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BRIEF REPORT

Associations Between Relationship Quality and Depressive Symptoms in Same-Sex Couples

Sarah W. Whitton and Amanda D. Kuryluk
University of Cincinnati

Extending research based on different-sex (i.e., heterosexual) couples, the authors explored associations between romantic relationship quality and depressive symptoms in a geographically diverse sample (N = 571) of U.S. adults in same-sex relationships. The authors also examined whether this association was moderated by individual characteristics (gender, age, and internalized heterosexism) or relationship factors (relationship length, commitment, and interdependence). Results indicated a moderate negative association between relationship quality and depressive symptoms, echoing findings from different-sex couples. This association was not moderated by gender, age, internalized heterosexism, or relationship length. In contrast, commitment and interdependence did demonstrate moderating effects. Although the negative association between relationship quality and depressive symptoms was present at all levels of commitment and interdependence, it was amplified at higher commitment and interdependence levels. In general, findings contribute to a growing literature suggesting many commonalities between same-sex and opposite sex couples. Specifically, they suggest the importance of relationship quality to the emotional well-being of LGBT adults, supporting clinical interventions and social policies that promote healthy and stable same-sex relationships.

Keywords: couple relationships, depressive symptoms, same-sex couples, LGBT

There is a well-established association between romantic relationship distress and depression (reviewed by Whisman & Baucom, 2012). Compared with individuals in high-quality relationships, those who report lower relationship quality tend to have higher concurrent (Whisman, 2001) and future depressive symptom levels (e.g., Beach, Katz, Kim, & Brody, 2003; Whisman & Uebelacker, 2009). These findings have had important theoretical implications, supporting interpersonal theories of psychopathology (e.g., Beach, Sandeen, & O'Leary, 1990) that emphasize the central role of intimate relationships in the development and maintenance of mental health problems. Clinically, this body of research has led to the development of effective couple-based treatments for depression, which aim to reduce depressive symptoms by improving the quality of the couple relationship (Whisman & Beach, 2012).

A major limitation of the existing literature is that it focuses almost exclusively on relationships between men and women, without attention to or sampling of same-sex relationships. This is unfortunate, given that same-sex couples represent a sizable minority of U.S. couples; nearly 650,000 committed same-sex couples live in the United States, representing about 6 in every 1,000 households (Gates, 2013; Gates & Cooke, 2013). Further, lesbian, gay, bisexual, and transgender (LGBT) adults, who live in a societal context of stigma and discrimination (Herek, Gillis, & Cogan, 2009), experience disproportionately high rates of mental health problems, including depression (Lewis, 2009). There is a need to identify predictors of depression among sexual minority adults, which might prove to be valuable targets of interventions to prevent or treat depression and thereby reduce these mental health disparities. Relationship-based predictors hold particular promise in this regard, as around one third of self-identified gay men and 50%–60% of lesbian women are currently involved in a cohabiting romantic relationship (Carpenter & Gates, 2008), and 92% of lesbian and 82% of gay youth expect to be in a long-term relationship as adults (D'Augelli, Rendina, & Sinclair, 2007).

There is some reason to expect that the links between relationship quality and depressive symptoms observed in different-sex (i.e., heterosexual) couples will also be observed in same-sex couples. In general, research shows more similarity than differences across couple type. Average levels of relationship quality, assessed with various indices, do not differ (Peplau & Fingerhut, 2007), and processes predictive of couple outcomes appear generally consistent (Kurdek, 2005) across same-sex and different-sex couples. However, as the field of family psychology begins to build our knowledge about same-sex relationships, it is important that this knowledge not be based entirely on a heteronormative framework or findings from heterosexual samples. As highlighted

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Sarah W. Whitton and Amanda D. Kuryluk, Psychology Department, University of Cincinnati.

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Correspondence concerning this article should be addressed to Sarah W. Whitton, Psychology Department, University of Cincinnati, Cincinnati, OH 45221-0376. E-mail: sarah.whitton@uc.edu

by ecological systems theory (Bronfenbrenner, 1979), individuals and their close relationships are influenced by the attitudes and ideologies of broader culture. The current social climate, which stigmatizes same-sex attractions and sexual behavior, leads to fundamental differences in the relationship experiences of sexual minority individuals compared with heterosexual individuals. Individuals in same-sex couples face unique stressors, including discrimination, rejection by loved ones, invalidation of their relationships, and pressures to conceal their identity or relationship (Meyer, 2003). As one example, most same-sex couples in the United States do not have access to legal marriage, which in June 2014 is prohibited in 31 states. Consequently, only around one third of cohabiting same-sex couples have a legally recognized relationship (Gates, 2013), though many of the unmarried couples would marry if they could (Reczek, Elliott, & Umberson, 2009). This factor may lead to differences between same-sex and different-sex couples in the association between relationship quality and depression; to date this association has been primarily documented within heterosexual marriage and, in some samples, has not been observed among unmarried different-sex cohabiting couples (Uebelacker & Whisman, 2006).

The primary aim of this study was to assess the association between relationship quality and depressive symptoms in a sample of adults in same-sex couples. The second aim was to explore whether particular individual characteristics (gender, age, and internalized heterosexism) and relationship factors (relationship length, commitment, and interdependence) might moderate this association. An important goal of current research on the interplay between intimate partnerships and mental health is to identify such moderators to determine which individuals are most at risk for depressive reactions to relationship distress (Whisman, 2001).

We selected potential moderators to evaluate based on existing research and relevant theory. We examined *gender* because meta-analyses indicate that, among married individuals, the cross-sectional correlation between relationship quality and depressive symptoms is stronger for women than for men (Proulx, Helms, & Buehler, 2007; Whisman, 2001). More generally, women are at greater risk than men for depressive reactions to interpersonal difficulties (Kendler, Thornton, & Prescott, 2001) and view relationship success as more central to their self-concepts (e.g., Cross & Madson, 1997). Because women's vulnerability to depression is theorized to largely result from gender roles within heterosexual relationships that can disempower women in relation to their male partners (e.g., Jack, 1991), it is unclear whether this vulnerability would also be present within same-sex couples. We also evaluated *age* as a moderator. In two samples of married heterosexual couples, the association between marital satisfaction and depressive symptoms was smaller at younger ages (Bookwala & Jacobs, 2004; Whisman, 2007), possibly because adults tend to have fewer social interaction partners as they grow older, increasing their emotional dependence on their spouses (Carstensen, 1992). *Internalized heterosexism*, the negative feelings that sexual minorities may feel toward their own sexuality as a consequence of living in a heterosexist society, has been linked with elevated depressive symptoms (Herek et al., 2009) and lower relationship quality (Frost & Meyer, 2009). We hypothesized that internalized heterosexism may also increase the association between relationship quality and depressive symptoms; based in the diathesis–stress model of psychopathology, we expected individuals high in internalized heterosexism may be at risk for depression partly because they are more sensitive to potential depressive effects of stressors such as relationship discord.

We also investigated how characteristics of the relationship may influence links between relationship quality and depressive symptoms. We explored *relationship length* as a moderator, based on previous findings that the association between different-sex relationship quality and depressive symptoms may be stronger in shorter, versus longer, marriages (Proulx et al., 2007; Whitton, Stanley, Markman, & Baucom, 2008). According to interdependence-based theories (e.g., Rusbult, 1980), relationships can be characterized by level of *commitment*, defined as one's intention and desire to maintain the relationship long term, and *interdependence* between partners, defined as the extent to which each partner depends on or needs the relationship. Individuals who are more committed to and dependent on their relationships may experience relationship discord as more distressing because the perceived costs of the relationship ending are higher (Rusbult, 1980, 1983). Indeed, in a sample of young adults in predominantly heterosexual dating relationships, the concurrent association between relationship quality and depressive symptoms was stronger at higher levels of relationship interdependence and commitment (Whitton & Kuryluk, 2012). We hypothesized that relationship length, commitment, and interdependence would show similar moderating effects among same-sex couples.

Method

Participants and Procedure

Participants were 571 individuals (62% women) who volunteered to take part in a larger, IRB-approved study of same-sex relationship development from April to November 2012. Inclusion criteria were age ≥18 years and current involvement in a committed, cohabiting relationship (of ≥6 months) with a same-sex partner. Participants were recruited through e-mail Listserv, website postings, and events for LGBT organizations. The online survey included an informed consent document and several measures of relationship and individual characteristics. Of the 718 participants who completed the survey, 110 participants were excluded from analyses because their partner had already completed the survey, to retain independence of data. An additional 37 participants were excluded because they did not complete the measure of depressive symptoms, leading to a final sample size of 571. Compared with the excluded participants, the final sample had longer relationships, $t(604) = -1.99$, $p < .05$, but did not differ on any other demographic variable (i.e., gender, race, ethnicity, age, or income).

In the present sample, 62.2% of participants identified as female, 35.7% as male, and 2.1% ($n = 12$) as "gender queer" or gave no response. Participants were primarily White (86.5%, 1.4% Black or African American, 1.4% Asian, 5.3% multiracial, 2.3% Native American, and 6.7% Hispanic) and an average of 40.9 ($SD = 12.0$) years old. The sample was demographically similar to all U.S. same-sex couple households (52% female, 85% White, 10% Hispanic, M age = 47.8 years; U.S. Census Bureau, 2012), but was slightly younger and included more women. Participants lived in 45 different U.S. states and Puerto Rico; 17.7% in the Northeast, 28.4% in the Midwest, 37.7% in the South, and 15.9% in the West. Median annual personal income was in the $40,000 to

$49,999 range. Most (88.4%) participants self-identified as gay or lesbian; 7.9% identified as bisexual and 2.8% as queer. Around one third of participants (27.8%) had formalized their relationships through a legal ceremony. Median relationship length was in the 7-8 year range.

Measures

Demographic and relationship information. Participants provided self-reports of individual characteristics, including self-identified gender and sexual orientation, race, ethnicity, age, income, state of residence, and relationship length and legal status. States were categorized into regions (Northeast, West, South, Midwest) as defined by the U.S. Census Bureau.

Depressive symptomatology. Depressive symptoms were assessed using the 20-item Center for Epidemiological Studies—Depression Scale (CES–D; Radloff, 1977), which sums participants' ratings of how often they experienced each of 20 depressive symptoms in the past week (e.g., "I felt sad") on a 4-point scale, ranging from 0 (*rarely or none of the time*) to 3 (*most or all of the time*). The CES–D has shown evidence of reliability and validity (Eaton & Kessler, 1981). In this sample, internal consistency was excellent ($\alpha = .91$).

Relationship quality. Using the four-item Couples Satisfaction Index (CSI-4; Funk & Rogge, 2007), participants provided global evaluations of their romantic relationship; for example, "Please indicate the degree of happiness, all things considered, of your relationship" (0 = *extremely unhappy;* 6 = *perfect*) and "In general, how satisfied are you with your relationship?" (0 = *not at all*; 5 = *completely*). The CSI-4, which has demonstrated good reliability and validity, provides more precision and power than traditional measures of relationship quality (Funk & Rogge, 2007). In this sample, internal consistency was good ($\alpha = .84$).

Commitment. Participants completed a three-item version of the Commitment Inventory—Dedication subscale (Stanley & Markman, 1992), used previously in large survey research (Stanley, Rhoades, Amato, Markman, & Johnson, 2010). Participants rated their level of agreement with three statements (e.g., "My relationship with my partner is more important to me than almost anything in my life") on a 7-point scale, ranging from 1 (*disagree completely*) to 7 (*agree completely*). The three-item Dedication scale has demonstrated high levels of internal consistency and validity (Stanley et al., 2010). Internal consistency for this sample was acceptable ($\alpha = .76$).

Interdependence. The five-item Quality of Alternatives subscale of the Investment Model Scale (Rusbult, Martz, & Agnew, 1998) measures the degree to which one's needs could be fulfilled in relationships other than that with the current partner (e.g., "If I weren't dating my partner, I would do fine—I would find another appealing person to date"). Scores represent the mean rating on a 7-point scale, ranging from 1 (*disagree completely*) to 7 (*agree completely*) across items, reverse-scored so higher scores reflect more interdependence. The Investment Model Scale has shown good internal consistency previously (e.g., Rusbult et al., 1998) and in this sample ($\alpha = .81$).

Internalized heterosexism. Using the seven-item Sexual Identity Distress Scale (SID; Wright & Perry, 2006), participants rated their agreement with statements describing how they think and feel about their sexual orientation (e.g., "For the most part, I enjoy being gay/lesbian/bisexual") on a 5-point scale, ranging from 1 (*strongly agree*) to 5 (*strongly disagree*). Items were summed after four items were reverse-scored so that higher scores represented more internalized heterosexism. The SID has demonstrated good internal consistency and evidence of construct validity (Wright & Perry, 2006). In this sample, internal consistency was good ($\alpha = .85$).

Results

All analyses were conducted using PASW Statistics 18. Means, standard deviations, and zero-order correlations among all variables are presented in Table 1. Preliminary analyses to assess the need to control for demographic factors revealed that depressive symptoms were higher among non-White participants than White participants and positively associated with age and income ($ps < .01$). Therefore, all hypothesis tests were run controlling for race and income. Gender and age, evaluated as moderators themselves, were also controlled in analyses examining other variables.

Consistent with hypotheses, a negative association between relationship quality and depressive symptoms was revealed, $r = -.33$, $p < .001$. To ensure that this association could not be accounted for by demographic variables, we regressed depressive symptoms first on gender, age, race, and income and then onto relationship quality. In this model, relationship quality predicted an additional 11% of variance in depression, beyond that accounted for by demographic factors, $F(1, 516) = 71.02$, $p < .001$.

Next, we assessed whether each of the individual (gender, age, internalized heterosexism) and relationship variables (relationship

Table 1
Correlations, Means, and Standard Deviations Among Variables

Variable	*M*	*SD*	Range	1	2	3	4	5	6	7	8
1. Depressive symptoms	9.25	8.98	0–55	—							
2. Relationship satisfaction	16.99	3.29	3–21	−.33**	—						
3. Gender (male = 0; female = 1)	.64	.48	0–1	−.01	.11*	—					
4. Age	40.91	12.01	18–74	−.13**	−.01	−.14**	—				
5. Internalized heterosexism	11.23	4.43	7–35	.14**	−.12**	−.01	−.12**	—			
6. Relationship length	4.45	1.65	1–6	−.07	.02	−.05	.52**	−.04	—		
7. Commitment	6.25	.96	1.67–7	−.19**	.61**	.00	.13**	−.09*	.19**	—	
8. Interdependence	5.31	1.24	1–7	−.14**	.36**	.23**	.07	−.02	.08	.42**	—

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

length, commitment, and interdependence) moderated the association between relationship quality and depressive symptoms and tested for gender differences in the moderating effects. We ran hierarchical regressions to test for interactions among relationship quality, each potential moderator, and gender in the prediction of depressive symptoms. Interaction terms were created by multiplying centered variables (Aiken & West, 1991). Initially, demographic controls were entered at Step 1; relationship quality, gender, and the potential moderator at Step 2; the three two-way interactions at Step 3; and the three-way interaction (i.e., Relationship Quality × Gender × Potential Moderator) at Step 4. None of the three-way interactions were significant, indicating that no moderating effects differed by gender, and none of the two-way Gender × Potential Moderator interactions were significant. Therefore, for simplicity, we present the models including only the two-way relationship Quality × Potential Moderator interactions (see Table 2).

Results indicated that only commitment and interdependence interacted with relationship quality in the prediction of depressive symptoms. Simple slopes analysis revealed a negative association between relationship quality and depressive symptoms regardless of level of commitment. The association was stronger, however, for those with high commitment (1 *SD* above the mean), $\beta = -.41$, $p < .001$, than for those with low commitment (1 *SD* below the mean), $\beta = -.34$, $p < .001$ (see Figure 1a). Similarly, although there was a negative association between relationship quality and depressive symptoms regardless of interdependence level, the association was stronger for those with high interdependence, $\beta = -.37$, $p < .001$, than for those with low interdependence, $\beta = -.31$, $p < .001$ (see Figure 1b).

Discussion

The present findings indicated a moderate negative association between relationship quality and depressive symptoms among adults in same-sex relationships. Relationship quality accounted for approximately 11% of the variance in depressive symptoms, representing a medium-sized effect similar to that observed in a meta-analysis of cross-sectional associations between heterosexual marital satisfaction and depressive symptoms (Whisman, 2001). Further, results indicate that the association between same-sex relationship quality and depressive symptoms is quite robust. It was not moderated by gender, age, internalized heterosexism, or relationship length, suggesting that higher same-sex relationship quality is associated with fewer depressive symptoms for both men and women, across observed ages (18–74 years), in relationships of different lengths, and for individuals with varying levels of internalized heterosexism. Adults in relationships characterized by more interdependence and commitment did show stronger concurrent links between depression and relationship quality. However, the size of these moderating effects was small, only accounting for an additional 1% of the variance in depression beyond that attributable to the main effect of relationship quality and demographic controls. Further, the simple slopes between relationship quality and depressive symptoms were in the moderate range across interdependence and commitment levels, suggesting that this association is present even for those in relatively uncommitted cohabiting same-sex relationships.

It is interesting that we did not observe a gender difference in the association between relationship quality and depressive symptoms, given that research has generally found the cross-sectional association to be stronger for women than for men (Proulx et al., 2007; Whisman, 2001). We may have failed to detect a true gender difference, especially because those observed in previous studies have been fairly small in magnitude and we had fewer men than women in the sample, reducing power for this analysis. Alternately, it is possible that women whose partners are women are not as vulnerable to depressive reactions to relationship distress as are women whose partners are men, because they are not subject to gender-based inequalities. Lesbian couples, for example, tend to value and practice greater equality in division of labor than do different-sex couples (Patterson et al., 2004). Gender roles, and differences between partners' gender roles, may be more important than gender itself for understanding vulnerability to depression

Table 2
Results of Hierarchical Regression Analysis

	Individual characteristic moderator						Relationship characteristic moderator					
	Gender		Age		Internalized heterosexism		Relationship length		Commitment		Interdependence	
	β	ΔR^2	β	ΔR^2	β	ΔR^2	β	ΔR^2	β	ΔR^2	β	ΔR^2
Step 1		.05***		.05***		.05***		.05***		.05***		.05***
Age	−.05		—		−.04		−.05		−.06		−.06	
Gender	—	.01	.01		.01		.01		.02		.00	
Race	−.14**		−.14**		−.14**		−.13**		−.15***		−.14**	
Income	−.13**		−.13**		−.12**		−.12**		−.13**		−.14**	
Step 2		.13***		.13***		.13***		.13***		.13***		.13***
Relationship quality	−.36***		−.36***		−.34***		−.36***		−.44***		−.38***	
Moderator	.01		−.05		.09*		−.01		.04		.02	
Step 3		.00		.00		.00		.00		.01*		.01*
Relationship Quality × Moderator	.02		.01		−.03		.02		−.14*		−.09*	
Total R^2		.18***		.18***		.19***		.18***		.19***		.19***

Note. Coefficients presented are from final models including all variables; Gender (male = 0; female = 1); Race (0 = other; 1 = White).
* $p < .05$. ** $p < .01$. *** $p < .001$.

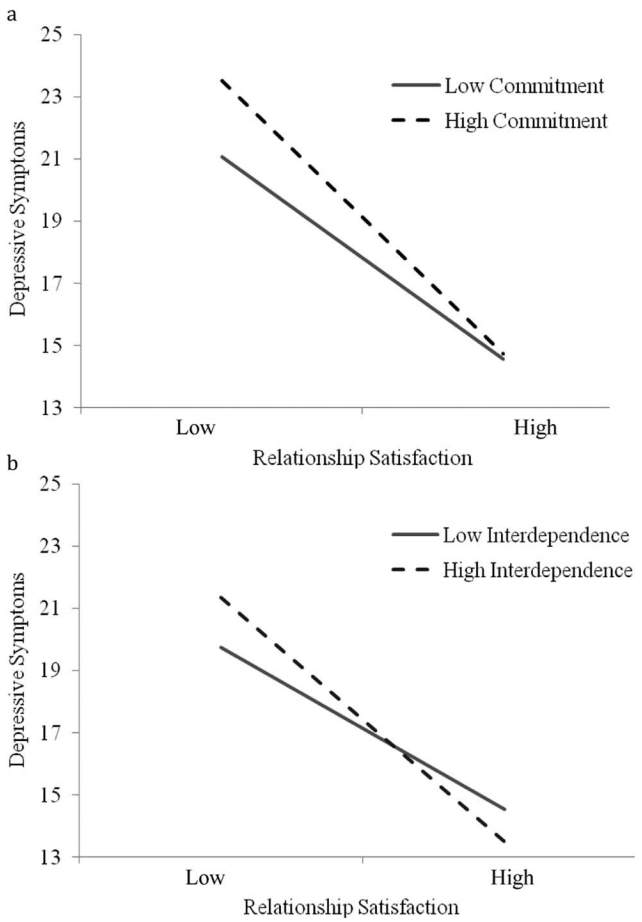

Figure 1. Interaction effects of (a) relationship satisfaction and commitment and (b) relationship satisfaction and interdependence on depressive symptoms. Low and high values are −1 *SD* and 1 *SD* from the mean, respectively. * $p < .05$. ** $p < .01$. *** $p < .001$.

among same-sex couples; future research should explore this possibility.

Study strengths and limitations should be noted. In contrast to between-groups designs comparing same-sex to different-sex couples, the study's within-group design allowed us to identify correlates of depressive symptoms within sexual minority adults, which can inform our understanding of risk and protective factors for LGBT mental health. However, the cross-sectional data prohibit conclusions about direction of effects; although our model emphasizes the influence of relationship quality on depressive symptoms, dysphoric symptoms also can affect relationship quality (Davila, Karney, & Hall, 2003). Analyses did not take into account the partner's relationship satisfaction or depression, which may influence observed associations (Whisman, Uebelacker, & Weinstock, 2004). The geographically diverse sample likely better captured the experience of U.S. same-sex couples than previous samples drawn only from coastal states or large urban areas; however, it was comprised of volunteers recruited online and through LGBT organizations. As a consequence, the sample was likely younger, more educated, connected to the LGBT community, and at lower risk for psychopathology than the general population of U.S. adults in same-sex relationships (Meyer & Wilson, 2009). Our understanding of the links between same-sex couples and depression would be enriched by future studies using other (e.g., probablility, respondent driven) sampling strategies.

Before confident conclusions can be drawn, our findings should be replicated, preferably in longitudinal studies that can discern direction of effects. Nevertheless, the robust association between relationship quality and depressive symptoms observed in this sample highlights the potential importance of intimate relationships to the well-being of LGBT adults. Just as high-quality marriages are beneficial to heterosexual adults' mental and physical health (e.g., Waite & Gallagher, 2000), these findings indicate that stable and happy same-sex relationships may promote psychological well-being among sexual minorities. As such, the results are suggestive that social policies and clinical interventions that promote healthy, stable same-sex relationships may serve to improve the mental health of LGBT individuals. For example, depressed adults in a same-sex partnership may benefit from couple therapy for depression (Whisman & Beach, 2012) and culturally sensitive relationship education programs to prevent couple distress and break-up among same-sex couples (e.g., Whitton et al., 2013) may be one effective intervention to help reduce the disproportionate rates of mental health issues in LGBT individuals.

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