine, 2013; Gotta et al., 2011). Any sexual behavior with someone outside the relationship is typically viewed as a relationship violation and is predictive of relationship distress and dissolution (e.g., Allen et al., 2005). By contrast, extradyadic sexual activity is common in male same-sex partnerships (Heaphy, Donovan, & Weeks, 2004; LaSala, 2004). Around 50% to 60% of gay men in same-sex relationships report engaging in extradyadic sex, compared to only 8% of lesbians, 14% of heterosexual women, and 10% of heterosexual men (Gotta et al., 2011). Many male same-sex couples have negotiated agreements that allow for specific forms of extradyadic sexual encounters. Rates of monogamous sexual agreements in male same-sex relationships have increased over the past few decades to around 45%, but remain significantly lower than those of female same-sex (85%) and different-sex couples (81%; Gotta et al., 2011).

Nonmonogamy sexual agreements allow for extradyadic sex, but typically include rules and boundaries to prevent jealousy and to preserve the primacy, intimacy, and stability of the relationship (e.g., Heaphy et al., 2004; Ramirez & Brown, 2010). Often, these agreements aim to prevent emotional connections with outside sexual partners (Adam, 2006; Bonello & Cross, 2010; LaSala, 2004), for instance, by allowing sex only with strangers, only once with the same person, only outside of the couple's home, only in "threesomes" that involve both members of the couple, or only in the absence of emotional involvement (e.g., Hosking, 2013; Parsons, Starks, DuBois, Grov, & Golub, 2013). A growing body of research suggests that male same-sex couples with nonmonogamy agreements are comparable to monogamous couples in terms of relationship quality and personal well-being (e.g., Bricker & Horne, 2007; Hoff, Beougher, Chakravarty, & Darbes, 2010; Whitton, Weitbrecht, & Kuryluk, 2015). At the same time, there may be some relational and personal risks associated with these arrangements. Nonmonogamy agreements have been associated with greater perceived quality of alternative partners and lower relationship commitment (Hoff et al., 2010; Whitton et al., 2015). Further, extradyadic sexual practices, particularly unprotected anal penetration with casual partners, is associated with an increased risk for sexually transmitted infections (Parsons et al., 2013).

Family Planning and Parenting

Same-sex couples are likely to desire or currently be raising children, such that 27% of female couples and 11% of male couples report currently having children in their households (Goldberg, Gartrell, & Gates, 2014). Further, approximately 86% of young gay men and 91% of young lesbian women claim that it is likely that they will raise children (D'Augelli, Rendina, Grossman, & Sinclair, 2006). It is well established that same-sex couples are as capable of successful parenting as are different-sex couples. Multiple studies have demonstrated that children show comparable outcomes across almost all measures of healthy development, including self-esteem, quality of life, psychological health, social competence, and academic outcomes (Goldberg et al., 2014; Patterson, 2004). Several studies have suggested that female same-sex parenting dyads may outperform different-sex parenting dyads on measures of parenting awareness (Bos, van Balen, & van den Boom, 2005, 2007). Further, compared to biological fathers in different-sex marriages, nonbiological lesbian mothers have demonstrated higher quality parent-child interactions, commitment as parents, and parenting effectiveness (Bos et al., 2005, 2007).

These findings are particularly notable when considering the contextual challenges faced by same-sex couples in developing their families and raising their children. Most studies of same-sex parents were prior to widespread availability of same-sex marriage, and same-sex parents continue to face inconsistent legal protections today (e.g., some states place barriers for the nonbiologically related parent to obtain full parenting protections). In addition, children raised by same-sex parents may face secondary stigma or bullying due to having same-sex parents (Goldberg et al., 2014). Same-sex couples also face the unique challenge of finding ways to create their families because sex with their partners will not lead to the birth of a child. Thus, couples desiring to become parents must explore other paths to parenthood. Furthermore, the majority of children raised by same-sex parents are from different-sex relationships (Goldberg et al., 2014); consequently, same-sex parents must often navigate the typical challenges of co-parenting with an ex-partner or step-parenting (e.g., negotiating custody and visitation agreements), as well as unique challenges due to being in a same-sex relationship (e.g., possible stigma from previous, different-sex partners and their families). Same-sex couples are also more likely to take alternative paths to parenthood. Specifically, They are 4.5 times more likely to adopt and 6 times more likely to raise a foster child compared to different sex couples (Goldberg et al., 2014). Other common avenues to parenthood include donor insemination in female couples and surrogacy in male couples. Importantly, many of these paths to parenthood involve considerable financial costs and legal support that may prohibit some desiring couples from pursuing parenthood or impose a significant financial burden on these families.

Social Support

Relationships develop within, and are influenced by, social context. Across couple type, greater social support is strongly associated with better relationship outcomes (Kurdek, 2004) and has been found to buffer couples

from the negative psychological effects of life stressors (Graham & Barnow, 2013). Further, being embedded in a supportive social network can encourage couples to work through difficult times because relationship dissolution will have negative social repercussions (Stanley, Rhoades, & Whitton, 2010). Unfortunately, low social support is considered a unique area of risk for same-sex couples, because it is often less readily available for them compared to different-sex couples (Green & Mitchell, 2002; Kurdek, 2004). Many same-sex couples experience the estrangement or rejection from family members. Other families-of-origin may tolerate, as opposed to fully embrace, an individual's same-sex relationship, which can nonetheless be experienced as stigmatizing and limit the quality of support given by these family members.

Similarly, religious involvement is generally considered a protective factor in different-sex relationships due to the increased access to reliable social and community support. In fact, most different-sex couples are married through religious organizations (Stanley, Amato, Johnson, & Markman, 2006), which may play a role in legitimizing the relationship through faith-based traditions. Although some faith-based traditions and communities are neutral or welcoming towards same-sex couples, other religious belief structures condemn these relationships, further limiting readily available support to these families (Barnes & Meyer, 2012).

Sexual minority individuals often supplement social support through strong interpersonal relationships within the LGBT community. These relationships are often referred to as "families-of-choice," indicating that friendships may take on a kinship quality (Graham & Barnow, 2013; Peplau & Fingerhut, 2007; Weeks, Heaphy, & Donovan, 2001). As a result, same-sex couples are more likely to cite friends than family as primary support providers, and research has demonstrated that support from friends may be more predictive of relationship outcomes in same-sex couples than is familial support (Blair & Pukall, 2015). At the same time, a reliance on the LGBT community may pose some risks to same-sex relationships. Specifically, partners in same-sex relationships are more likely to maintain friendships with ex-partners or individuals with whom they have had sexual relations, as well as with other sexual minority, same-sex individuals (Harkless & Fowers, 2005; Weinstock, 2004). As a consequence, they may have considerable contact with individuals to whom they might become attracted. This is in contrast to heterosexual adults whose friends tend to be other heterosexual individuals of the same gender who are not potential romantic partners.

Sexual Minority Stress

One of the most important ways in which same-sex couples differ from different-sex couples is that they live in a society that stigmatizes their nonheterosexual identities and relationships. The negative mental health effects of a stigmatized sexual identity on individuals have been well documented (e.g., Lehavot & Simoni, 2011; Meyer, 2003). Recent work has also begun to describe how minority stress can be experienced individually by each partner and jointly by the couple (LeBlanc, Frost, & Wight, 2015; Frost et al., 2017); these individual- and dyadic-level stressors can interact to adversely affect the couple's relationship quality. Therefore, to understand same-sex couple processes, clinicians must appreciate the unique, stigma-based minority stressors that same-sex couples face, including experiences of discrimination, internalization of negative social beliefs about sexual minorities (i.e., internalized heterosexism), and issues related to the concealment and disclosure of their stigmatized sexual identity (Meyer, 2003).

Discrimination

Sexual minority individuals experience pervasive discrimination, ranging from daily hassles and microaggressions to acute acts of violence (Balsam, Rothblum, & Beauchaine, 2005; Katz-Wise & Hyde, 2012; Lee, Gamarel, Bryant, Zaller, & Operario, 2016). Such victimization related to one's sexual minority identity has significant adverse effects on individuals, predicting negative mental health outcomes more strongly than does victimization unrelated to sexual orientation (Descamps, Rothblum, Bradford, & Ryan, 2000). In addition, discrimination can place significant stressors on a couple's relationship. Partners often have different histories of discriminatory experiences, based on family-of-origin and geographic location (e.g., growing up in more liberal or more socially conservative regions). Consequently, partners may differ in anticipation of future discriminatory events, expectations of rejection, and ideas about how to handle expected or experienced discrimination. Couples may therefore experience conflict as they attempt to cope with discrimination as individuals and as a team.

Internalized Heterosexism

Internalized heterosexism refers to a broad range of negative self-perceptions and emotions that occur as a result of being a sexual minority. This psychological phenomenon develops as individuals are continually exposed to pervasive, systemic, negative messages about sexual minorities and subsequently devalue their same-sex attractions and relationships (Szymanski, Kashubeck-West, & Meyer, 2008). It is can also be characterized by the intrapersonal conflict of desiring to be heterosexual while experiencing same-sex attraction, often referred to in earlier literature as *internalized homophobia* (Meyer & Dean, 1998).

Research has established causal associations between internalized heterosexism/internalized homophobia and

poor mental health (Herek, Cogan, Gillis, & Glunt, 1998; Meyer & Dean, 1998; Szymanski & Chung, 2003) and one study has demonstrated that higher internalized heterosexism is associated with lower relationship satisfaction (Frost & Meyer, 2009). Importantly, internalized heterosexism may operate outside of one's conscious awareness. For example, heteronormative messages about sexual relationships may lead an individual to have implicit, negative perceptions of sexual intimacy within same-sex relationships. This may lead to unwanted feelings of shame or difficulties establishing emotional connection with one's partner during sexual encounters.

Disclosure of Sexual Identity and Same-Sex Relationship Status

Disclosure of one's sexual orientation (i.e., "outness") is generally associated with individual, stress-related growth, including reductions in shame due to concealing one's sexual orientation and increases in opportunities to gain support for one's sexual minority identity (Oswald, 2000; Vaughan & Waehler, 2009). Similarly, studies suggest that sexual minority people with higher levels of outness generally report higher relationship quality than those with lower levels of outness (Jordan & Deluty, 2000; Knoble & Linville, 2012). This may be due in part to the psychological and emotional cost associated with concealing one's sexual orientation or same-sex relationship, such as having to change and monitor one's behavior in certain contexts (e.g., referring to one's partner as a "friend"; removing symbols of the couple's relationship during family visits). Lack of disclosure may also limit the couple's ability to foster a support network because other people cannot support the couple's relationship if they are not aware of the couple's relationship status. Further, avoiding social events (e.g., work functions, family gatherings) in order to avoid revealing their same-sex relationship can restrict each partner's amount of social contact.

However, there are also important risks associated with disclosing one's sexual minority identity, including possible rejection, discrimination, and violence (Baiocco et al., 2016), each of which can negatively impact not only the individual but the relationship as well. Because these risks vary across time and life contexts (e.g., work, family, friends, school, public), disclosure of one's sexual minority identity and same-sex relationship is best conceptualized as an ongoing process in which individuals and couples must make continuous decisions about if, when, to whom, and how to disclose. Partners may disagree at times about their desired degree of relationship disclosure or to whom they should disclose (Ossana, 2000; Spitalnick & McNair, 2005), which can lead to painful emotions and relationship concerns. For example, should one partner wish to conceal the couple's relationship from his family due to fears of rejection, the other partner may question his partner's love or commitment to the relationship. Other couples may disagree about whether it feels safe to display affection in certain public contexts (e.g., holding hands at the grocery store). The partner who is more comfortable may feel rejected by the other's reluctance to be affectionate, while the less comfortable partner may feel pressured into making themselves vulnerable to anti-LGBT attacks. Negotiating these weighty and ongoing decisions with sensitivity to each other's different perspectives can be quite challenging for couples. Perhaps for that reason, same-sex couples have expressed a desire for relationship interventions to include content about how to approach relationship disclosure as a team (Scott & Rhoades, 2014).

Heterosexism and Intersectionality of Multiple Identities

Heterosexism intersects with other identity markers and forms of oppression (e.g., sexism, racism, ageism, transphobia), leading to uniquely oppressive experiences (Szymanski, 2005, Szymanski et al., 2014). For example, some sexual minority women face sexual objectification, particularly from heterosexual men, for being in a same-sex relationship. Men in same-sex relationships may be perceived to violate societal norms of masculinity, in which engaging in romantic or sexual relationships with other men is viewed as de-masculinizing. LGB people of color must negotiate and integrate the complex intersections of multiple oppressed identities that may result in unique psychological stressors (Ferguson, 2016). Partners may also vary in gender identity or expression, such as identifying or presenting outside of the gender binary (genderqueer, nonbinary, butch woman, androgynous, etc.). This may lead to additional forms of discrimination due to living outside of traditional gender norms, as well as transphobia (e.g., prejudice towards transgender/gender nonconforming people). Each of these intersections of multiple stigmatized identities can create additional challenges to the well-being of individual partners as well as to maintaining a healthy and satisfying relationship.

Clinical Considerations and Relationship Intervention Adaptations for Same-Sex Couples

Given the notable similarities between same-sex and different-sex couples, evidence-based, cognitive-behavioral relationship interventions that emphasize communication, conflict resolution, and strengthening commitment are likely to improve same-sex couple outcomes despite having been primarily designed for and tested on different-sex couples (Hartwell, Serovich, Grafsky, & Kerr, 2012; Jacobson & Christensen, 1998; Markman et al., 2010). However, in order to maximize their benefit to same-sex couples, we argue that various micro-level adaptations to the interventions themselves and delivery of these interventions with cultural sensitivity are necessary. Specifically, existing interventions should be adapted to eliminate heterosexist bias, their core content (i.e., cognitive-

behavioral strategies) should be tailored to improve relevance and appeal for same-sex couples, and novel content to address issues unique to this population should be added. In the following sections we discuss each of these proposed adaptations to intervention content. We include concrete examples of such adaptations, drawing from our experiences developing the Strengthening Same-Sex Relationships (SSSR) programs, culturally sensitive relationship education programs designed specifically for male (SSSR-M; Buzzella et al., 2012) and female same-sex couples (SSSR-F; Whitton, Scott, Dyar, et al., 2017; Whitton, Scott, & Weitbrecht, 2017).

Removing Heterosexist Bias

Because most relationship interventions were developed for and tested on different-sex couples, they are infused with heteronormativity. For example, advertisements for relationship education and couple therapy often exclusively include images of different-sex couples and use language referencing heteronormative relationships (e.g., *husband/wife).* Initial paperwork can contain similar bias, such as asking for husband's name and wife's name. Though often not intended by the service providers, this language can be perceived by sexual minorities as indicating that services are only intended for different-sex couples (Scott & Rhoades, 2014). Clinicians seeking to serve same-sex couples should evaluate all advertisements and intake forms for signs of heterosexist bias. If possible, advertisements should show images of same-sex couples and use inclusive language. For example, *relationship education* or *couple therapy* is preferred to *premarital education* or *marriage counseling* and paperwork should refer to *partner 1/partner 2* rather than *husband/wife* or *male/female.*

Supplemental clinical materials such as worksheets, vignettes, and skill demonstration videos used within traditional couple interventions also often exclusively show different-sex couples. Same-sex couples have reported that they can have difficulty identifying with the different-sex couples in videos of healthy communication skills, which can detract from their skill acquisition and be alienating (Buzzella et al., 2012; Whitton & Buzzella, 2012). To maximize the cultural sensitivity and efficacy of relationship interventions with same-sex couples, we recommend that videos, pictures, and vignettes include depictions of same-sex couples. In qualitative data from evaluations of the SSSR programs, a key theme that emerged was appreciation for the depiction of same-sex couples in the workbooks and demonstration videos (Whitton, Scott, & Weitbrecht, 2017). Couples described that not only did this allow them to identify with the depicted couples, but it was also affirming and conveyed that the intervention was designed specifically for their relationships.

We also suggest that clinicians evaluate all additional resources (e.g., mental health resources, legal aid) they may provide couples for heterosexist bias and relevance. We recommend providers develop a local LGBT-friendly resource guide that has been well vetted to be sensitive to the needs of same-sex couples. This may be particularly important when working with couples facing legal challenges, intimate partner violence, or mental health issues outside the scope of traditional couple interventions. Practitioners are encouraged to partner with community organizations, such as local LGBT centers, shelters, reproductive centers, or advocacy groups, to assist with this process.

Many interventions also include heterosexist assumptions about couple processes, such as the presence of gender-role driven behavior and gender-based relationship inequality (Whitton & Buzzella, 2012), which can be perceived by sexual minorities as alienating and discourage engagement in treatment (Scott & Rhoades, 2014; Shelton & Delgado-Romero, 2011). As an example, the unhealthy pattern of communication in which one partner pursues and the other withdraws from conflict is often taught with reference to heteronormative patterns (e.g., the female partner pursues while the male partner withdraws). When working with same-sex couples we recommend that clinicians provide psychoeducation on common couple interaction patterns (pursue/withdraw, pursue/pursue, withdraw/withdraw) and their negative effects without using a gender-based framework. Instead, clinicians can emphasize that these patterns vary across individuals and couples, and encourage couples to identify any patterns present in their own relationship. However, gender differences do not need to be ignored entirely; it may be helpful to note that in our society there are socialization forces that encourage women to communicate about interpersonal conflicts but discourage men from doing so.

In SSSR, we provide both male and female couples with psychoeducation about each interaction pattern and how it may negatively affect their relationship. Then, based on evidence that among same-sex couples men are more likely to withdraw and women are more likely to pursue (Baucom et al., 2010), we tailored the content included in the male and female versions of the program. In SSSR-F, we highlight how, due to the socialization of women, many women may be prone to pursue conflict. Then, cognitive and behavioral strategies to counter these tendencies are taught (e.g., identifying cognitive distortions such as, "If we don't talk about this now, we never will"; taking a temporary break or "time-out" from conflict discussions). By contrast, in SSSR-M, research on the socialization of men to avoid conflict, withdraw, and conceal emotional expression is presented, followed by questions based in motivational interviewing to facilitate a consideration of the costs of withdrawing. We

then introduce communication skills to promote safely sharing emotional experiences. In both programs, couples are encouraged to identify their own communication patterns—which may or may not follow gender socialization—as a precursor to shifting problematic patterns.

As a final note, clinicians are encouraged to recognize and value the diversity of gender expressions among same-sex couples. Many participants may not identify as cisgender men or women (i.e., individuals whose gender identity matches their sex assigned at birth). Rather, increasing numbers of individuals identify as transgender, gender nonconforming, or genderqueer. Skilled clinicians will therefore need to be able to address relationship patterns of interaction in ways that respect each person's gender identity and each couple's combination of gender identities (e.g., not presuming that one partner is the "man" or "woman" of the relationship). Furthermore, it may be beneficial to approach interventions from a strengths-based perspective, highlighting how same-sex couples have more flexibility in establishing relationship roles outside of the constraints of heteronormative, gender-based standards.

Enhancing Core Content

Although important, removing heterosexist bias alone will not be sufficient in meeting the needs of same-sex couples. A thorough understanding of how core relationship processes common to all couples intersect with the unique experiences of same-sex couples and other identities can enhance the quality and cultural sensitivity of relationship interventions. In general, therapists should approach relationship topics from an affirming stance that is open to exploring experiences associated with being in a same-sex couple, balancing knowledge of common ways that minority stressors may influence couple functioning with an openness to learning about the couple's specific experiences. Clinicians should take caution not to attribute relationship distress and dynamics solely to the couple's same-sex relationship status (Shelton & Delgado-Romero, 2011) and avoid the microaggression of assuming that the couple's main concerns will be related to their sexual minority identities. For many same-sex couples, these issues are not as salient or distressing as other relationship problems (e.g., disagreements about finances or children). Clinicians should also recognize that same-sex couples often demonstrate unique strengths in terms of communication, egalitarianism, and closeness, and seek to highlight these strengths in the same-sex couples they treat. Within this overall approach, there are several content areas of standard cognitive-behavioral relationship interventions that can benefit from enhancement to meet the specific needs of same-sex couples.

Many relationship education programs include modules on clarifying and negotiating shared relationship expectations. Due to the lack of same-sex relationship role models or clear social norms for what same-sex relationships should look like, this content can be particularly helpful to same-sex couples. In fact, we recommend expanding these modules to address particular expectations that are prone to lack of clarity or disagreement between same-sex partners. As one example, discrepant expectations about relationship disclosure may be common in same-sex couples, leading to misunderstandings and feelings of rejection by one or both partners. In the SSSR programs, a unit on helping couples clarify relationship expectations was enhanced with a particular focus on expectations about relationship disclosure. This allowed facilitators the opportunity to provide psychoeducation about the complexities surrounding these decisions. The program included discussions of potential advantages of relationship disclosure (e.g., the couple not having to "hide" their identity and opportunities to gain more social support), as well as disadvantages (e.g., possibilities of rejection, violence, or discrimination). Couples were also informed on the ways that discrepant expectations about outness can lead to conflict and emotional pain, especially if there is not clear communication about each partner's reasoning. Couples were then provided an opportunity to select a relationship expectation topic to discuss using structured communication skills and encouraged to use problem-solving skills to develop a shared plan should a discrepancy in expectations exist. Other suggested topics for discussion during this module included parenting, in-law relationships, division of household tasks, social support, and spiritual/religious involvement—all topics that may be informed by the couple's sexual minority identity.

The couple's sexual relationship is also often addressed in relationship interventions, and is appropriate in work with same-sex couples. However, given the differences in sexual norms and practices between different-sex, male same-sex, and female same-sex relationships, content may need to be tailored and enhanced to maximize its relevance to each couple type. In SSSR-F, content on sexuality was augmented with material directly targeting the particular preferences and needs of female same-sex partnerships. Specifically, in line with qualitative data indicating that female same-sex couples often have the therapeutic goal of increasing sexual frequency while maintaining intimacy (Scott & Rhoades, 2014), we included *sensate focus*—an intervention focused on exchanging nongenital touching while providing positive feedback (Masters & Johnson, 1970; Weiner & Avery-Clark, 2014). Strategies to improve communication about sexual desires, initiate more sexual encounters, and provide feedback in a structured and positive manner

were also taught. Psychoeducation surrounding female sexuality also helped normalize challenges and strengths surrounding these issues. In SSSR-M, the topic of sexual commitment and open communication regarding sexual practices was emphasized (see Novel Content below for more information).

Family planning and parenting are often addressed in relationship interventions, as they are top sources of conflict among different-sex couples (Stanley, Markman, & Whitton, 2002). Given the unique challenges that same-sex couples face in parenting and becoming parents, the standard content could benefit from enhancement to best meet the unique needs of same-sex couples. In order to support couples surrounding this topic, we recommend that clinicians develop a basic understanding of how local law and policy may affect family planning for same-sex couples in their state or jurisdiction (see the Human Rights Campaign for local details). For example, if a couple lives in a state that bars second-parent adoption for the nonbiologically related parent, the clinician can assist the couple in discussing the emotional experiences of each partner and how they can strengthen their shared sense of commitment as co-parents. Parents may also face additional stress surrounding the financial cost of parenting and lack of legal protections for their families. Thus, clinicians may need to work with couples to problem solve and approach these issues as a team due to the increased risk for destructive communication patterns during times of stress (Conger, Rueter, & Elder, 1999; Neff & Karney, 2004).

Novel Content

Relationship interventions may also benefit from incorporating novel content to address the specific experiences of same-sex couples. At a basic level, psychoeducation can be presented to explicitly counter negative stereotypes of same-sex relationships, thereby reducing the impact of internalized heterosexism. In the SSSR program, the couples attending were asked to generate common stereotypes they had heard about same-sex relationships. Group facilitators then offered an overview of relevant research findings, dispelling many of the myths inherent in these negative stereotypes (e.g., disputing that same-sex relationships are inferior to different-sex relationships). By directly discussing relationship strengths, including role flexibility and communication, providers were also given an opportunity to show their support for same-sex relationships.

Given the unique challenges associated with oppression and discrimination faced by same-sex couples (Meyer, 2003), modules on cognitive-behavioral strategies for coping with stress individually and as a couple were created for the SSSR programs. Psychoeducation regarding the role of stress on relationship outcomes, grounded in the Family Stress Model (Conger et al., 1999), was used to normalize relationship challenges associated with stress. Framing this unit as stress management, which could include stressful experiences with discrimination, allowed couples to consider the impact of discrimination on their relationship without assuming that they identified discrimination as a specific problem. The unit included an introduction to emotion regulation and coping skills aimed to provide partners with tools to combat stress at the individual level. For example, in SSSR, couples were taught to recognize common but ineffective coping patterns, including rumination, reductions in self-care, social withdrawal, and feelings of pessimism and hopelessness, and to counter them with specific cognitive-behavioral strategies (e.g., cognitive restructuring, behavioral activation; Hatzenbuehler, 2009). Dyadic coping strategies (i.e., ways couples can work together to cope with stress) were also presented, such as reinforcing commitment to their relationships, using effective communication skills, and focusing on supporting one another during times of heightened stress.

Moreover, given that low social support represents a unique area of risk for same-sex couples, content focused on increasing available support may be helpful. For example, SSSR provided psychoeducation on the role of social support in enhancing relationship quality as well as challenges unique to same-sex couples in establishing this support. Couples were then provided with strategies and resources to improve support, including both local LGBT-specific and LGBT-friendly organizations. Thus, practitioners should familiarize themselves with local community resources, such as LGBT centers, programs, and LGBT-friendly religious/spiritual organizations that may provide regular opportunities for couples to receive social support within the community. It may also be helpful to discuss what constitutes healthy relationship support, including finding others that generally approve of the couple's relationship and developing plans for limiting contact with unsupportive people.

For male couples in particular, psychoeducation and guidance regarding nonmonogamy agreements may help couples establish shared expectations regarding this topic. In SSSR, information was provided indicating that monogamous and nonmonogamous male same-sex couples can be equally satisfied with their relationships, but that this rests on clear expectations and effective communication about each partner's wants. Additionally, the physical health and commitment risks associated with nonmonogamy agreements were described (Hoff et al., 2010; Parsons et al., 2013; Whitton et al., 2015). The program then provided a framework for couples who agreed to nonmonogamy to develop the specific rules of their agreements. This included asking partners to specify which sexual partners

are allowable, under what circumstances extradyadic sex can occur (e.g., only outside the home, never with the same partner twice), and what protections from sexually transmitted infections are required.

The current section discussed specific clinical and program recommendations to improve intervention relevance and clinician cultural sensitivity when working with same-sex couples. However, it is important to recognize that although specific knowledge, skills, and adaptations are necessary, all clinicians remain subject to implicit biases regarding sexual minorities and same-sex couples that may interfere with providing culturally competent care, even if these recommendations are generally followed. Therefore, in the following section, we review recommendations for combating these implicit biases when working with same-sex couples.

Implicit Bias as a Barrier to Culturally Competent Care

Given the pervasiveness of stigma towards sexual minorities, all clinicians are urged to reflect on and counteract any personal attitudes that may negatively impact their ability to effectively work with same-sex couples (APA, 2012). Such implicit biases have been shown to negatively impact clinical outcomes (Fallin-Bennett, 2015; Foglia & Fredriksen-Goldsen, 2014). For example, clinicians may unintentionally avoid discussing uncomfortable subject matter, which may be communicated through verbal (e.g., changing the subject) or nonverbal means (e.g., avoiding eye contact).

One important step to counter implicit bias is to recognize that the tendency to develop and utilize stereotypes is a normal human process (Burgess, van Ryn, Dovidio, & Saha, 2007) that can help increase the speed of information processing (APA, 2002). Even well-meaning providers who view themselves as nonbiased against sexual minorities, or even providers who strive to be allies, may have implicit biases against same-sex couples (APA, 2012). In fact, this would be expected given that most providers grew up in a heterosexist society pervasive with negative messages about LGB individuals. Historically, same-sex attracted individuals were considered mentally ill even within the psychological field (APA, 2012), and broad societal acceptance of same-sex relationships has only developed in the last decade. Consequently, providers working with same-sex couples who are not explicitly biased may still harbor unexplored negative beliefs about sexual minorities or same-sex couples. Clinicians must lower their psychological resistance to evaluating personal biases, so they can strive to develop a "high level of awareness about their own beliefs, values, needs, and limitations [that] may [otherwise] impede the progress of a client in psychotherapy" (APA, 2012, p. 15).

There are several strategies that clinicians can use to help mitigate the impact of any explicit or implicit biases they may hold. One is to increase contact with same-sex attracted individuals or same-sex couples in settings where power differentials, such as those present in a therapy setting, do not exist. Remaining aware of common stereotypes, even if not explicitly held, will allow for purposeful attention to disconfirming evidence. Additionally, as implicit biases are especially likely to be activated when individuals are under stress, providers should try to slow down and increase deliberate action during periods of stress. Although efforts to simply suppress biases can lead to a rebounding of the bias once conscious efforts to suppress are eliminated, recurrent and sustained efforts to change a stereotype can be effective (APA, 2002; Burgess et al., 2007; Stone & Moskowitz, 2011; Teal, Gill, Green, & Crandall, 2012). Therefore, perhaps the most important strategy to counter implicit bias against same-sex couples is to engage in ongoing education, consultation, and interaction with sexual minorities. Useful resources can be found in the Appendices of the APA Guidelines for Practice with LGB Clients (2012).

Promoting Institutional and Policy-Level Changes

In this paper, we have primarily focused on suggesting micro-level changes to improve the quality and cultural sensitivity of relationship interventions offered to same-sex couples. However, there are also mezzo- and macro-level changes that would benefit this population. At the mezzo-level, to improve the environments in which sexual minorities receive relationship interventions, we recommend that institutions expand educational and training opportunities, including at medical centers, universities, and the Veterans Administration (VA). As an example, each VA medical center is now required to have an identified LGBT Veteran Care Coordinator to monitor and enhance the experience of LGBT veterans and promote training opportunities for staff to develop cultural competence. Other systems of care may benefit from similar programs or initiatives. Institutions are also encouraged to partner with LGBT community groups to foster opportunities for collaboration and continuing education. Clinics and centers that provide relationship interventions should also advertise using inclusive materials and through LGB-friendly venues that will attract same-sex couples and thus decrease disparities in access to these services.

At the macro-level, we encourage clinicians and researchers to advocate for larger institutions and organizations (e.g., APA) to make continuing education or trainings specific to same-sex couples required for couple and marital therapists. We also encourage APA and other professional mental health organizations to

continue supporting local and federal initiatives to provide consistent protections for LGBT families, such as antidiscrimination laws for same-sex couples that provide full parenting protections to both partners. Similarly, we encourage these organizations to oppose legislative efforts that would allow for LGBT families to be discriminated against based on the personal religious beliefs of service providers (e.g., opposing "religious-liberty" laws), as these laws would likely disproportionately harm LGBT families. We believe these suggestions are consistent with APA guidelines encouraging clinicians to recognize and address systemic and institutional forms of oppression (APA, 2012).

Conclusions and Future Directions

In sum, same-sex couples will likely benefit from adapted relationship-focused interventions employed by culturally competent clinicians. More research conducted outside of the heteronormative lens of traditional relationship interventions is needed to evaluate the effectiveness of these programs as well as which clinical skills and adaptations are most useful in providing culturally sensitive care. The current state of the literature could also be improved by expanding research on the various intersectional identities and circumstances of same-sex couples, including how race, age, income, gender identity and expression, and parenting may influence relationship dynamics, and how clinicians can in turn provide culturally sensitive services. Given the quickly developing nature of this field of research, continuing education will be necessary to develop and maintain cultural competence in serving this population. The current paper sought to provide an introduction to the knowledge and skills necessary to begin this process.

References

Adam, B. D. (2006). Relationship innovation in male couples. *Sexualities, 9,* 5–26.

Allen, E. S., Atkins, D. C., Baucom, D. H., Snyder, D. K., Gordon, K., & Glass, S. P. (2005). Intrapersonal, interpersonal, and contextual factors in engaging in and responding to extramarital involvement. *Clinical Psychology: Science and Practice, 12,* 101–130.

American Psychological Association. (2002). *Guidelines on multicultural education, training, research, practice, and organizational change for psychologists.* Retrieved January 5, 2016 from http://www.apa.org/pi/oema/resources/policy/multicultural-guidelines.aspx

American Psychological Association. (2012). *Guidelines for psychological practice with lesbian, gay, and bisexual clients.* Retrieved January 3, 2016 from http://www.apa.org/pi/lgbt/resources/guidelines.aspx

Baiocco, R., Fontanesi, L., Santamaria, F., Ioverno, S., Baumgartner, E., & Laghi, F. (2016). Coming out during adolescence: Perceived parents' reactions and internalized sexual stigma. *Journal of Health Psychology, 21*(8), 1809–1813.

Balsam, K. F., Beauchaine, T. P., Rothblum, E. D., & Solomon, S. E. (2008). Three-year follow-up of same-sex couples who had civil unions in Vermont, same-sex couples not in civil unions, and heterosexual married couples. *Developmental Psychology, 44*(1), 102–116.

Balsam, K. F., Rothblum, E. D., & Beauchaine, T. P. (2005). Victimization Over the Life Span: A Comparison of Lesbian, Gay, Bisexual, and Heterosexual Siblings. *Journal of Consulting and Clinical Psychology, 73*(3), 477–487.

Bancroft, J., Loftus, J., & Long, J. S. (2003). Distress about sex: A national survey of women in heterosexual relationships. *Archives of Sexual Behavior, 32*(3), 193–208.

Barnes, D. M., & Meyer, I. H. (2012). Religious affiliation, internalized homophobia, and mental health in lesbians, gay men, and bisexuals. *American Journal of Orthopsychiatry, 82*(4), 505–515.

Baucom, B. R., McFarland, P. T., & Christensen, A. (2010). Gender, topic, and time in observed demand-withdraw interaction in cross- and same-sex couples. *Journal of Family Psychology, 24*(3), 233–242.

Bedoya, C. A., & Safren, S. A. (2009). Capturing (and communicating) complexity: Adapting CBT for clients with multiple diversity. *Pragmatic Case Studies in Psychotherapy, 5*(4), 22–27.

Blair, K. L., & Pukall, C. F. (2014). Can less be more? Comparing duration vs. frequency of sexual encounters in same-sex and mixed-sex relationships. *The Canadian Journal of Human Sexuality, 23*(2), 123–136.

Blair, K. L., & Pukall, C. F. (2015). Family matters, but sometimes chosen family matters more: Perceived social network influence in the dating decisions of same- and mixed-sex couples. *Canadian Journal of Human Sexuality, 24*(3), 257–270.

Bonello, K., & Cross, M. C. (2010). Gay monogamy: I love you but I can't have sex with only you. *Journal of Homosexuality, 57*(1), 117–139.

Bos, H. M. W., van Balen, F., & van den Boom, D. C. (2005). Lesbian families and family functioning: An overview. *Patient Education and Counseling, 59,* 263–275.

Bos, H. M. W., van Balen, F., & van den Boom, D. C. (2007). Child adjustment and parenting in planned lesbian-parent families. *American Journal of Orthopsychiatry, 77,* 38–48.

Bricker, M. E., & Horne, S. G. (2007). Gay men in long-term relationships: The impact of monogamy and non-monogamy on relational health. *Journal of Couple & Relationship Therapy, 6,* 27–47.

Burgess, D., van Ryn, M., Dovidio, J., & Saha, S. (2007). Reducing racial bias among health care providers: Lessons from social-cognitive psychology. *Journal of General Internal Medicine, 22*(6), 882–887.

Butzer, B., & Campbell, L. (2008). Adult attachment, sexual satisfaction, and relationship satisfaction: A study of married couples. *Personal Relationships, 15,* 141–154.

Buzzella, B. A., Whitton, S. W., & Tompson, M. C. (2012). A preliminary evaluation of a relationship education program for male same-sex couples. *Couple and Family Psychology: Research and Practice, 1*(4), 306–322.

Byers, E. S. (2005). Relationship satisfaction and sexual satisfaction: A longitudinal study of individuals in long-term relationships. *Journal of Sex Research, 42,* 113–118.

Cabaj, R. P. (1988). Homosexuality and neurosis: Considerations for psychotherapy. *Journal of Homosexuality, 15*(13-23).

Christensen, A., Atkins, D. C., Baucom, B., & Yi, J. (2010). Marital status and satisfaction five years following a randomized clinical trial comparing traditional versus integrative behavioral couple therapy. *Journal of Consulting and Clinical Psychology, 78*(2), 225–235.

Conger, R. D., Rueter, M. A., & Elder, G. H. (1999). Couple resilience to economic pressure. *Journal of Personality and Social Psychology, 76*(1), 54–71.

Conley, T. D., Ziegler, A., Moors, A. C., Matsick, J. L., & Valentine, B. (2013). A critical examination of popular assumptions about the benefits and outcomes of monogamous relationships. *Personality and Social Psychology Review, 17,* 124–141.

D'Augelli, A. R., Rendina, H. J., Grossman, A. H., & Sinclair, K. O. (2006). Lesbian and gay youths' aspirations for marriage and raising children. *Journal of LGBT Issues in Counseling, 1,* 77–98.

Descamps, M. J., Rothblum, E., Bradford, J., & Ryan, C. (2000). Mental health impact of child sexual abuse, rape, intimate partner violence, and hate crimes in the National Lesbian Health Care Survey. *Journal of Gay and Lesbian Social Services, 11,* 27–55.

Epstein, N. B., & Baucom, D. H. (2002). *Enhanced cognitive-behavioral therapy for couples: A contextual approach*. Washington, DC: American Psychological Association.

Fallin-Bennett, K. (2015). Implicit bias against sexual minorities in medicine: cycles of professional influence and the role of the hidden curriculum. *Academic Medicine, 90*(5), 549–552.

Ferguson, A. D. (2016). Cultural and clinical issues when working with sexual minorities of color. In I. Marini & M. A. Stebnicki (Eds.), *The professional counselor's desk reference* (2nd ed., pp. 519-524). New York: Springer.

Fischer, M. S., Baucom, D. H., & Cohen, M. J. (2016). Cognitive-behavioral couple therapies: Review of the evidence for the treatment of relationship distress, psychopathology, and chronic health conditions. *Family Process, 55*(3), 423–442.

Foglia, M. B., & Fredriksen-Goldsen, K. I. (2014). Health disparities among LGBT older adults and the role of unconscious bias. *Hastings Center Report, 44*, S40–S44.

Frost, D. M., & Meyer, I. H. (2009). Internalized homophobia and relationship quality among lesbians, gay men, and bisexuals. *Journal of Counseling Psychology, 56*(1), 97–109.

Frost, D. M., LeBlanc, A. J., de Vries, B., Alston-Stepnitz, E., Stephenson, R., & Woodyatt, C. (2017). Couple-level minority stress: An examination of same-sex couples' unique experiences. *Journal of Health and Social Behavior, 58*(4), 455–472.

Goldberg, A. E., Gartrell, N. K., & Gates, G. (2014). *Research Report on LGB-Parent Families*. Retrieved January 23, 2017 from http://williamsinstitute.law.ucla.edu/wp-content/uploads/lgb-parent-families-july-2014.pdf

Goodrich, T. J., Rampage, C., Ellman, B., & Halstead, K. (1988). *Feminist family therapy: A casebook*. New York: W. W. Norton & Co.

Gotta, G., Green, R. -J., Rothblum, E., Solomon, S., Balsam, K., & Schwartz, P. (2011). Heterosexual, lesbian, and gay male relationships: A comparison of couples in 1975 and 2000. *Family Process, 50*(3), 353–376.

Gottman, J. M., Levenson, R. W., Swanson, C., Swanson, K., Tyson, R., & Yoshimoto, D. (2003). Observing gay, lesbian and heterosexual couples' relationships: Mathematical modeling of conflict interaction. *Journal of Homosexuality, 45*(1), 65–91.

Graham, J. M., & Barnow, Z. B. (2013). Stress and social support in gay, lesbian, and heterosexual couples: Direct effects and buffering models. *Journal of Family Psychology, 27*(4), 569–578.

Green, R. J., & Mitchell, V. (2002). Gay and lesbian couples in therapy: Homophobia, relationship ambiguity, and social support. In A. S. Gurman & N. S. Jacobson (Eds.), *Clinical handbook of couple therapy* (pp. 546–568). New York, NY: Guilford Press.

Greenstein, T. N. (2009). National context, family satisfaction, and fairness in the division of household labor. *Journal of Marriage and Family, 71*(4), 1039–1051.

Harkless, L. E., & Fowers, B. J. (2005). Similarities and differences in relational boundaries among heterosexuals, gay men, and lesbians. *Psychology of Women Quarterly, 29*(2), 167–176.

Hartwell, E. E., Serovich, J. M., Grafsky, E. L., & Kerr, Z. Y. (2012). Coming out of the dark: Content analysis of articles pertaining to gay, lesbian, and bisexual issues in couple and family therapy journals. *Journal of Marital and Family Therapy, 38*(1), 227–243.

Hatzenbuehler, M. L. (2009). How does sexual minority stigma "get under the skin"? A psychological mediation framework. *Psychological Bulletin, 135*(5), 707–730.

Heaphy, B., Donovan, C., & Weeks, J. (2004). A different affair? Openness and nonmonogamy in same sex relationships. In J. Duncombe (Ed.), *The State of Affairs: Explorations in Infidelity and Commitment* (pp. 167–186). New York: Routledge.

Herek, G. M., Cogan, J. C., Gillis, J. R., & Glunt, E. K. (1998). Correlates of internalized homophobia in a community sample of lesbians and gay men. *Journal of the Gay and Lesbian Medical Association, 2*, 17–25.

Herek, G. M., Kimmel, D. C., Amaro, H., & Melton, G. B. (1991). Avoiding heterosexist bias in psychological research. *American Psychologist, 46*(9), 957–963.

Hoff, C., Beougher, S., Chakravarty, D., & Darbes, L. (2010). Relationship characteristics and motivations behind agreements among gay male couples: Differences by agreement type and couple serostatus. *AIDS Care, 22*, 827–835.

Hook, J. N., Davis, D. E., Owen, J., Worthington, E. L., Jr., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology, 60*(3), 353–366.

Hosking, W. (2013). Agreements about extra-dyadic sex in gay men's relationships: Exploring differences in relationship quality by agreement type and rule-breaking behavior. *Journal of Homosexuality, 60*, 711–733.

Jacobson, N. S., & Christensen, A. (1998). *Acceptance and change in couple therapy: a therapist's guide to transforming relationships*. New York, NY: Norton.

Johnson, S. D. (2012). Gay affirmative psychotherapy with lesbian, gay, and bisexual individuals: Implications for contemporary psychotherapy research. *American Journal of Orthopsychiatry, 82*(4), 516–522.

Jordan, K. M., & Deluty, R. H. (2000). Social support, coming out, and relationship satisfaction in lesbian couples. *Journal of Lesbian Studies, 4*(1), 145–164.

Julien, D., Chartrand, E., Simard, M. -C., Bouthillier, D., & Bégin, J. (2003). Conflict, social support and relationship quality: An observational study of heterosexual, gay male and lesbian couples' communication. *Journal of Family Psychology, 17*(3), 419–428.

Katz-Wise, S. L., & Hyde, J. S. (2012). Victimization experiences of lesbian, gay, and bisexual individuals: A meta-analysis. *Journal of Sex Research, 49*(2-3), 142–167.

Khaddouma, A., Norona, J. C., & Whitton, S. W. (2015). Individual, couple, and contextual factors associated with same-sex relationship instability. *Couple and Family Psychology: Research and Practice, 4*(2), 106–125.

Knoble, N. B., & Linville, D. (2012). Outness and relationship satisfaction in same-gender couples. *Journal of Marital and Family Therapy, 38*(2), 330–339.

Kurdek, L. A. (1998). Relationship outcomes and their predictors: Longitudinal evidence from heterosexual married, gay cohabiting, and lesbian cohabiting couples. *Journal of Marriage and Family, 60*, 553–568.

Kurdek, L. A. (2004). Are gay and lesbian cohabiting couples really different from heterosexual married couples? *Journal of Marriage and Family, 66*(4), 880–900.

Kurdek, L. A. (2005). What do we know about gay and lesbian couples? *Current Directions in Psychological Science, 14*(5), 251–254.

Lau, C. Q. (2012). The stability of same-sex cohabitation, different-sex cohabitation, and marriage. *Journal of Marriage and Family, 74*(5), 973–988.

LaSala, M. C. (2004). Monogamy of the heart: Extradyadic sex and gay male couples. *Journal of Gay and Lesbian Social Services, 17*, 1–24.

Lee, J. H., Gamarel, K. E., Bryant, K. J., Zaller, N. D., & Operario, D. (2016). Discrimination, mental health, and substance use disorders among sexual minority populations. *LGBT Health, 3*(4), 258–265.

LeBlanc, A. J., Frost, D. M., & Wight, R. G. (2015). Minority stress and stress proliferation among same-sex and other marginalized couples. *Journal of Marriage and Family, 77*(1), 40–59.

Lehavot, K., & Simoni, J. M. (2011). The impact of minority stress on mental health and substance use among sexual minority women. *Journal of Consulting and Clinical Psychology, 79*(2), 159–170.

Lo, H., & Fung, K. P. (2016). Culturally competent psychotherapy. *The Canadian Journal of Psychiatry, 48*(3), 161–170.

Markman, H. J., & Rhoades, G. K. (2012). Relationship education research: Current status and future directions. *Journal of Marital and Family Therapy, 38*(1), 169–200.

Markman, H. J., Stanley, S. M., & Blumberg, S. L. (2010). *Fighting for Your Marriage: A Deluxe Revised Edition of the Classic Best-seller for Enhancing Marriage and Preventing Divorce*. San Francisco, CA: Jossey-Bass.

Masters, W. H., & Johnson, W. E. (1970). *Human sexual inadequacy*. Boston, MA: Little Brown, & Co.

McCarthy, J. (2015). *Record-High 60% of Americans Support Same-Sex Marriage*. Retrieved from http://www.gallup.com/poll/183272/record-high-americans-support-sex-marriage.aspx

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*(5), 674–697.

Meyer, I. H., & Dean, L. (1998). Internalized homophobia, intimacy, and sexual behavior among gay and bisexual men. In G. M. Herek (Ed.), *Stigma and sexual orientation: Understanding prejudice against lesbians, gay men, and bisexuals*. Thousand Oaks, CA: Sage Publications.

Neff, L. A., & Karney, B. R. (2004). How does context affect intimate relationships? linking external stress and cognitive processes within marriage. *Personality and Social Psychology Bulletin, 30*(2), 134–148.

Ossana, S. M. (2000). Relationship and couples counseling. In R. M. Perez, K. A. DeBord, & K. J. Bieschke (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients* (pp. 275–302). Washington, DC: American Psychological Association.

Oswald, R. (2000). Family and friendship relationships after young women come out as bisexual or lesbian. *Journal of Homosexuality, 38*(3), 65–83.

Parsons, J. T., Starks, T. J., DuBois, S., Grov, C., & Golub, S. A. (2013). Alternatives to monogamy among gay male couples in a community survey: Implications for mental health and sexual risk. *Archives of Sexual Behavior, 42*(2), 303–312.

Patterson, C. J. (2004). Lesbian and gay parents and their children: Summary of research findings. *Lesbian and gay parenting: A resource for psychologists*. Washington, DC: American Psychological Association.

Peplau, L. A., & Fingerhut, A. W. (2007). The close relationships of lesbians and gay men. *Annual Review of Psychology, 58*, 405–424.

Peplau, L. A., Fingerhut, A., & Beals, K. P. (2004). Sexuality in the relationships of lesbians and gay men. In J. Harvey, A. Wenzel, & S. Sprecher (Eds.), *Handbook of sexuality in close relationships* (pp. 350–369). Mahwah, NJ: Erlbaum.

Puts, D. A., Welling, L. L. M., Burriss, R. P., & Dawood, K. (2012). Men's masculinity and attractiveness predict their female partners' reported orgasm frequency and timing. *Evolution and Human Behavior, 33*(1), 1–9.

Ramirez, O. M., & Brown, J. (2010). Attachment style, rules regarding sex, and couple satisfaction: A study of gay male couples. *ANZJFT Australian And New Zealand Journal of Family Therapy, 31*(2), 202–213.

Reczek, C., Elliott, S., & Umberson, D. (2009). Commitment without marriage: Union formation among long-term same-sex couples. *Journal of Family Issues, 30*, 738–756.

Romero, A. P. (2017). *1.1 million LGBT adults are married to someone of the same sex at the two year anniversary of Obergefell v. Hodges*. Retrieved on August 27, 2017 from https://williamsinstitute.law.ucla.edu/experts/adam-romero/obergefell-effect/

Rosenfeld, M. J. (2014). Couple longevity in the era of same-sex marriage in the United States. *Journal of Marriage and Family, 76*, 905–918

Scott, S. B., Ritchie, L., Knopp, K., Rhoades, G. K. and Markman, H. J. (2017). Sexuality within female same-gender couples: Definitions, frequency, and satisfaction. *Archives of Sexual Behavior, 47*(3), 681–692.

Scott, S. B., & Rhoades, G. K. (2014). Relationship education for lesbian couples: Perceived barriers and content considerations. *Journal of Couple and Relationship Therapy, 13*(4), 339–364.

Sewell, K. K., McGarrity, L. A., & Strassberg, D. S. (2016). Sexual behavior, definitions of sex, and the role of self-partner context among lesbian, gay, and bisexual adults. *The Journal of Sex Research, 54*(7), 825–831.

Shelton, K., & Delgado-Romero, E. A. (2011). Sexual orientation microaggressions: The experience of lesbian, gay, bisexual, and queer clients in psychotherapy. *Journal of Counseling Psychology, 58*(2), 210–221.

Signorile, M. (2015). *It's not over: Getting beyond tolerance, defeating homophobia, and winning true equality*. Boston, MA: Mariner Books Houghton Mifflin Harcourt.

Solomon, S. E., Rothblum, E. D., & Balsam, K. F. (2005). Money, housework, sex, and conflict: Same-sex couples in civil unions, those not in civil unions, and heterosexual married siblings. *Sex Roles, 52*(9-10), 561–575.

Spitalnick, J. S., & McNair, L. D. (2005). Couples therapy with gay and lesbian clients: An analysis of important clinical issues. *Journal of Sex & Marital Therapy, 31*(1), 43–56.

Stanley, S. M., Amato, P. R., Johnson, C. A., & Markman, H. J. (2006). Premarital education, marital quality, and marital stability: Findings from a large, random household survey. *Journal of Family Psychology, 20*(1), 117–126.

Stanley, S. M., Rhoades, G. K., & Whitton, S. W. (2010). Commitment: Functions, formation, and the securing of romantic attachment. *Journal of Family Theory and Review, 2*, 243–257.

Stanley, S. M., Markman, H. J., & Whitton, S. W. (2002). Communication, conflict, and commitment: Insights on the foundations of relationship success from a national survey. *Family Process, 41*, 659–675.

Stone, J., & Moskowitz, G. B. (2011). Nonconscious racial bias in medical decision-making: What can be done to reduce it? *Medical Education, 45*, 768–776.

Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. *American Psychologist, 53*(4), 440–448.

Szymanski, D. M. (2005). Heterosexism and sexism as correlates of psychological distress in lesbians. *Journal of Counseling & Development, 83*, 355–360.

Szymanski, D. M., & Chung, Y. B. (2003). *Internalized homophobia in lesbians. Journal of Lesbian Studies, 7*(1), 115–125.

Szymanski, D. M., Dunn, T. L., & Ikizler, A. S. (2014). Multiple minority stressors and psychological distress among sexual minority women: The roles of rumination and maladaptive coping. *Psychology of Sexual Orientation and Gender Diversity, 1*(4), 412–421.

Szymanski, D. M., Kashubeck-West, S., & Meyer, J. (2008). Internalized heterosexism: A historical and theoretical overview. *The Counseling Psychologist, 36*(4), 510–524.

Teal, C. R., Gill, A. C., Green, A. R., & Crandall, S. (2012). Helping medical learners recognise and manage unconscious bias toward certain patient groups. *Medical Education, 46*(1), 80–88.

U.S. Census Bureau. (2014). *Household Characteristics of Opposite-Sex and Same-Sex Couple Households: ACS 2014*. Retrieved from http://www.census.gov/acs

Vaughan, M. D., & Waehler, C. A. (2009). Coming out growth: Conceptualizing and measuring stress-related growth associated with coming out to others as a sexual minority. *Journal of Adult Development, 17*(2), 94–109.

Warbelow, S. and Diaz, B. (2017). *State Equality Index*. Washington, DC: Human Rights Campaign Foundation. Received January 30, 2018 from https://www.hrc.org/campaigns/state-equality-index

Weeks, J., Heaphy, B., & Donovan, C. (2001). *Same sex intimacies: Families of choice and other life experiments*. London: Routledge.

Weiner, L., & Avery-Clark, C. (2014). Sensate focus: Clarifying the Masters and Johnson's model. *Sexual and Relationship Therapy, 29*(3), 307–319.

Weinstock, J. S. (2004). Lesbian ex-lover relationships: Underestimated, under-theorized and under-valued? *Journal of Lesbian Studies, 8*(3-4), 1–8.

Whitton, S. W., & Buzzella, B. A. (2012). Using relationship education programs with same-sex couples: A preliminary evaluation of program utility and needed modifications. *Marriage & Family Review, 48*, 667–688.

Whitton, S. W., Scott, S. B., Dyar, C., Weitbrecht, E. M., Hutsell, D. W., & Kuryluk, A. D. (2017). Piloting relationship education for female same-sex couples: Results of a small randomized waitlist-control trial. *Journal of Family Psychology, 31*(7), 878–888.

Whitton, S. W., Scott, S. B., & Weitbrecht, E. M. (2017). Participant perceptions of relationship education programs adapted for same-sex couples. *Journal of Couple & Relationship Therapy*, 1–28, https://doi.org/10.1080/15332691.2017.1372835.

Whitton, S. W., Weitbrecht, E. M., Kuryluk, A. D., & Hutsell, D. W. (2016). A randomized waitlist-controlled trial of culturally sensitive relationship education for male same-sex couples. *Journal of Family Psychology, 30*, 763–768.

Whitton, S. W., Weitbrecht, E. M., & Kuryluk, A. D. (2015). Monogamy agreements in male same-sex couples: Associations with relationship quality and individual well-being. *Journal of Couple & Relationship Therapy, 14*(1), 39–63.

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