HHS Public Access

Author manuscript

J Gay Lesbian Ment Health. Author manuscript; available in PMC 2020 January 01.

Published in final edited form as:

J Gay Lesbian Ment Health. 2019 ; 23(1): 63–82. doi:10.1080/19359705.2018.1539428.

Enacted individual-level stigma, anticipated relationship stigma, and negative affect among unpartnered sexual minority individuals

Michael A. Castro, MPH[1], **Lisa Rosenthal, Ph.D.**[2], **Tyrel J. Starks, Ph.D.**[1,3,4]

[1]Center for HIV/AIDS Educational Studies and Training (CHEST), 142 West 36th Street, 9th Floor, New York, NY 10018, USA

[2]Psychology Department, Pace University, 41 Park Row, 13th Floor, Room 1317, New York, NY 10038

[3]Department of Psychology, Hunter College of the City University of New York (CUNY), 695 Park Ave, New York, NY 10065, USA

[4]Doctoral Program in Health Psychology and Clinical Science, The Graduate Center of CUNY, 365 5th Ave, New York, NY 10034, USA

Abstract

Purpose: To examine associations of enacted individual-level stigma and anticipated relationship stigma with negative affect among single sexual minority individuals. We hypothesized that enacted individual-level stigma and anticipated relationship stigma would be positively associated with negative affect. We also explored possible mediation models of how these variables might relate.

Methods: A nation-wide online survey was completed by 154 single sexual minority individuals 18+ years old, measuring enacted individual-level stigma, anticipated relationship stigma, and negative affect.

Results: There were significant, positive bivariate associations of enacted individual-level stigma with anticipated relationship stigma and negative affect. In path model analyses, there was support for enacted individual-level stigma mediating an indirect pathway between anticipated relationship stigma and negative affect, as well as support for enacted individual-level stigma simultaneously predicting anticipated relationship stigma and negative affect.

Conclusions: Findings expand the body of theoretical work examining multidimensional aspects and mechanisms of stigma. Results suggest that while anticipated relationship stigma is not directly associated with negative affect among single sexual minority individuals, it may still be relevant for well-being among these individuals through its association with enacted individual-level stigma. Clinicians and public health officials may consider addressing multiple forms of stigma, including both individual-level and relationship-based stigma.

Corresponding author: Tyrel J. Starks, PhD, tel +1 212 206 7919; fax +1 212 206 7994; tstarks@chestnyc.org.

Keywords

sexual minority; relationship stigma; negative affect; enacted individual-level stigma; mental health

INTRODUCTION

Currently 60% of adults in the U.S. agree that marriages between same-sex couples should be recognized by the law (McCarthy, 2015), and in June 2015 the Supreme Court ruled in favor of the legality of same-sex marriages across the country (McGill, 2015). Despite this public support and legal recognition of same-sex couples, stigmatization of same-sex couples and sexual minority individuals (persons who identify as gay, lesbian, bisexual, or queer) persists. Hatzenbuehler, Phelan, and Link (2013) define stigma as involving the co-occurrence of possessing a socially devalued attribute or identity and the experiences that result from that at the intrapersonal (e.g., internalized homophobia), interpersonal (e.g., experiences of discrimination based on sexual orientation), and structural (e.g., institutional policies that systematically privilege heterosexual individuals) levels, such as stereotyping, marginalization, and discrimination.

Hatzenbuehler et al. (2013) also argue, and much evidence supports, that stigma is a fundamental cause of health disparities that adversely affects the physical and mental well-being of stigmatized individuals. Stigma exerts this effect through various processes of stress, isolation, reduced resources, and unhealthy responses. Specific to sexual minority individuals, (Meyer, 1995) suggests that minority stressors, including internalized stigma (i.e., direction of negative societal attitudes about sexual minority individuals toward the self; internalized homophobia/homonegativity), anticipated stigma (i.e., expectations of rejection and discrimination based on one's sexual orientation; rejection-sensitivity), and enacted stigma (i.e., actual experiences of unfair treatment and violence due to one's sexual orientation; discrimination) each independently have adverse effects on a variety of mental health outcomes. Supporting these conceptualizations, much research has linked these different forms of stigma attributed to a variety of identities or social group memberships to a range of poorer mental and physical health outcomes (e.g., Chaudoir, Earnshaw, & Andel, 2013; Link & Phelan, 2006; Meyer, 1995; Paradies, 2006; Pascoe & Smart Richman, 2009; Williams & Mohammed, 2009). Much work has specifically found that stigma experienced by sexual minority individuals is associated with poorer mental and physical health outcomes, with for example longitudinal evidence that victimization specific to one's sexual identity explains disparities between sexual minority and heterosexual youth in depressive symptoms and suicidality (Burton, Marshal, Chisolm, Sucato, & Friedman, 2013), as well as meta-analytic evidence that internalized stigma among sexual minority individuals is associated with greater internalizing mental health issues (Newcomb & Mustanski, 2010).

The majority of research on stigma has focused on stigma directed at an individual due to one's individual identities or social group memberships (i.e., individual-level stigma), and much of that research has focused specifically on enacted individual-level stigma, or individual-level discrimination (e.g., see Pascoe & Smart Richman, 2009; Williams &

Mohammed, 2009 for reviews). However recent theory and research indicate that in addition to individual-level stigma, people in societally stigmatized relationships (e.g., same-sex, interracial, age-gap relationships) experience unique relationship stigma (or couple-level minority stress), or stigma directed at a couple due to societal devaluation of the type of romantic relationship (Frost, 2011; Frost et al., 2017; Gamarel, Reisner, Laurenceau, Nemoto, & Operario, 2014; LeBlanc, Frost, & Wight, 2015; Lehmiller & Agnew, 2006, 2007; Rosenthal & Starks, 2015). This relationship stigma is unique from individual-level stigma, including having unique consequences for outcomes while accounting for individual-level stigma; it can be experienced by individual members of or jointly by the couple; and similar to individual-level stigma can take different forms including internalized, anticipated, and enacted (Frost et al., 2017; Gamarel et al., 2014; LeBlanc et al., 2015; Rosenthal & Starks, 2015).

The small but growing body of research on relationship stigma has mostly focused on enacted relationship stigma and its consequences for relationship functioning. Specifically, enacted relationship stigma has been associated with lower relationship commitment (Lehmiller & Agnew, 2006, 2007; Rosenthal & Starks, 2015), relationship quality (Gamarel et al., 2014), trust, love, and sexual communication (Rosenthal & Starks, 2015). Additionally, enacted relationship stigma has been connected to lower intimacy and satisfaction, as well as to greater relationship conflict (Frost, 2011). Further, those who experience greater enacted relationship stigma have been found to be more likely to experience relationship dissolution (Lehmiller & Agnew, 2007). The little research that has explored the connection between relationship stigma and mental health has found evidence of adverse consequences. Specifically, enacted relationship stigma has been associated with greater anxiety and depressive symptoms (AUTHORS, revision under review; Gamarel et al., 2014). More research on mental health consequences of relationship stigma is needed.

As reviewed, although some research has identified that relationship stigma can be anticipated (e.g., Frost et al., 2017), most research in this area has focused on enacted relationship stigma. And, research on relationship stigma has exclusively focused on couples or individuals already in committed romantic relationships. Yet, relationship stigma could be anticipated by an individual who is single (e.g., expecting that if one were to enter into a potential same-sex relationship, one would experience stigma targeting the relationship), with potential consequences for that individual, including for mental health. Although this has never been tested, research on anticipated stigma in other domains suggests that anticipated relationship stigma could also adversely affect the mental health of sexual minority individuals who are single. For example, Starks, Rendina, Breslow, Parsons, and Golub (2013) found that the anticipation of being stigmatized if they were to contract HIV in the future was positively associated with depressive symptoms even among men who were HIV negative. Thus, it is plausible that anticipation of a future relationship being stigmatized could adversely affect the well-being of single sexual minority individuals.

The purpose of the current study was to examine patterns of associations among anticipated relationship stigma, enacted individual-level stigma, and negative affect in a sample of single sexual minority individuals. We hypothesized that both anticipated relationship stigma and enacted individual-level stigma would be positively associated with negative affect. Further,

given past evidence that different forms of stigma or stigma mechanisms are associated with each other and sometimes mediate each other's associations with other outcomes (e.g., Trub, Quinlan, Starks, & Rosenthal, 2017), we also explored three different possible models of how these variables might relate to each other in order to contribute to our understanding of stigma processes and mechanisms. Specifically, we explored whether anticipated relationship stigma might mediate the association of enacted individual-level stigma with negative affect, whether enacted individual-level stigma might mediate the association of anticipated relationship stigma with negative affect, or whether enacted individual-level stigma might simultaneously predict anticipated relationship stigma and negative affect. Understanding these dynamics can contribute to stigma theory, guide future research, and inform stigma-focused interventions.

METHODS

Participants

A total of 854 individuals responded to recruitment messages and followed the study link to register and complete a preliminary eligibility screener for the larger study. Based upon responses to the brief eligibility survey, 541 (63.3%) of the initial respondents were at least 18 years old, not currently in a relationship, reporting U.S. residence, and able to complete the survey in English. Of these, 535 (98.9%) started the baseline survey and 327 (62.6%) completed it. Among complete responses, 274 (87.8%) reported a U.S. residence; 172 (62.8%) U.S. residents identified as male and 99 (36.1%) identified as female. Due to their small number and because transgender individuals may experience additional forms of discrimination on the basis of being outside of the gender binary which may also meaningfully shape their anticipated relationship outcomes, the three respondents who identified as transgender were removed from subsequent analyses. Eligibility for the current investigation, a secondary analysis, was limited to individuals who identified as cisgender men or women 18 years of age or older and also reported 1) sexual minority self-identification (i.e., gay, lesbian, bisexual, queer), and 2) HIV-negative sero-status (confirmed by at least one test in the past 5 years for sexual minority men). HIV positive individuals experience a unique additional source of stigma specifically related to being HIV positive therefore HIV status may meaningfully impact individual's decisions and expectancies about relationship related factors as well, thus they were excluded from the current analysis and warrant a separate study. Among cis-gender identified participants, 157 (92.3%) men and 32 (32.3%) women identified as gay/lesbian or bisexual. Among gay and bisexual men, 122 (77.7%) reported a negative HIV status based upon an HIV test in the previous 5 years and were retained in the analytic sample for this study along with the 32 women who identified as gay/lesbian or bisexual (N_{final} = 154). All procedures were approved by the Institutional Review Board of [BLINDED FOR REVIEW].

Procedures

These data are taken from a larger study, which focused on correlates of sexual behavior and drug use among unpartnered individuals. Specifically, the study examined how expectancies about relationships are associated with these outcomes. Data were collected online between March and May 2014, via *ProofPilot*, an internet survey host. Participants were recruited

online through Huffington Post and social networking sites, and incentivized snowball sampling. Participants who referred someone to the study received a promotional code that could be redeemed for a small discount at an online vendor (approximate value ranged between $1.00 and $10.00). Materials contained study contact information and a direct link to the survey platform.

The study link directed participants to the *ProofPilot* survey platform. Potential participants created a password-protected user account and provided demographic information that could be utilized to determine preliminary eligibility. Participants who were preliminarily eligible (those who were 18 years of age or older, reported they were not currently in a relationship, U.S. residence, and indicated they were able to communicate in English) were given the option to view detailed consent information and enroll. Participants viewed consent information on the initial survey screen. Participants indicated their consent by clicking a button, which then advanced them to the survey. Those who did not wish to continue clicked an alternative button, which directed them to a screen thanking them for their time. Similar to the recruitment incentive, participants received a promotional code that could be redeemed for a discount (approximate value ranged between $1.00 and $10.00) at an online vendor upon completion.

Measures

Demographic characteristics—Participants reported their gender, sexual identity, date of birth, racial identity, and level of education. To determine eligibility, HIV status was assessed using two questions. The first question asked when the participant was most recently tested for HIV. The second asked what the result of this HIV test was. Sexual minority men were classified as HIV negative if they reported a test in the past 5 years and the result was HIV negative. Sexual minority women were classified as HIV negative if they reported a negative test result or stated that they had never been tested for HIV. This approach to designating HIV status is commensurate with the level of risk in these respective populations, as rates of HIV among sexual minority women are dramatically lower compared to that of sexual minority men. In a study of 708 lesbian and bisexual women, it was found that most STIs are very unlikely to be passed from women to women, and further there were no reported cases of HIV transmission in this sample (Bailey, Farquhar, Owen, & Mangtani, 2004) .

Enacted individual-level stigma—Participants' experiences with enacted individual-level stigma were assessed using, the 9-item version of the Everyday Discrimination Scale (Williams, Yu, Jackson, & Anderson, 1997), which also included an additional item that asks people to make one or more attributions (e.g., race, gender, sexual orientation, etc.) for their reported experiences (e.g., Seng, Lopez, Sperlich, Hamama, & Meldrum, 2012). The scale demonstrated good internal reliability (Cronbach's α = .88). The scale has a theoretical range of 9 to 52, and higher scores indicate more frequent experiences of enacted individual-level stigma. Participants indicated the frequency of each item on a Likert-type scale from 1 (*never)* to 6 (*almost every day*). The scale asked participants about how often they felt discriminated against in different aspects of their life (e.g., "You are called names or insulted" and "You are treated with less respect than other people are").

Anticipated relationship stigma—Participants' anticipated relationship stigma was assessed using a modified 6-item version of the Lehmiller and Agnew (2006) 4-item marginalization scale (Rosenthal & Starks, 2015). The 6-item marginalization scale was adjusted to separate out stigma from friends and family into different items, and was also adapted to include the word 'would' because the original measure was intended to measure stigma directed at people in relationships (i.e., couples), while in this study we were assessing anticipation of relationship stigma among single individuals. The adapted measure demonstrated good internal reliability (Cronbach's α = .81). The scale has a theoretical range of 6 to 30, and higher scores indicate greater anticipated relationship stigma. Participants indicated their level of agreement with each item on a Likert-type scale from 1 (*strongly disagree*) to 5 (*strongly agree*). The scale evaluated participants' feelings about how others would view, react, and respond to their romantic relationships (e.g., "I believe that most people would generally disapprove of my romantic relationships").

Negative affect—Participants answered 5 questions from the Center for Epidemiological Studies Depression Scale that have been shown to comprise a latent factor assessing negative affect (J. C. Cole, Rabin, Smith, & Kaufman, 2004; Radloff, 1977). The scale demonstrated good internal reliability (Cronbach's α = .87). The scale has a theoretical range of 5 to 25, and higher scores indicate greater negative affect. Participants indicated the frequency at which they felt each item over the past two weeks (e.g., "I felt depressed," and "I had crying spells") on a Likert-type scale from 1 (*not at all, less than 1 day per week*) to 5 (*nearly every day for two weeks*).

Analytic Plan—Bivariate associations among demographic variables, negative affect, enacted individual-level stigma, and anticipated relationship stigma were evaluated using measures of bivariate association matched to variable distributions. Hypothesized associations and exploratory models were tested using path modeling procedures in Mplus version 7.3, and maximum likelihood estimation was employed in all models to facilitate the use of bootstrapping tests of indirect associations. The effect of missing race data was evaluated by re-running models using full information maximum likelihood estimation. Conclusions were unchanged. In an initial model, the ultimate endogenous variable – negative affect – was regressed on enacted individual-level stigma, anticipated relationship stigma, gender, age, and race. In turn, anticipated relationship stigma was regressed on enacted individual-level stigma, gender, age, and race. Subsequently, enacted individual-level stigma was regressed on anticipated relationship stigma, gender, age and race. In a final model, enacted individual-level stigma simultaneously predicted both negative affect and anticipated relationship stigma, controlling for age, gender, and race as covariates. In this latter model, negative affect and enacted individual-level stigma were permitted to correlate. Gender, age, and race were included in the models because previous research suggests there are established differences in outcomes, specifically depression, based on these demographic variables. Exploratory analyses related to indirect associations were tested using a bootstrapping tests approach with 5,000 bootstrapping draws. Follow-up analyses examined the utility of education level as an additional covariate. Education did not contribute significantly to the prediction of endogenous variables in any model, and the significance of other model parameters was unchanged by its inclusion.

RESULTS

Demographic data for the sample are in Table 1. The average age of respondents was 32.2 years (*SD* = 10.8 years). The majority of the sample was White (66.9%), self-identified as gay (79.6%), and had earned at least a four year college degree (65.6%). The sample was evenly dispersed across the country, with 28.6% residing in the Northeast, 17.3% residing in the Pacific region, 26.6% residing in the Southern region, and 17.5% residing in the Midwest.

Bivariate associations

Table 2 displays results of tests of bivariate associations. Negative affect was positively associated with enacted individual-level stigma, and men reported significantly lower negative affect scores than women. Enacted individual-level stigma was positively associated with anticipated relationship stigma, and negatively associated with age. Men also reported significantly lower enacted individual-level stigma compared to women. Anticipated relationship stigma was significantly associated with race, such that White participants reported lower anticipated relationship stigma compared to participants of color.

Path model results

An initial model was calculated to test hypotheses about the direct associations of enacted individual-level stigma and anticipated relationship stigma with negative affect. As described above, this path model also examined the indirect association of enacted individual-level stigma with negative affect through anticipated relationship stigma. Associations among constructs of primary interest in the model are depicted in Figure 1. Table 3 contains coefficients for all modeled parameters included in the path model.

Hypotheses about direct associations were partially supported. Enacted individual-level stigma was significantly positively associated with negative affect; however, the direct association of anticipated relationship stigma with negative affect was non-significant. In turn, anticipated relationship stigma was significantly positively associated with enacted individual-level stigma. In addition, age and male gender identity were negatively associated with enacted individual-level stigma. Finally, race was significantly associated with anticipated relationship stigma. White participants had lower anticipated relationship stigma compared to participants of color. Age and gender were unrelated to anticipated relationship stigma. Finally, while enacted individual-level stigma was significantly associated with anticipated relationship stigma, the absence of a direct association between anticipated relationship stigma and negative affect precluded the possibility of a significant indirect pathway from enacted individual-level stigma to negative affect through anticipated relationship stigma.

A subsequent exploratory equivalent model was calculated to test whether anticipated relationship stigma might be indirectly associated with negative affect through enacted individual-level stigma. This model is depicted in Figure 2. Table 4 contains coefficients for all parameters included in the model. Through this exploratory mediation analyses it was found that the indirect association of anticipated relationship stigma with negative affect

through enacted individual-level stigma was statistically significant (B = .05; 95% CI: 0.00, 0.10; β=.06; p = .05).

In a final model, enacted individual-level stigma simultaneously predicted anticipated relationship stigma and negative affect. Associations among constructs of primary interest in this model are depicted in Figure 3. After controlling for gender, age, and race, enacted individual-level stigma was significantly associated with both negative affect (B = 0.17; 95% CI: 0.07, 0.26; β = .31; $p \leq .01$) and anticipated relationship stigma (B = 0.12; 95% CI: 0.02, 0.26; β = .20; $p \leq .01$).

DISCUSSION

This study extends the growing literature on relationship stigma by examining for the first time the association between anticipated relationship stigma and negative affect among single sexual minority individuals. Contrary to hypotheses, anticipated relationship stigma was not directly associated with negative affect. However, consistent with hypotheses, enacted individual-level stigma was directly positively associated with negative affect. Enacted individual-level stigma and anticipated relationship stigma were also positively associated. Further, exploratory model testing supported two different models: one in which anticipated relationship stigma was indirectly associated with negative affect through its association with greater enacted individual-level stigma, and one in which enacted individual-level stigma simultaneously predicted anticipated relationship stigma and negative affect. The model in which enacted individual-level stigma was indirectly associated with negative affect through anticipated relationship stigma was not supported. These are cross-sectional findings, and therefore we cannot establish the temporal order of effects necessary to draw causal conclusions. However, these findings provide some insight into more or less plausible models of how these variables relate to each other.

Findings are inconsistent with past research that has found enacted relationship stigma to have direct negative consequences for the mental health of those in marginalized relationships, including those in same-sex relationships (AUTHORS, revision under review; Gamarel et al., 2014). The current investigation is distinct from those past studies in that it explored anticipated rather than enacted relationship stigma among single rather than partnered individuals, which may explain the discrepancy. This may suggest that anticipated relationship stigma is not as relevant to well-being as enacted relationship stigma, or that any form of relationship stigma is not as relevant to the well-being of single individuals as it is to that of partnered individuals. However, the pattern of findings could also suggest that the psychological anticipation of experiencing stigma directed at a potential relationship is still relevant for sexual minority individuals who are not in relationships.

The first supported model is consistent with anticipated relationship stigma being indirectly associated with negative affect through enacted individual-level stigma, suggesting that anticipated relationship stigma may play a relevant, albeit indirect, role in negative affect. One possible explanation for this model is that the anticipation of stigma directed at one's potential same-sex relationship may enhance sensitivity to or awareness of experiences of enacted individual-stigma, which in turn is associated with negative affect. The second

supported model is consistent with enacted individual-level stigma more simply simultaneously predicting both anticipated relationship stigma and negative affect. This is also meaningful because if enacted individual-level stigma increases anticipated relationship stigma, this can result in fear and avoidance of partnering itself. Research has consistently found that being in a well-functioning relationship is associated with better psychological health (Bookwala & Schulz, 1996; Bradburn, 1969; Gove, 1973; Gove, Hughes, & Style, 1983; Tucker, Friedman, Wingard, & Schwartz, 1996). More recently, Wight, LeBlanc, and Lee Badgett (2013) examined psychological distress among self-identified sexual minority individuals and found that legally married sexual minority individuals were significantly less distressed than those in non-legally recognized relationships. Thus, single individuals who are both experiencing greater enacted individual-level stigma and therefore anticipate greater relationship stigma might be prevented from reaping these benefits of well-functioning romantic relationships that have the potential to be protective of their well-being. Based on this possibility, an interesting direction for future research is to examine if sexual minority individuals anticipating greater relationship stigma are more likely to avoid romantic relationships, and if this then in turn has consequences for well-being.

This study adds to the growing body of theoretical and empirical work exploring the dynamics of stigma. Stigma is known to be experienced in different forms or through different mechanisms (e.g., internalized, anticipated, enacted) and at multiple levels (e.g., individual, structural) (Hatzenbuehler et al., 2013). Across these forms and levels, most of this work focuses on stigma that is directed at an individual based on an identity or social group membership. However, there is now a growing body of theory and research on stigma directed at relationships due to societal stigma of certain types of relationships, referred to as relationship stigma or couple-level minority stress (Frost, 2011; Frost et al., 2017; Gamarel et al., 2014; LeBlanc et al., 2015; Lehmiller & Agnew, 2006, 2007; Rosenthal & Starks, 2015). This study adds to this growing body of research, suggesting that anticipated stigma directed at the sort of relationships sexual minority individuals might form in the future is not directly associated with negative affect, but is directly associated with enacted experiences of stigma directed at them as individuals, which is in turn associated with negative affect.

A demographic association of interest also emerged in analyses. White participants reported lower anticipated relationship stigma than participants of color. This finding is consistent with other findings that for example Black individuals tend to disapprove of sexual minority relationships more strongly than White individuals (Lewis, 2003). This may increase the likelihood that Black participants experience interpersonal interactions that instill expectancies that their romantic relationships would be viewed as unacceptable to members of their communities.

Clinical Implications

It is well established that sexual minority individuals experience more depression and anxiety than their heterosexual counterparts, and with recent advances in LGBT affirmative mental health treatments (Pachankis, Hatzenbuehler, Rendina, Safren, & Parsons, 2015) these findings should serve to orient clinicians to the importance of expectations for

romantic relationships, even for sexual minority individuals who are single. When exploring experiences of stigma and rejection with these clients, clinicians may find it useful to also assess the messages clients have received about the acceptability of their relationships. Stigma directed at the sorts of relationships these individuals might form may indirectly be relevant to experiences of negative affect, even if they choose not to engage in such relationships. Furthermore, receiving negative messages about the acceptability of their potential relationships may impair the ability of sexual minority individuals to engage in relationships successfully, making relevant social skills training a potentially useful component of intervention.

Limitations

These findings should be viewed in light of several limitations. These self-reported, cross-sectional data were collected from a sample of HIV-negative, well educated, and mostly White, single sexual minority individuals across the U.S., which may limit generalizability to other populations. In particular, this sample's experiences may reflect its relatively privileged status in society compared to sexual minority individuals who also face other forms of stigma and disadvantage related to socioeconomic status, race, and other characteristics. This could have resulted in less enacted individual-level stigma and anticipated relationship stigma than might have been found in another sample facing more forms of stigma. For example, individuals living with HIV face an additional burden of HIV-related stigma from both society and potential relationship partners (Mahajan et al., 2008; Smit et al., 2012). Other forms of stigma add additional layers of stigmatization to an already complex model, therefore research comparing more diverse samples would be beneficial. Furthermore "single" individuals are not necessarily a homogenous group, and variation in dating behavior and intentions (e.g., relationship seeking, sexually active, casually dating, etc.) may exist that could affect variables studied, such as anticipated relationship stigma. Future studies should assess and examine whether there are differences between people with different dating behaviors and intentions in their anticipated relationship stigma. This study utilized a brief measure of negative affect, which may have limited associations found with this variable. Although this measure has been used in previous studies, a more robust measure of depression would provide useful information about symptom-specific associations.

Further, the measure used in the current study is best viewed as assessing anticipation of interpersonal forms of relationship stigma. Relationship stigma may also be internalized or enacted based on past relationships among single individuals, and relationship stigma can be experienced at other levels, such as structurally, none of which were explored in the current investigation. Future studies should examine how these multiple forms and levels of relationship stigma may interact with one another and with individual-level stigma to determine negative affect and other outcomes for sexual minority individuals. The anticipated relationship stigma measure also has not been psychometrically validated in the current form, which could have limited associations found with this variable; however, the original measure was developed to reflect both approval and disapproval of one's relationship, and findings suggested that marginalized groups (e.g., same-sex couples, interracial couples, and couples with a 10 or more year age difference) perceived

significantly greater marginalization than their non-marginalized counterparts (Lehmiller & Agnew, 2006). The current study's use of the measure is novel in assessing anticipation of these issues, particularly among single individuals, and the utility of this form of the measure deserves more attention in future research.

Finally, while this study examined enacted individual-level stigma, its measurement was not specific to a single stigmatized identity or attribute. Rather, the items assessed enacted individual-level stigma or discrimination due to any reason, and then participants could choose one or more attributions for those experiences. Thus, the enacted individual-level stigma assessed was not necessarily due specifically or only to one's sexual orientation, which could be considered a limitation and may have led to different findings than if a sexual orientation specific measure had been used. However, as intersectionality theory suggests and increasing research using an intersectional framework supports, people often experience multiple intersecting forms of stigma, which are connected to interlocking systems of oppression, that cannot be disentangled from each other (e.g., E. R. Cole, 2009; Crenshaw, 1989; Earnshaw et al., 2018; Guy-Sheftall, 1995; Hill Collins, 2000; Rosenthal, 2016). When facing stigma, it is not always clear the reasons for it, and sometimes stigma is unique to the intersection of multiple identities (e.g., Rosenthal & Lobel, 2018). Future work might want to test if findings replicate using a more specific measure of sexual orientation-based discrimination. Further, this was not a study of intersectionality, but findings suggest the value of exploring more in-depth individuals' dynamic and complex intersecting identities, the stigma that comes along with them, and its consequences.

Conclusions

Although attitudes and legislation toward sexual minority individuals and same-sex couples have become more positive, stigma toward these individuals and couples still exists. Findings from this study expand a growing body of literature on relationship stigma, exploring the consequences of anticipation of this specific form of stigmatization for single sexual minority individuals. In this sample of single, sexual minority individuals, anticipated relationship stigma was not directly associated with negative affect, but it was indirectly linked to negative affect through its association with enacted individual-level stigma. More research is needed on how anticipated relationship stigma interacts with enacted individual-level stigma and the mechanisms through which it may impact those who are not yet in a relationship.

Acknowledgements

Data collection was funded through a scholarly research award from Pace University. Data analysis was supported in part by a National Institute on Drug Abuse grant (R34 DA036419; PI Starks). The authors would like to acknowledge the contributions of the *ProofPilot* team, including Mathew Amsden, Lochlan McHale, and David Sperber. They would also like to acknowledge the study's media partner, *the Huffington Post*, especially Noah Michelson. Special thanks also to Julia Bassiri, Jennifer Kierce, Lucio Forte and Storey Day.

REFERENCES

AUTHORS. (revision under review) Relationship stigma and well-being among adults in interracial and same-sex relationships. Social and Personal Relationships.

Bailey JV, Farquhar C, Owen C, & Mangtani P (2004). Sexually transmitted infections in women who have sex with women. Sexually Transmitted Infections, 80(3), 244–246. [PubMed: 15170014]

Bookwala J, & Schulz R (1996). Spousal similarity in subjective well-being: the Cardiovascular Health Study. Psychology and Aging, 11(4), 582. [PubMed: 9000291]

Bradburn NM (1969). The structure of psychological well-being.

Burton CM, Marshal MP, Chisolm DJ, Sucato GS, & Friedman MS (2013). Sexual Minority-Related Victimization as a Mediator of Mental Health Disparities in Sexual Minority Youth: A Longitudinal Analysis. Journal of Youth and Adolescence, 42(3), 394–402. doi:10.1007/s10964-012-9901-5 [PubMed: 23292751]

Chaudoir SR, Earnshaw VA, & Andel S (2013). "Discredited" versus "discreditable": understanding how shared and unique stigma mechanisms affect psychological and physical health disparities. Basic and Applied Social Psychology, 35(1), 75–87. [PubMed: 23729948]

Cole ER (2009). Intersectionality and research in psychology. American Psychologist, 64(3), 170. [PubMed: 19348518]

Cole JC, Rabin AS, Smith TL, & Kaufman AS (2004). Development and validation of a Rasch-derived CES-D short form. Psychological Assessment, 16(4), 360–372. [PubMed: 15584795]

Crenshaw K (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. U. Chi. Legal F, 139.

Earnshaw VA, Rosenthal L, Gilstad-Hayden K, Carroll-Scott A, Kershaw TS, Santilli A, & Ickovics JR (2018). Intersectional experiences of discrimination in a low-resource urban community: An exploratory latent class analysis. Journal of Community & Applied Social Psychology, 28(2), 80–93.

Frost DM (2011). Stigma and intimacy in same-sex relationships: a narrative approach. Journal of Family Psychology, 25(1), 1. [PubMed: 21355641]

Frost DM, LeBlanc AJ, 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. [PubMed: 29172770]

Gamarel KE, Reisner SL, Laurenceau JP, Nemoto T, & Operario D (2014). Gender minority stress, mental health, and relationship quality: A dyadic investigation of transgender women and their cisgender male partners. Journal of Family Psychology, 28(4), 437. [PubMed: 24932942]

Gove WR (1973). Sex, marital status, and mortality. American journal of sociology, 79(1), 45–67.

Gove WR, Hughes M, & Style CB (1983). Does marriage have positive effects on the psychological well-being of the individual? Journal of Health and Social Behavior, 122–131. [PubMed: 6886367]

Guy-Sheftall B (1995). Words of fire: An anthology of African-American feminist thought: The New Press.

Hatzenbuehler ML, Phelan JC, & Link BG (2013). Stigma as a fundamental cause of population health inequalities. American Journal of Public Health, 103(5), 813–821. [PubMed: 23488505]

Hill Collins P (2000). Black feminist thought : knowledge, consciousness, and the politics of empowerment. Retrieved from http://www.taylorfrancis.com/books/9780203900055

LeBlanc AJ, Frost DM, & Wight RG (2015). Minority Stress and Stress Proliferation Among Same-Sex and Other Marginalized Couples. Journal of Marriage and Family, 77(1), 40–59. [PubMed: 25663713]

Lehmiller JJ, & Agnew CR (2006). Marginalized relationships: The impact of social disapproval on romantic relationship commitment. Personality and Social Psychology Bulletin, 32(1), 40–51. [PubMed: 16317187]

Lehmiller JJ, & Agnew CR (2007). Perceived marginalization and the prediction of romantic relationship stability. Journal of Marriage and Family, 69(4), 1036–1049.

Lewis GB (2003). Black-white differences in attitudes toward homosexuality and gay rights. Public Opinion Quarterly, 67(1), 59–78.

Link BG, & Phelan JC (2006). Stigma and its public health implications. The Lancet, 367(9509), 528–529.

Mahajan AP, Sayles JN, Patel VA, Remien RH, Ortiz D, Szekeres G, & Coates TJ (2008). Stigma in the HIV/AIDS epidemic: a review of the literature and recommendations for the way forward. AIDS (London, England), 22(Suppl 2), S67.

McCarthy J (2015). Record-high 60% of Americans support same-sex marriage. Gallup Social Issues.

McGill N (2015). Supreme Court ruling on ACA to have long-lasting health impact: APHA applauds same-sex marriage rule. The Nation's Health, 45(6), 8–8.

Meyer IH (1995). Minority stress and mental health in gay men. Journal of Health and Social Behavior, 36(1), 38–56. [PubMed: 7738327]

Newcomb ME, & Mustanski BS (2010). Internalized homophobia and internalizing mental health problems: A meta-analytic review. Clinical Psychology Review, 30(8), 1019–1029. [PubMed: 20708315]

Pachankis JE, Hatzenbuehler ML, Rendina HJ, Safren SA, & Parsons JT (2015). LGB-Affirmative Cognitive-Behavioral Therapy for Young Adult Gay and Bisexual Men: A Randomized Controlled Trial of a Transdiagnostic Minority Stress Approach. Journal of Consulting and Clinical Psychology, 83(5), 875–889. doi:10.1037/ccp0000037 [PubMed: 26147563]

Paradies Y (2006). A systematic review of empirical research on self-reported racism and health. International Journal of Epidemiology, 35(4), 888–901. [PubMed: 16585055]

Pascoe EA, & Smart Richman L (2009). Perceived discrimination and health: a meta-analytic review. Psychological Bulletin, 135(4), 531. [PubMed: 19586161]

Radloff LS (1977). The CES-D scale: A self report depression scale for research in the general population. Applied psychological measurement, 1(3), 385–401.

Rosenthal L (2016). Incorporating intersectionality into psychology: An opportunity to promote social justice and equity. American Psychologist, 71(6), 474. [PubMed: 27571527]

Rosenthal L, & Lobel M (2018). Gendered racism and the sexual and reproductive health of Black and Latina Women. Ethnicity & health, 1–26.

Rosenthal L, & Starks TJ (2015). Relationship stigma and relationship outcomes in interracial and same-sex relationships: Examination of sources and buffers. Journal of Family Psychology, 29(6), 818–830. [PubMed: 26121534]

Seng JS, Lopez WD, Sperlich M, Hamama L, & Meldrum CDR (2012). Marginalized identities, discrimination burden, and mental health: Empirical exploration of an interpersonal-level approach to modeling intersectionality. Social Science & Medicine, 75(12), 2437–2445. [PubMed: 23089613]

Smit PJ, Brady M, Carter M, Fernandes R, Lamore L, Meulbroek M, … Rockstroh JK (2012). HIV-related stigma within communities of gay men: a literature review. AIDS Care, 24(4), 405–412. doi:10.1080/09540121.2011.613910 [PubMed: 22117138]

Starks TJ, Rendina HJ, Breslow AS, Parsons JT, & Golub SA (2013). The psychological cost of anticipating HIV stigma for HIV-negative gay and bisexual men. AIDS and Behavior, 17(8), 2732–2741. doi:10.1007/s10461-013-0425-0 [PubMed: 23420102]

Trub L, Quinlan E, Starks TJ, & Rosenthal L (2017). Discrimination, Internalized Homonegativity, and Attitudes Toward Children of Same-Sex Parents: Can Secure Attachment Buffer Against Stigma Internalization? Family Process, 56(3), 701–715. [PubMed: 27718220]

Tucker JS, Friedman HS, Wingard DL, & Schwartz JE (1996). Marital history at midlife as a predictor of longevity: alternative explanations to the protective effect of marriage. Health Psychology, 15(2), 94. [PubMed: 8681925]

Wight RG, LeBlanc AJ, & Lee Badgett MV (2013). Same-sex legal marriage and psychological well-being: findings from the California Health Interview Survey. American Journal of Public Health, 103(2), 339–346. [PubMed: 23237155]

Williams DR, & Mohammed SA (2009). Discrimination and racial disparities in health: evidence and needed research. Journal Of Behavioral Medicine, 32(1), 20–47. [PubMed: 19030981]

Williams DR, Yu Y, Jackson JS, & Anderson NB (1997). Racial differences in physical and mental health socio-economic status, stress and discrimination. Journal of Health Psychology, 2(3), 335–351. [PubMed: 22013026]

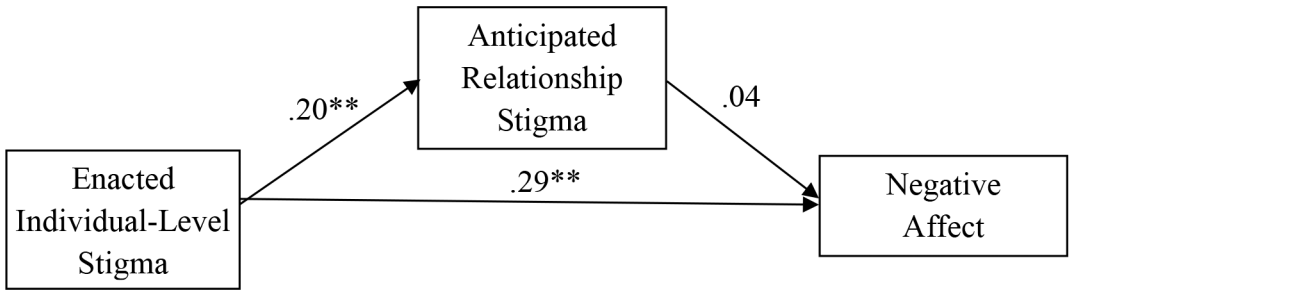

Figure 1.

Indirect pathway from enacted individual-level stigma to negative affect through anticipated relationship stigma.

NOTE: Standardized path coefficients (β) are displayed; $^{**}p \leq .01$

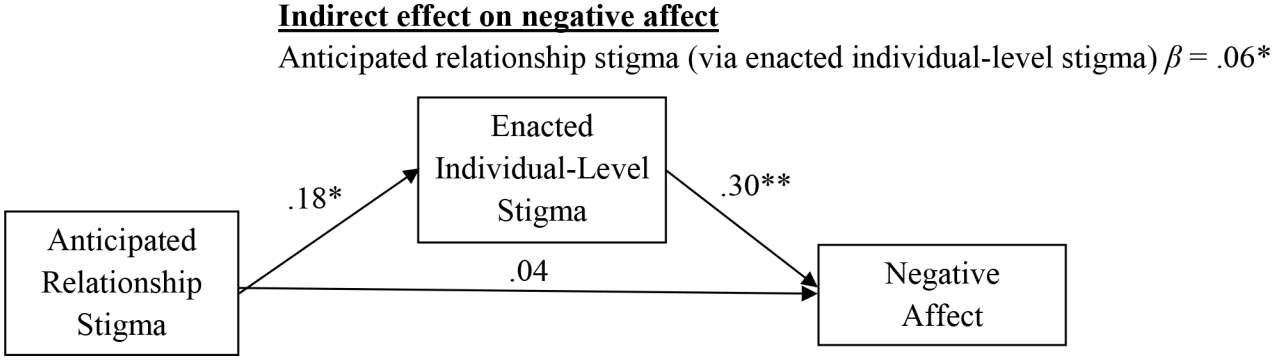

Figure 2.

Indirect pathway from anticipated relationship stigma to negative affect through enacted individual-level stigma.

NOTE: Standardized path coefficients (β) are displayed; *$p \leq .05$; **$p \leq .01$

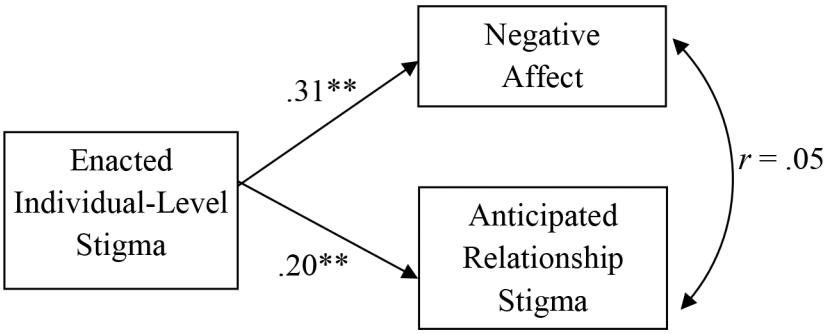

Figure 3.

Enacted individual-level stigma as a simultaneous predictor of negative affect and anticipated relationship stigma.

NOTE: Standardized path coefficients (β) are displayed; $^{**}p \leq .01$

Table 1.

Demographics

Overall	**154 (100.0)**
Sex	
Male	122 (79.2)
Female	32 (20.8)
Sexual Orientation	
Gay	117 (79.6)
Bisexual	22 (15.0)
Queer/Uncertain/other	15 (9.7)
Race	
White	101 (66.9)
African American	16 (10.0)
Latino	15 (9.4)
Other	10 (6.3)
Completed College	
Less than four years	53 (34.4)
4 or more years	101 (65.6)
Region	
Northeastern	44 (28.6)
Midwestern	27 (17.5)
Southern	41 (26.6)
Pacific	42 (27.3)
	M (SD)
Age	32.2 (10.8)

Table 2.

Bivariate Associations

	1	2	3	4	5	6	*M (SD)*
1. Negative affect (range 5–25)	-	-	-	-	-	-	9.3 (4.10)
2. Enacted individual-level stigma (range 6–27)	.31**	-	-	-	-	-	20.3 (7.75)
3. Anticipated relationship stigma (range 9–52)	.10	.23**	-	-	-	-	14.0 (4.54)
4. Age (range 19–66)	.00	−.29**	−.11	-	-	-	32.2 (10.8)
							referent n (%)
5. Race (ref: non-white)	.04	−.04	−.23**	.07	-	-	53 (34.4)
6. Education (ref: < 4 yr degree)	−.15	−.11	−.12	.08	.09	-	53 (34.4)
7. Gender (ref: female)	−.17*	−.27**	−.10	.16	.05	0.13	32 (20.8)

NOTE: actual range is listed in the table;

* $p < .05$;

** $p < .01$

Table 3.

Indirect effect of enacted individual-level stigma on negative affect through anticipated relationship stigma: Model parameters

	Negative affect R^2 = .11			Anticipated relationship stigma R^2 = .11			Enacted individual-level stigma R^2 = .13		
	B	95% CI	β	B	95% CI	β	B	95% CI	β
Enacted individual-level stigma	0.16**	(0.06, 0.26)	.30	0.12**	(0.03, 0.21)	.20	--	--	--
Anticipated relationship stigma	0.04	(−0.13, 0.22)	.05	--	--	--	--	--	--
Gender (ref = female)	−1.00	(−3.05, 1.05)	−.10	−0.33	(−2.10, 1.44)	.03	−4.28**	(−6.39, −1.28)	−.23
Age	0.04	(−0.03, 0.11)	.11	−0.01	(−0.08, 0.05)	−.03	−0.18**	(−0.28, −0.09)	−.26
Race (ref = non-white)	0.49	(−1.08, 2.06)	.06	−2.18**	(−3.75, −0.60)	−.22	−0.33	(−3.02, 2.36)	−.02

NOTE: *B* = unstandardized regression coefficient; *β* = standardized regression coefficient;

** $p \leq .01$.

Table 4.

Indirect effect of anticipated relationship stigma on negative affect through enacted individual-level stigma: Model parameters

	Negative Affect R^2 = .11			Enacted individual-level stigma R^2 = .07			Anticipated relationship stigma R^2 = .17		
	B	**95% CI**	***β***	**B**	**95% CI**	***β***	**B**	**95% CI**	***β***
Enacted individual-level stigma	0.16**	(0.06, 0.26)	.30	--	--	--	--	--	--
Anticipated relationship stigma	0.04	(−0.13, 0.22)	.05	0.31*	(0.06, 0.56)	.18	--	--	--
Gender (ref = female)	−1.00	(−3.05, 1.05)	−.10	−4.02**	(−6.98, −1.06)	−.21	−0.83	(−2.58, 0.92)	−.07
Age	0.04	(−0.03, 0.11)	.11	−0.17**	(−0.27, −0.08)	−.24	−0.04	(−0.09, 0.02)	−.08
Race (ref = non-white)	0.52	(−1.08, 2.06)	.06	0.36	(−2.37, 3.10)	.02	−2.22**	(−3.82, −0.61)	−.23

NOTE: *B* = unstandardized regression coefficient; *β* = standardized regression coefficient;

* $p \leq .05$;

** $p \leq .01$.