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A Study of the Relationship Between Minority Stress Factors and the Experience of Partner Loss for GLB-Identifying Adults

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A STUDY OF THE RELATIONSHIP BETWEEN MINORITY STRESS FACTORS AND THE EXPERIENCE OF PARTNER LOSS FOR GLB-IDENTIFYING ADULTS

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Abstract

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While grief related to the loss of an intimate partner is expected to be an emotionally distressing experience for anyone, for those who identity as gay, lesbian, or bisexual (GLB), grief associated with the loss of an intimate partner may produce additional stress that complicates the grief process. Based on sexual minority stress theory and the current research on the construct of grief, it was hypothesized that those GLB-identifying individuals who experience higher levels of minority stress (as measured by the minority stress variables of discrimination, harassment, and rejection experiences, internalized homonegativity, and degree of outness) would also experience greater dysfunction and increased levels of grief-specific symptomatology (assessed by outcome scores on the Inventory of Complicated Grief) following the death of the intimate partner. This effect would occur outside of the potential effects of the amount of time since the loss, the nature of the loss, the age of the surviving partner, and if social support was sought. This study was conducted via an anonymous online survey. Participants were 54% male, 87% Caucasian, had a median age range of 54-55. Hierarchical multiple regression (2 steps) was utilized to analyze the data. Sexual minority stress had a significant relationship with the experience of grief for GLB individuals who have experienced the loss of a committed partner. Sexual minority stress demonstrated significant additional influence above the control variables ($\Delta R^2 = .13$). Further analysis revealed the relative influence of each individual variable, with years since loss emerging as the variable with the most

unique influence in the explanation of variance in grief in both steps of the regression model. Limitations, clinical implications, and future research are discussed.

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Chapter 1

Introduction

The loss of an intimate partner is an event experienced by many people. More than two million Americans die in the United States each year, most leaving behind friends, family, and intimate partners who mourn their loss (Silverman & Prigerson, 2002). Given this statistic, it is not difficult to understand how the loss of a committed, intimate partner is one of few life events that most individuals can assume they are likely to experience in the course of their lifespan. Beyond the commonality of this experience, the loss of an intimate partner can be one of the most powerful, painful, and challenging experiences one is faced with. A study conducted by Lunt, Caserta, and Dimond (1993) reported that 72% of participants reported that the death of their spouse was the most stressful experience of their lives. The death of an intimate partner is often coupled with increased psychological distress and physiological difficulties, including greater risk of suicide and death of the surviving partner (Prigerson, Bridge et al., 1999).

While grief associated with major loss is expected to be an emotionally distressing experience for almost anyone, there are specific populations for which this type of major loss has additional components of stress and anxiety (Hatzenbuehler, Nolen-Hoeksema, & Erickson et al., 2008). Doka (1989) discussed the lack of equality and linearity in terms of social reactions to grief, suggesting that how one experiences the social response to his or her grief is informed by a multitude of social factors. For those who identify as Gay, Lesbian, and Bisexual and experience the loss of a committed intimate partner, the stigma related to inclusion in a marginalized minority group can be such a social factor. These stigmatized identities render those who identify as sexual

minorities prone to experience overt prejudice, discrimination, and violence (Hatzenbuehler et al., 2008). The resulting reaction is often a hyper-vigilant expectation of rejection and oppression from one's environment (Hatzenbuehler et al., 2008). Termed minority stress, this phenomenon is understood as the unique, chronic, and socially-based stress that is the result of stigma, discrimination, prejudice, and violence that is present in the lives of minority groups (Meyer, 2003). Considering the adverse impact of minority stress, for those who are members of marginalized minority populations, the loss of an intimate partner can be coupled with non-traditional social consequences, and can further disenfranchise members of this group (Fenge &Fannin, 2009; Green & Grant, 2008). GLB-identifying individuals who have lost an intimate partner may not have had their loss socially validated by those in their social circles or communities, may have been prevented from planning or attending the funeral or other end of life rituals, and may not have received the end of life benefits (insurance policies, access to the estate) that traditionally is understood as being a right in heterosexual partnerships (Fenge & Fannin, 2009).

Unique stressors such as these can complicate the grieving or bereavement process, and might contribute to both its longevity and intensity. Specifically for those who identify as GLB, the risk of negative impact due to sexual (minority) stress during the process of grieving might result in what researchers have termed disenfranchised, or "gay" grief (Fenge & Fannin, 2009). Understanding that grief and bereavement are not universally standard processes, but might be better conceptualized as unique and heavily influenced by co-occurring social influences, is crucial to appreciating grief in the lives of those who identify as GLB (Green & Grant, 2008). However, the relevant literature

relating grief and sexual identity is focused on the experiences of gay men losing a partner or friend to HIV/AIDS (Green & Grant, 2008). Because of the lack of empirical attention given to others who are sexual minorities who lose their partner in ways unrelated to HIV/AIDS, it is important to consider how minority status may influence the experience of grief and bereavement for GLB-identifying adults. Thus the focus of this study was to expand the knowledge base of intimate partner loss among those who identify as GLB, with particular focus on how minority stress factors influence the experience of grief and bereavement.

Grieving the Loss of an Intimate Partner

Currently in Western cultures, the psychological concept of grief is understood as the emotional reaction to the loss of a loved one, characterized by sadness, longing, sorrow, despair, and anguish (Granek, 2010). The loss of an intimate partner and the subsequent experience of grief is one of the few life events that is common to many adults. Common grief reactions included within the realm of the normal, uncomplicated grief experience may include a subset of the following: yearning for the lost person, preoccupation with the deceased, dreams or illusions involving the deceased, sighing, crying, anger, searching for the lost loved one, anxiety, sadness, despair, protesting the death, insomnia, fatigue, lethargy, loss of interest in previously enjoyed activities, emotional numbness, nightmares, inability to accept the loss, and the loss of a sense of meaning (Jacobs, 1999).

While there are a plethora of symptoms associated with grief and bereavement, some suggest that there are a few fundamental qualities that underlie the experience of major loss (Prigerson et al., 1995). One of the core components of grief seems to be a

constellation of symptoms termed separation anxiety, or separation stress (Silverman & Prigerson, 2002). Theoretically grounded in the work of attachment theory, separation anxiety in the context of major loss can trigger alarm, anxiety, and insecurity when the attachment object (deceased person) is lost (van Doorn, Kasl, Berry, & Prigerson, 1998). Psychological symptoms include episodes of intense longing, preoccupation with thoughts of the lost person, crying, and even dreams or hallucinations of the deceased. Behaviorally, these often manifest as searching for the lost person by visiting places they frequented in life or waiting for the deceased to return (Silverman & Prigerson, 2002).

A second core element of the grief experience is traumatic distress. Horowitz (1997) describes the experience of traumatic distress as consisting of two parts. The first, intrusive fears of the event reoccurring emerge as frightening thoughts, illusions, hypervigilance, startle reactions, and feelings of helplessness. The second element is characterized by actively avoiding thoughts of the loss, and includes denial of the death, detachment from the environment, emotional numbing, and avoidance of any objects or places that might cause troubling memories of the traumatic event to resurface. The combination of these two factors (separation and traumatic distress) forms the foundation for a unique understanding of grief that is exclusive of other closely related mental health symptomatology, such as anxiety, depression, and adjustment (Prigerson, Frank et al., 1995). This new, exclusive conceptualization of grief also informed the development of Prolonged Grief Disorder (PGD), a psychological diagnosis proposed for inclusion in the DSM-V (Prigerson, Horowitz et al., 2009).

Considering the problems associated with general loss, studies suggest that the grief associated specifically with losing a spouse is one of the most serious threats to

mental health and well-being that individuals encounter during their lifetime (Stroebe & Schut, 1999). For those who experience the loss of a spouse, some of the most problematic elements of grief are the remaining spouse's continued emotional involvement with the deceased, adjusting to the loss, and the meaning-making process that occurs following such a monumental change (Carnelley, Wortman, Bolger, & Burke, 2006). For example, Bonanno et al. (2004) found that frequent, intensive thinking about one's lost spouse (at times up to 4 times per day 18 months post-loss) was quite common, and those who think about their lost spouse more often demonstrate the worst adjustment to their loss. Additionally, the loss of a spouse can challenge what Janoff-Bulman (1992) suggested are core beliefs about our internal selves- namely, that the world is benevolent, and that what happens to us is logical. When these core beliefs are shattered due to such a major loss, and the surviving spouse fails to reconstruct the meaning of the loss in a positive way, the result can often be poor adjustment and psychological distress (Davis, Nolen-Hoeksema, & Larson, 1998).

Although the loss of a spouse can be an emotionally distressing experience from a general perspective, there are specific populations for which the death of a spouse can result in additional stress and anxiety. Individuals in marginalized social groups experience additional layers of psychological distress as a function of an attribute that distinguishes them (e.g., race, socioeconomic status, sexual orientation). Specifically for those who identify as gay, lesbian, or bisexual (GLB), grief associated with the loss of an intimate partner may produce additional stress and/or anxiety that complicate and prolong the grief process (Almack, Seymour, & Bellamy, 2010).

Sexual Minority Stress

Sexual minorities have an extensive history of marginalization and oppression (Fenge & Fannin, 2009). Even in academia, it was not until 1973 that homosexuality was declassified as a mental disorder (Meyer, 2003). Although aimed at destigmatizing this group, some argue that homosexuality was linked to pathology even after declassification, resulting with many in the social sciences continuing to associate sexual minority status with the presence of mental illness (Meyer, 2003). Recent research focused on understanding the mental health of the GLB population supports this idea, suggesting that those who do identify as sexual minorities are at increased risk of experiencing higher rates of psychological distress. Rates of substance abuse, affective disorders, and suicide attempts are higher among those who identify as GLB compared to heterosexual groups (Cochran, 2001; Gilman et al., 2001; Herrell et al., 1999; Sandfort, de Graaf, Bijl, & Schnabel, 2001). To explain this relationship (and to counter the historical causal linkage between homosexuality and mental illness), some social scientists attribute the occurrence of this phenomenon to the increased levels of stigma, prejudice, and discrimination present in the lives of GLB individuals (Friedman, 1999). These stressors combine to create a distressing social environment that can potentially lead to the increased frequency of mental distress (Friedman, 1999).

The stress associated with occupying a marginalized space in society, termed minority stress, is a critical factor to consider when conceptualizing the lived experience of those who identify as GLB (Meyer, 2003). The minority stress model posits that members of a stigmatized minority group experience both overt and subtle systemic oppression that often manifests in the forms of prejudice, discrimination, and violence

(Hatzenbuehler et al., 2008). Theoretically, the underlying assumptions of the minority stress model indicate that the stressors must be unique (additive to the general amount experienced by all people), chronic (stressors that are stable and related to social structures or systems), and socially based (stressors that are related to underlying dynamics of social processes, institutions, or constructions) (Meyer, 2003).

Therefore, the heightened prevalence of psychological distress and other issues such as substance abuse among sexual minorities is argued to be the result of the stress associated with having a sexual minority status (Hatzenbuehler et al., 2008; Meyer, 2003). Other potential risks for sexual minorities according to the research on social stress include discriminatory events, expectations of rejection, and internalized homonegativity (Hatzenbuehler et al., 2008; Meyer, 2003).

Due to the social consequences of occupying a marginalized space in society, it seems likely that the effects of minority stress influence or complicate the normal process of grieving the loss of an intimate partner for a GLB individual. The following section details how minority stress may impact the experience of partner loss for a gay, lesbian, or bisexual individual.

The GLB Grief Experience

The loss of a spouse or close intimate friend and the grieving process that is expected as a result in heterosexual relationships is deemed acceptable and sanctioned by society (Green & Grant, 2008). Conversely, due to the social rejection of same-sex relationships and the systemic distaste for non-heteronormative life choices, GLB individuals who lose a partner may not be afforded the same social grieving allowances to which their heterosexual counterparts are granted (Bevan & Thompson, 2003).

Historically, embedded in some social discourse is the notion that those who identify as GLB are conceptualized as "other," namely, as a threat to traditional heteronormative family values, as well as a group who does not conform to the universal standard of heterosexuality (Fenge & Fannin, 2009). Subsequently, as a result of this social discourse, many may regard same-sex relationships as essentially inferior and lacking the necessary components of a true intimate relationship. Because of such socially systemic marginalization, losing a partner as a GLB-identified individual is a stigmatized loss. Due to the lack of social value attached to same-sex partnerships, many may not consider a GLB major loss as great or significant as the loss of a spouse in a heterosexual relationship (Bevan & Thompson, 2003; Green & Grant, 2008). Thus, the grief experience for GLB identifying individuals is socially unacknowledged and discredited, resulting in what researchers have termed "disenfranchised grief" (Bevan & Thompson, 2003).

"Gay Grief." Grief can be conceptualized as a socially constructed concept, in which the rules governing normative behavior and social expectations can vary greatly from culture to culture (Schwartzberg, 1992). Given the way in which western society marginalizes the GLB community, characteristics such as social invisibility, overt discrimination, and inequality of rights likely renders the grief experience qualitatively differently for those who identify as GLB. Termed "gay grief," this experience is characterized by the aspects of coping with a major loss that is related to one's sexual identity (Schwartzberg, 1992). Doka (1989) recognized the occurrence of this hidden phenomenon in socially marginalized groups. Because the decreased value and relatively lower importance with which society gauges same-sex partner loss, a GLB-identified

individual may not receive the same social validation as a heterosexual counterpart (Fenge & Fannin, 2009). The primary difficulties related to losing a partner while entrenched in the predominant context of the heterosexual world primarily include the surviving partner feeling that his or her grief experience is illegitimate, and that he or she does not have the inherent right to mourn, and, as a result, potentially expose vulnerabilities and difficulties in bereavement, adaptation, and mental and emotional distress (Fenge & Fannin, 2009).

A principal long-term clinical risk of disenfranchised grief is identification with a sense of disempowerment (Kim, 2009). When a surviving partner adopts the idea that he or she is not worthy of the human right to grieve a meaningful relationship, he or she may develop an internalized sense of inferior citizenship (Green & Grant, 2008). The surviving partner may feel that he or she does not belong to the greater society any longer because fundamental human rights have not been protected or sanctioned. The grieving partner may then experience stress related to the lack of community support, comfort, and acceptance that are important during times of major loss (Kim, 2009). He or she may feel alone, isolated, and invalidated- ultimately adding stress and anxiety and complicating the experience of grief (Bevan & Thompson, 2003; Ferge & Fannin, 2009).

Statement of the Problem

Research suggests that the stress associated with occupying a marginalized space in society is often associated with increased levels of psychological distress (Doka, 1989; Fenge & Fannin, 2009; Hatzenbuehler et al., 2008). The literature on grief also suggests that bereavement is one of the most difficult experiences human beings endure throughout their lifespans (Lund et al., 1993; Stroebe & Schut, 1999). However, little is

known about how those who identify as a minority experience the grief process. The major purpose of this study was to explore how the experience of major loss, defined as the death of a committed partner, and the subsequent grief process might be affected by the experience of minority stress factors. Specifically, is the experience of minority stress (stress manifested as a result of harassment, discrimination, internalized homonegativity, and social knowledge of sexual orientation or "outness"), related to problems in grieving?

Research Question and Hypotheses

The current study examined the relationship between occupying a marginalized space in society and problematic grieving. Specifically, does the experience of minority stress impact the grieving process for those who identify as gay, lesbian, or bisexual? After controlling for the potential effects of the age of the surviving partner, the length of time post-loss, the nature of the death, and the presence of social support, it was hypothesized that those GLB-identifying individuals who experience higher levels of minority stress (as measured by the minority stress variables of discrimination, harassment, and rejection experiences, internalized homonegativity, and degree of outness) will also experience greater dysfunction and increased levels of grief-specific symptomatology (assessed by the outcome score on the Inventory of Complicated Grief) following the death of the intimate partner.

Significance of study

Grieving the loss of a committed, intimate partner is a challenging life circumstance that commonly results in increased levels of psychological distress for the surviving partner. For those who identify as GLB, the stress associated with occupying a marginalized space in society can result in additive layers of psychological distress in the

bereavement experience. Given that most research on the relationship between grief and loss and sexual identity has been limited to gay men who have lost a partner or friend specifically to HIV/AIDS, and that some researchers suggest current grief models may be inadequate for understanding this construct for those who identify as GLB, additional research focusing on this relationship is needed.

Chapter 2

Literature Review

The focus of this study is on the effects of minority stress on the grief experience for those who identify as gay, lesbian, or bisexual (GLB) who have lost a committed, intimate partner. It has been suggested that the loss of a partner or spouse is one of the most universal and most painful life events one can experience (Fenge & Fannin, 2009). For those who identify as GLB, the stress associated with identifying as a member of a marginalized group may further complicate the experience of major loss. In these cases, psychological distress typical during the experience of grief and bereavement may be compounded by minority stress components; specifically, the additive stressors discrimination, harassment, social rejection, internalized homonegativity, and monitoring others' knowledge of their sexual orientation on losing a committed, intimate partner (Balsam, Molina, Beadnell, Simoni, & Walters, 2011; Hatzenbuehler et al., 2008). This chapter will discuss the nature of the typical grief and bereavement process, the components and effects of minority stress in the lives of those who identify as GLB, and conclude by combining features of both in consideration of the "GLB grief experience."

Grieving

Grief and the experience of major loss is one of the few rites of passages in the lives of human beings that is common to all cultures throughout history (Granek, 2010). It is thought that bereavement, or the state that characterizes the grieving response, is a universal, ubiquitous experience that most individuals encounter at some point in their lifetime (Shear & Shair, 2005). As a psychological concept, grief can be understood as the emotional reaction to bereavement, or the death of a significant loved one (Granek,

2010; Smith, Kalus, Russell, & Skinner, 2009). Although it may be generally accepted that one's own grief experience is unique and dependent upon personal characteristics (such as circumstances surrounding death, one's coping style, previous grief experiences, spirituality/religiosity, and concurrent life stressors), historically, the normal grief experience is thought to be typically characterized by painful affectual states such as sadness, longing, sorrow, and anguish (Breen & O'Connor, 2007; Granek, 2010) and to follow the general pattern of a marked increase in depression and other negative affectual states that gradually decrease over time. The grief response is considered to be a normal, healthy, and necessary reaction that helps us to cope with major loss (Shear, 2012).

Like the ubiquitous experience of bereavement itself, the process of grief has evolved and has come to be known both in the scientific literature and popular culture as a stage process, whereby the griever passes through predicted, order phases characterized by an intrinsic state. Elisabeth Kubler-Ross's seminal work (1970) on death and dying is credited with the inception of the grief stage model, beginning with denial and isolation and progressing through anger, bargaining, depression, and ultimately, acceptance. It is believed that Kubler-Ross's stage model originally was meant to describe the process of death acceptance for the dying, and somehow, over time, became generalized as a grieving process for the bereaved. More recently, the field of psychology has become skeptical of such a generalized model for grieving, suggesting that it is asocial and intrapsychic, and does not account for the complexities of individual variance or contextual variables (Hagman, 2001). Shear and Mulhare (2008) suggest that adjustment to the loss of a loved one occurs in a vacillating pattern, alternating between confrontation with the painful reality and avoidance and denial (numbing). When

numbing, the bereaved may focus on positive memories, an imagined reunion, or other neutral thoughts that bring emotional comfort. This oscillating between periods of disbelief and periods of acknowledgement suggest that a discrete, predictable stage model may be insufficient and inappropriate in understanding the process of grieving (Shear & Mulhare, 2008).

Empirical studies of other types of grieving patterns not adherent to the classic stage model are becoming increasingly present in the literature (Bonnano et al., 2002). Recent studies propose alterative courses of grief, including delayed onset, absence of negative affect (resiliency), and the chronic presence of symptoms (complicated grief). A study conducted by Bonnano et al. (2002) focusing on many different patterns and trajectories of grief revealed that grief reactions can be understood along a continuum, ranging from resilient reactions to complicated, problematic grief reactions. What many in the social science disciplines believe is the "common" or typical grief experience was the least frequently endorsed (10.7% of sample) when compared to the other grieving patterns. This normative pattern is characterized by an acutely felt loss, mild depression and some difficulty concentrating, frequent thoughts of the loved one, and uncertainty about the future. However, the key feature of normative grief that sets it apart from complicated grief is that gradually, the loss is successfully integrated into the survivor's life. Interestingly, the most common (45.9% of sample) was a resilient pattern of grieving. Even though mourners of this type felt that the loss was difficult, they were ultimately able to adjust and make meaning of the event. Resilient grieving is further indicated by relatively stable or low-depression affect, relatively rapid acceptance of the loss, and quickly accommodating to a life without the lost loved one. Both normal and

resilient grieving patterns progress through the acute distress following loss to a stable, permanent response that is termed "integrated grief" (Shear & Mulhare, 2008). Grief is thought to be integrated when the survivor may still feel some sadness and longing, however, they do find some capacity for interest in everyday life. The lost loved one is not forgotten and the bereaved may still retain his or her connection with the deceased, however, the mourner's mind is no longer preoccupied by distressing, painful thoughts.

Complicated Grief

There has been some dispute both between and within social science and medical disciplines regarding the existence of unique grief and bereavement symptomatology. (Granek, 2010; Stroebe, Abakoumkin, & Stroebe, 2010). Some argue that the present diagnostic symptoms of grief and mourning (shock, sorrow, anger, despair, depression, anxiety) are not unique to the loss of a loved one, and commonly occur as a reaction to other traumatic life circumstances (e.g., loss of employment, moving away from home). However, there is increasing sentiment among those who study grief and bereavement that a separate symptom set exists for grief in general, but especially so for grief that becomes especially severe. For example, a study by Prigerson, Frank et al. (1995) found that a significant number of mourners who experienced major loss exhibited symptomatology not accounted for by any existing mental disorder listed in the *Diagnostic and Statistical Manual of Mental Disorders IV*. This symptom set was also found to be predictive of long lasting physical and psychological impairments, including suicide (Latham & Prigerson, 2004; Prigerson, Bierhals et al., 1997). Findings such as these suggest that the construct of grief is more complex than a merely complicated form of other closely related, existing mental disorders (such as depression, anxiety, or post-

traumatic stress), having its own unique set of neurobiological and clinical symptoms (Neria et al., 2007). Although grief has been demonstrated to occur co-morbidly with either post-traumatic stress disorder or major depressive disorder in 75% of bereavement cases, observed symptomatology has been demonstrated to be different enough from other disorders to qualify as its own diagnosis (Neria, et al., 2007; Shear, Jackson, Essock, Donahue, & Felton, 2006; Silverman, et al., 2000). Whereas depression symptoms have been demonstrated to be relieved as a result of chronic grief-focused treatment, chronic grief symptoms were not relieved with depression-focused treatment (Reynolds et al., 1999; Shear et al., 2001).

Yearning, or the extent to which one longs for the one who has died despite the presence of surviving friends and family, is thought to be a specific affective state distinctive to grief (Prigerson, Horowitz et al., 2009). This feature renders yearning to be the primary or "core" grief emotion and a mandatory criterion for Prolonged Grief Disorder (PGD) proposed for the DSM-V (Parkes, 1996; Prigerson, Horowitz et al., 2009). Although not technically designated as a recognized mental disorder, grief researchers and clinicians in the area generally consider complicated grief as the elevation of a specific set of symptoms of grief in those who have had significant and profound difficulty adjusting to their loss (Boelen & Prigerson, 2007). It is comprised of two distinct features: (1) separation distress (preoccupation with thoughts of the deceased, upsetting memories, and longing and searching for the deceased), and (2) traumatic distress (disbelief, mistrust, anger, shock, detachment from others, and experiencing somatic symptoms of the deceased) (Prigerson & Jacobs, 2001). Grief becomes problematic when what is generally accepted as the acute grief reaction typical

of normal grieving is prolonged without any foreseeable relief (Shear & Mulhare, 2008). Whereas typical grief reactions eventually return to a normal state of functioning, those who experience complicated grief experience prolonged distress for more than 6 months, sometimes extending to a year or more. Literature suggests that integrated grieving is characterized by acknowledgement of the finality of the loss, a revision of the intrinsic representation of the deceased person for the survivor, followed by an adjustment in life goals (Bowlby, 1994; Shear & Mulhare, 2008). This healing process is interrupted by constant rumination and avoidance of emotional processing for complicated grievers. In this way, complicated grief is characterized by pervasively impaired functioning and the inability to incorporate the loss into the survivor's life, resulting in a repetitive loop of sadness, bitterness, and yearning (Boelen, van den Bout, & van den Hout, 2006). Given the features described above, complicated grief (or the proposed Prolonged Grief Disorder) is theorized to be distinct from the "normal" experience of grief in that it is thought to impair many domains of typical functioning, is persistent despite medical and/or psychological interventions**,** is present for a period of time longer than is generally anticipated (given the range of the typical grieving pattern), and that the symptoms experienced are distinct from normal grief and grief-related disorders (Smith et al 2009). Studies estimate the prevalence of this type of complicated grief to range from 10-20% (Prigerson & Jacobs, 2001).

A study focused on affect experienced by widowed women conducted by Stroebe, Abakoumkin, and Stroebe (2010) found that yearning emerged as the only emotion that was consistently associated with the death of a spouse despite the presence of social support. In other similar studies, increased levels of Prolonged Grief Disorder were found

to be related to increased risk for both physical and psychological problems as well as a decreased quality of life, even when controlling for the effects of depression and anxiety (Prigerson, Bierhals et al., 1997; Prigerson, Frank et al., 1995; Silverman, Jacobs et al., 2000). Using data collected from 346 mourners who were bereaved from 6 months to 2 years, Boelen and Prigerson (2007) further provided evidence for the distinctive features of Prolonged Grief Disorder, depression, and anxiety. In this study, Boelen and Prigerson used confirmatory factor analysis to support the distinctiveness of these factors, as well as demonstrate the predictive strength of Prolonged Grief Disorder symptomatology on mental health, suicidal ideation, Prolonged Grief Disorder Severity, and depression severity. These studies both offer support for the relevance of unique grief-specific symptoms as well as highlight the clinical importance of these emotions outside of the traditional focus on depression and anxiety.

Risk Factors

There are a significant number of studies in the grief literature aimed at identifying specific characteristics associated with problematic grief. Much of that research is focused on the early life events of the bereaved, such as the development of attachment style and the occurrence of traumatic events such as the death of a parent, separation anxiety, or childhood abuse and/or neglect (van Doorn et al., 1998). The nature of the relationship (e.g. level of closeness, relationship to the deceased) between the bereaved and the deceased has also been suggested as a significant determinant of grief adjustment (Bonnano et al., 2002). Last, some studies of individual circumstantial factors (low social support, financial dependency) have also been linked to significant problems in grieving (Smith et al., 2009). Most of the inquiry into risk potential for

complicated or problematic grief has historically been concerned with internal or intrinsic psychological variables, and except for a few recent studies focusing on the effect of social support on the grief process, little empirical attention has been given to external or sociological factors (Bevan & Thompson, 2003; Hibberd, Elwood, & Galovski, 2010). Broadening the understandings of the grief construct to be inclusive of social or ecological influences and consequences can deepen our knowledge and perhaps capture a more complete picture of how major loss impacts the human experience.

Grief and major loss are clearly intensely difficult experiences for all human beings. However, considering the more sociological perspective mentioned above, it seems likely that there are some groups of people for whom grief and major loss may be particularly distressing. For those who identify as gay, lesbian, or bisexual, the stress associated with occupying a marginalized space in society may complicate or prolong their grief experience.

Minority Stress

Being a member of a stigmatized minority group and its effects on the mental health of those who identify as gay, lesbian, and bisexual has been the subject of much attention in the empirical literature (Hatzenbuehler, McLaughlin, Keyes, & Hasin, 2010; Huebner, Rebchook, & Kegeles, 2004; Mays & Cochran, 2001). Historically, many believed that a gay, lesbian, or bisexual sexual orientation was itself indicative of mental illness, evidenced by the inclusion of homosexuality in the Diagnostic and Statistical Manual of Mental Disorders (DSM) (Bayer, 1981). It wasn't until the late 1960s and early 1970s that advocates began to challenge traditional, conservative perspectives of homosexuality, and argued for its declassification, which officially occurred in 1973

(Drescher, 2010). Although the diagnostic understanding of homosexuality as a mental disorder officially ended with its removal from the DSM, negative stigma remains in both the academic and social discourse (Hancock & Greenspan, 2010). Research focused on the mental health deficits of those who identify as GLB still persists within the social sciences, perpetuating the perception of fundamental differences between homosexuals and heterosexuals, casting heterosexuals as the normative standard to which all else is compared, and fueling support for the stigmatization and marginalization of homosexuals (Meyer, 2003).

Meyer (2003) argued that through retrospective analysis, much of the research focused on the mental health of GLB individuals was based on flawed logic and poorly operationalized research questions. Historically within the social sciences, the research question has been, "Is homosexuality a mental disorder," with the corresponding operationalized question then becoming, "Do homosexuals have high rates of mental disorders?" (Hancock & Greenspan, 2010). Meyer (2003) posited that the operationalized question does not conceptually address the research question, and suggested that classification as mental disorder is a relative question of what society generally agrees to be abnormal. Therefore, the prevalence of mental or psychological distress among those who identify as GLB is not theoretically consistent substantive evidence for classification- it is merely an observation of characteristics of that group (Kidd, Veltman, Gately, Chan, & Cohen, 2011; Meyer, 2003).

Researchers have recently begun to empirically revisit mental health for the GLB population (Hancock & Greenspan, 2010; Warner et al., 2004). Results from these analyses suggest increased mental health difficulties for those who identify as GLB. For

example, in a large multi-stage household survey aimed at measuring psychiatric disorders, Cochran and Mays (2000a) examined life history data collected by the National Health and Nutrition Examination Survey of 3, 648 males aged 17 to 39 who reported long-term sexual relationships with men. Their results suggested greater susceptibility to depression and increased risk potential for suicide over the lifetime as compared to heterosexual counterparts. In other similar studies, Cochran and Mays (2000b) used data from the National Household Survey on Drug Abuse to study the psychiatric histories of those who reported same-gender sexual partner compared to those who reported only opposite gender sexual partners. They found a greater risk for psychiatric morbidity for some mental disorders in the GLB population compared to the heterosexual group. Like prior studies, Cochran, Sullivan, and Mays (2001) examined data from the National Survey of Midlife Development in the United States. In a sample of 2,917 individual aged 25 to 75 years, gay, lesbian, and bisexual individuals were at increased risk for psychological distress compared to those who identified as heterosexual. Gay and bisexual men reported higher rates of depression and panic-related disorders, while lesbian and bisexual women exhibited elevated rates of generalized anxiety disorder when compared to a heterosexual group.

Another study by Sandfort et al. (2001) reported similar findings. In their study of 5,998 Dutch adults, the researchers found psychiatric illnesses more prevalent among those who were classified as gay or lesbian compared to those who were classified as heterosexual. Gay men demonstrated higher rates of both mood and anxiety disorders than heterosexual men, and lesbian women indicated higher rates of substance abuse

disorders than their heterosexual counterparts. Over their lifetimes, those who reported two or more diagnoses were more likely to identify as homosexual.

Although there is some empirical support for the increased prevalence of mental illness among those who identify as GLB, researchers now are considering alternative explanations for these observations. Instead of concluding that homosexuality itself must be a mental illness, social scientists are leaning toward more socio-cultural explanations for these phenomena (Meyer, 2003). Many believe that increased levels of social stress and other reactions to negative interpersonal and environmental influences such as discrimination, stigma, and prejudice can lead to higher risk of psychological disorders for those who belong to systemically marginalized groups (Friedman, 1999). For example, Lehavot and Simoni (2011) found in a sample of 1,381 lesbian and bisexual women that sexual minority stress was associated with high levels of psychological distress and substance use. These effects were attributed by the authors, in part, to decreased levels of psychosocial support.

Stress can be understood as events or conditions that cause change and require an individual to adapt to new circumstances (Meyer, 2003). Inherent in this definition is the idea that as the individual is coping with adaptation to change, his or her capacities to endure such change reach their limits, thus resulting in psychological distress (Dohwenrend, 2000). Although there is a long legacy of stress research in the social sciences literature, the notion of social stress is a relatively new concept. Social stress broadens the traditional definition of stress to include environmental conditions, not just personal events, as significant sources that result in mental or psychological distress (Meyer, 2003). Given this addition to the traditional stress theories, it follows that those

who are from marginalized or oppressed groups might experience heightened levels of social stress, as stress emerges as the result of disharmony between the marginalized individual and the dominant culture (Dickerson, 2008). According to Meyer (2003), social stress, or minority stress, is the negative affectual state experienced by those minorities in marginalized groups as a result of stigma related to group membership.

Minority stress theory posits three assumptions: (1) that stress is experienced by all people, and that minority stress is additive stress that those who are stigmatized must cope with above and beyond those of the dominant culture, (2) that minority stress is chronic due to the systemic sociocultural processes of oppression and marginalization of minorities, and (3), that minority stress is derived from social structures and processes that originate as forces external to the person (Meyer, 2003). Central to the theory of minority stress are three components: the experience of prejudice events, stigma, and an intrinsic sense of internalized homonegativity (Meyer, 2003). The following sections describe each of the major components of the minority stress model.

Prejudice, harassment, and discrimination. Anti-homosexual attitudes and hate-related discrimination and violence have been present throughout history (Herek & Berrill, 1992). Persecution by the Nazis during World War II and the enforcement of anti-sodomy laws are examples of how homosexuals have experienced discrimination and violence in the past and continue to encounter these experiences. Currently worldwide, those who identify as GLB are subject to transgressions against their human rights, torture, violence, and death (Amnesty International, 2001). These attitudes toward homosexual individuals are often structured into formal legislation and are sanctioned by sociocultural norms (Amnesty International, 2001).

A study by Mays and Cochran (2001) helped to shed light on the prevalence and consequences of experiences of violence, discrimination, and prejudice for those who identify as GLB. Using data from the National Survey of Midlife Development in the United States, 2,917 adults aged 25-74 were surveyed about their experiences of discrimination. Results revealed that homosexual (n = 41) individuals reported experiencing significantly more day-to-day discrimination (were called names or insulted, being threatened or harassed), 42% of which participants attributed to their sexual orientation. This study also found that those who identified as GLB (n = 73) were more likely than their heterosexual counterparts to experience more serious, life impacting prejudice events, such as losing a job being forced out of the neighborhood by neighbors, or being denied or given inferior medical services. Respondents in this survey noted that these prejudicial and discriminatory events had decreased their quality of life, and reported more often than the heterosexual group that discriminatory experiences made life more difficult. Perceived discrimination was also correlated to psychiatric morbidity, with homosexual individuals more likely to experience stress-related psychological difficulty.

A similar study by Burns, Kamen, Lehman, and Beach (2012) of 307 gay men demonstrated a relationship between discrimination events and increased levels of social anxiety. Discrimination was shown to be the most closely related to mental health when compared to other minority stress constructs (internalized homonegativity, gay identity development). Research by Feinstein, Goldfried, and Davila (2012) suggests a more specific structural relationship among minority stress constructs. In their study of 467 gay men and lesbian women, the authors demonstrate how the connection between

discrimination events and resulting depression and social anxiety symptoms were mediated by internalized homogegativity and rejection sensitivity. These results suggest that there may be some important underlying mechanisms by which discrimination events impact the mental health of sexual minority members.

A study by Herek, Gillis, and Cogan (1999) revealed that of 2, 259 individuals surveyed, approximately 20% of women and approximately 25% of men reported being victimized due to their sexual orientation. Lesbian women and gay men (n = 1878) who had experienced an assault or some other biased crime were more likely to exhibit depression, posttraumatic stress, anger, and anxiety than those who had experienced non-biased crimes or no crime at all. These individuals were also more likely to perceive the world as unsafe, to express that others are malevolent, and to experience a low level of personal mastery than non-victims.

Similar to previous studies, a study by D'Augelli and Grossman (2001) surveyed 416 GLB-identifying older adults to explore how stigma and victimization experiences are related to mental health. Results demonstrated that approximately two-thirds of older GLB identifying adults had experienced verbal abuse, about one quarter were threatened with violence, and 16% had experienced actual violence, such as punching, kicking, or beating. Conversely, those who experienced no violence or only verbal attacks demonstrated higher self-esteem and fewer suicidal ideations than their peers who had endured violence. Alternatively, poorer mental health and increased risk for suicide was correlated with experiencing physical attacks.

Internalized homonegativity. If social stress is the expectation of discrimination, prejudice, oppression, and rejection from others, internalized homonegativity can be

understood as directing these negative antigay attitudes inward toward the self (Meyer, 2003). Shidlo (1994) conceptualized internalized homonegativity as the intrinsic result of negative stereotypes and myths regarding homosexuality that are pervasive in society and are adopted in one's own culture. Herek (2004) notes that internalized homonegativity can be the result of an intrapsychic conflict between same-sex desires and the societal imperative to be heterosexual, which can sometimes lead to the rejection of one's sexual orientation. In this way, internalized homonegativity is self-stigmatization, or internalized stress in response to social values that leads to poor self-concept, personal devaluation, identity separation (separating one's sexual identity from their sense of self), and identity denigration (Meyer & Dean, 1998; Moradi, van den Berg, & Epting, 2009). Many in social sciences research discuss the importance of understanding internalized homonegativity, citing how it is one of the few minority stress constructs that is unique to lived experience of GLB individuals (Gonsiorek, 1982; Maylon, 1982). Meyer and Dean (1998) frame internalized homonegativity as one of the most critical and dangerous of minority stress constructs, in that although it finds its origins in heterosexist attitudes, it can self-perpetuate even when GLB-identifying individuals are not currently experiencing great levels of social stigma or overt oppression.

Although internalized homonegativity is theoretically thought to be truncated once the GLB individual successfully completes the coming out process by integrating a healthy sense of sexuality into his or her identity, this internal stress might never fully be extinguished due to the effects of early life socialization and perpetual exposure to antigay attitudes and behaviors (Meyer, 2003; Troiden, 1989;). Some believe that even the most well-adjusted GLB individuals maintain some degree of residual internalized

homonegativity which becomes integrated into their self-perceptions, ultimately with the potential to result in psychological distress (Schwartzberg, 1992). For example, a study conducted by Szymanski and Gupta (2009) found that among 106 gay, lesbian, and bisexual men and women, racial minority stress and internalized homonegativity were found together to be significant predictors of negative self-esteem, and that internalized homonegativity was a unique positive predictor of psychological distress (operationalized as symptoms of depression, anxiety, interpersonal sensitivity, somatization, and obsessions/compulsions).

A study by Frost and Meyer (2009) using data gathered from 396 gay, lesbian, and bisexual individuals revealed that internalized homonegativity was related to greater levels of relationship problems, both generally and among coupled participants, independent of degree of outness and community connectedness. Other studies have supported these results. Meyer and Dean (1998) reported that gay men with high levels of internalized homonegativity were less likely to be involved in romantic relationships. When they were in relationships, these men reported more relational discord when compared to gay men with less internalized homonegativity. Ross and Rosser (1996) demonstrated that internalized homonegativity was related to shorter relationships as well as relationships of poor quality in gay and bisexual men. Gains and colleagues (2005) further these claims by revealing how high levels of internalized homonegativity were related to the tendency to lack effort in maintaining the relationship in times of partner conflict.

Sexual minority concealment, outness, and stigma. Meyer (2003) suggested that the experience of stigma for those who identify as GLB is the expectation of

discrimination, prejudice, oppression, and rejection. Concealment of one's sexual orientation is a common occurrence for GLB individuals, as it is often necessary to hide one's true identity for fear of workplace discrimination, physical harm, or out of feelings of shame or guilt (D'Augelli & Grossman, 2001).

Statistics suggest that an unmasked sexual minority identity can be a risky social liability, especially in the workplace. Mays and Cochran (2001) reported that homosexual individuals are four times more likely than heterosexuals to get fired from a job due to perceived discrimination, Badgett (1995) reported that non-heterosexual men earned 11-27% less than their heterosexual counterparts with similar qualifications. In an integrative review of the literature on GLB individuals in the workplace, Croteau (1996) found that the issue of concealment or openness about one's sexual orientation and the fears related to potential discrimination or harassment was a salient feature of many workers' subjective occupational experiences. This fear of discrimination or some other adverse effect of one's sexual orientation being known seemed to be the primary motivation for "hiding" a GLB identity in the workplace (Croteau, 1996).

Stigma and the resulting perpetual concealment of one's sexual orientation may in itself be deleterious for mental health because it keeps GLB identifying individuals in hiding and away from associating with others who are gay, lesbian, or bisexual (Meyer, 2003). A two-stage study conducted by Postmes and Branscombe (2002) utilizing 126 African American females suggested that identification with one's minority group can serve as a buffer or protective factor against the negative effects of segregation and out-group rejection, as well as foster psychological well-being. Although this study used race as its minority factor, the same logic might be extended to sexual minorities. A study

conducted by Schrimshaw, Siegel, Downing, and Parsons (2013) with 203 undisclosed bisexual men demonstrated a predictive relationship between degree of concealment and mental health, with greater concealment predicting negative psychological wellbeing.

The GLB Grief Experience

Given the social consequences of a non-heterosexual identity, some suggest that the grief experience for someone who identifies as gay, lesbian, or bisexual is likely not to be captured, understood, or reflect traditional linear stage models of grief and bereavement (Green & Grant, 2008; Schwartzberg, 1992). Doka (1989) argues that not all deaths are equal; in fact, some are respected and revered while others are devalued and ignored, depending on society's estimation of the relationship's worth. Entrenched within our society are messages of value and recognition in regard to specific relationships and their losses (Fenge & Fannin, 2009). Considering the negative antigay discourse present in many areas of society, Doka contends that many GLB-identifying individuals who experience the loss of a loved one encounter disenfranchised grief, or a grief experience that is not socially recognized or sanctioned. For example, due to the compounding stigmatization of HIV/AIDS, a gay-identifying male who loses an intimate partner to the illness may not have his loss validated by his family, friends, or the community at large. Instead, he may feel that he cannot openly mourn, he may feel shame or embarrassment, or even that his loss is not as traumatic or distressing as a heterosexual death (Bevan & Thompson, 2003). His grief experience becomes disenfranchised because his loss is assumed to be not as meaningful, powerful, important, traumatic, or profound as a heterosexual loss, such as a husband losing his wife. Disenfranchised grief suggests that the grief experience of a marginalized individual is not just unseen or ignored, but is

invalidated and rejected (Corr, 1998/1999). The social attitude toward GLB individuals who lose an intimate partner may be so ambivalent, the surviving partner may feel he or she may not have the right to grieve such a loss (Fenge & Fannin, 2009). Given this ambivalence, because the intimate relationship between two gay males is generally not socially valued, gay grief is perceived as illegitimate and irrelevant. Overall, disenfranchised grief suggests that such an experience is unequal to the heterosexual experience of loss (Green & Grant, 2008). As a result, bereavement becomes complicated and the meaning-making process that some argue is essential for processing and working through such a critical loss is stymied (Baxter, 2004).

Due to the pervasive, systemic stigma associated with homosexuality, not much is known about the GLB grief experience (Green & Grant, 2008). Although much of the empirical work conducted focused on gay men who have lost a partner to HIV/AIDS, these studies shed tremendous insight on the nature of major loss for those who identify as homosexual (Fenge & Fannin, 2009). A longitudinal study by Sikkema, et al. (2006) focused on the grief experiences of 167 individuals who lost partners to HIV/AIDS and revealed significant numbers of lifetime loss experiences, averaging 43 deaths per participant due to the disease. Approximately half of participants (46.3) indicated losing their spouse or partner as their major loss during the previous two years, while 14.2% reported their primary loss being another family member, such as a sibling or child.

A study conducted by Sikkema, Kochman, DiFranceisco, Kelly, and Hoffman (2003) with 268 individuals positive for HIV/AIDS who had lost an intimate partner or spouse to the disease in the previous two years revealed that the surviving partners

demonstrated high levels of grief, even after more than three years post-loss. Traumatic stress and substance abuse were also related to these grief reactions.

Last, a significant longitudinal study by Hatzenbuehler et al. (2008) focusing on the association between minority stress and negative physical and psychological health outcomes in a sample of 74 bereaved gay men revealed a predictive relationship between the experience of minority stress and risky sexual behavior, substance use, and depressive symptoms. The authors postulated that coping poorly with minority stress may be related to escape-avoidance behavior (evidenced by risky sexual behavior and increased substance abuse), as well as feelings of hopelessness (precursor to depression).

Each of these studies highlights the prevalence, salience, and magnitude of the experience of major loss for those who identify as GLB. Those who occupy this particular demographic seem to experience multiple and continual incidents of grief and bereavement, evidenced by the average number of losses for many GLB people (often family, friends, neighbors, and community members) who previously composed important aspects of the survivors' social support network (Schwartzberg, 1992). Shernoff (1998) described the effect of these multiple losses as producing a perpetual state of mourning in which the individual continually feels the effects of major loss; certainly such widespread and perpetual bereavement has the potential to create an intrinsic sense of long enduring grief (Schwarzberg, 1992).

The experience of minority stress appears to have negative consequences on the general quality of life for those who identify as gay, lesbian, or bisexual (Fenge & Fannin, 2009; Meyer, 2003). However, the relationship of minority stress experiences with grief and the bereavement of a lost partner has not been adequately addressed in the

empirical literature. Research examining the complexity of the grief experience for those who identify as GLB is needed in the field. Therefore, the purpose of this study was to explore potential relationships between the social consequences of occupying a marginalized space in society and the experience of major loss of a partner.

Chapter 3

Method

This study explored the relationship between the loss of a partner in a same-sex committed relationship and the experience of grief and bereavement. Specifically, this study tested for a relationship between minority stress and magnitude of grief by means of a predictive model, where the degree of grief experienced was predicted by the levels of perceived sexual minority stress. Sexual minority stress was defined by the presence of internalized homonegativity, discrimination and harassment experiences, and the participant's degree of outness. Loss of a partner was defined as experiencing the death of a significant other within a monogamous relationship. Grief reactions were expected to be more severe for those participants who endorsed higher levels of sexual minority stress. This study was approved by the Institutional Review Board (IRB) before data collection occurred.

Participants

One hundred and forty-eight individuals initially participated in this study. Of those, 141 were retained to constitute the final sample. Participants who did not complete the survey or identified as heterosexual were removed from the sample. Of those who did not complete the study, most seemed to stop responding after the demographic questionnaire. Participants were a national convenience sample of adults over the age of 18 who identify as gay, lesbian, or bisexual and have experienced the death of an intimate partner from a committed relationship. A committed relationship was defined as a monogamous, intimate partnership with another person. Commitment was not limited to legal marriage or any other legal designation of status.

Of the 141 total participants, 76 were male and 64 were female. Fifty-five percent identified as gay, 42% as lesbian, and 3% identified as bisexual. This sample was 87% Caucasian, 3% African American, 1% Hispanic, 2% biracial, 4% multiracial, and 2% self-identified their race/ethnicity as Jewish. The median age of participants was 55, with ages ranging from 23 to 77 years old. Most (40%) categorized their commitment status with their deceased partner as a domestic partnership, 9% were married, and 3% were partners in a civil union, while other participants had found alternative ways of recognizing their partnership (commitment ceremonies, life partners, etc).

Demographic Items, Control Variables, and Predictor Measures

Participants were asked to complete the following measures: a demographic questionnaire (see Appendix C); the Inventory of Complicated Grief (ICG; Prigerson, Maciejewski, Reynolds, Bierhals, Newsom, Fasiczka, et al., 1995; see Appendix D); the Internalized Homophobia Scale (TIHS; Wright, Dye, Jiles, & Marcello, 1999; see Appendix E); the Heterosexual Harassment, Rejection, & Discrimination Scale (HHRDS; Szymanski, 2006; see Appendix F), and the Out to the World subscale of the Outness Inventory (Meyer, Rossano, Ellis, & Bradford, 2002; see Appendix G).

Demographic information (Appendix C) gathered for each participant and partner (at the time of death) included: gender, race/ethnicity, and sexual orientation. An item assessing commitment status before death was also included in the demographic questionnaire. The entire survey took approximately 15-20 minutes to complete.

Control Variables. Due to the multidimensional nature of grief and bereavement, it is possible that many personal, social, and circumstantial factors could moderate the experience of healing from loss and should be considered as control factors in analysis.

The following details a rationale for inclusion/omission with respect to some of those most pertinent for this study.

Time since loss. A large-scale study conducted by Carnelley et al. (2006) of 768 adults who had lost a spouse revealed that although grief responses are highly individual, the severity of negative grief reactions tended to lessen as more time passed since the loss. Feigelman, Jordan, and Gorman (2009), demonstrated this same effect in their study of bereaved parents, whose grief symptoms began to subside between three and five years post-loss. These studies support the notion that the normal emotional distress related to grieving typically gradually dissipates as time passes, and support the consideration of time since the loss as a control variable in this study (Prigerson & Jacobs, 2001). The median time post-loss reported by participants was 5 years, with time spans ranging from less than one year to 31 years. The greatest percentage of participants (22%) had experienced the loss of their partner within one year of taking the survey.

Nature of death and social support. Research conducted by Currier, Holland, Coleman, and Neimeyer (2008) suggested that among a college student sample, the severity of grief reactions increased as the nature of the trauma of the death increased from anticipated natural death, to sudden natural death, and finally to violent death. A review of sudden and violent loss literature suggested that generally, the degree to which the loss was expected and the amount of violence associated with the loss are correlated with duration and severity of the grief process (Kristensen, Weisaeth, & Heir, 2012). A meta-analytic review utilizing 40 studies of problematic grief revealed that the nature and circumstances surrounding the loss of a loved one has been demonstrated to be important in predicting complicated grief reactions in bereavement, with more complications in

grieving surrounding traumatic and/or unexpected death (Lobb et al., 2010). This same review found that positive emotional and social support was instrumental as protective factors against complicated grief. Participants were asked to report the nature of their partner's death as a free response on the survey. Guided by Neimeyer's criteria for determining the level of trauma or unexpectedness related to the loss, the researcher and another rater separately categorized the participants' losses as either "unexpected/traumatic" or "expected/natural." Examples of unexpected/traumatic losses were homicide, suicide, natural disasters, quickly progressing illness and disease, and war-related deaths. Examples of expected/natural deaths were long-term or chronic illnesses and deaths due to "old age." Due to the subjectivity associated with categorizing this data, an estimate of inter-rater reliability was computed, utilizing Cohen's kappa statistic. The inter-rater reliability statistic for this item was K= .74. Landis and Koch (1977) describe the strength of this level of inter-rater agreement to be substantial. In this sample, 38% of participants were coded as experiencing a traumatic loss, while 62% were coded as experiencing an expected loss. Regarding social support, 63% indicated that they sought some sort of help to deal with the loss, while 37% reported that they did not.

Predictor Measures

Internalized Homophobia (TIHS; Wright et al., 1999). Internalized homonegativity was assessed by using The Internalized Homophobia Scale. This is a 9-item Likert-style scale used to measure the degree to which an individual experienced internalized homonegativity in the past year. Some items were reverse scored before a sum was calculated. Higher scores indicated greater levels of internalized

homonegativity. An example of an item included on this scale is, "How often have you wished you weren't LGB?" Responses are rated on a 4-point scale ranging from 1 (never) to 4 (often). Possible scores ranged from 9 (minimum) to 45 (maximum). The mean score on the TIHS for this study was 14.97 (*SD* = 4.45), similar to scores reported by Rostosky, Riggle, Horne, & Miller (2009) (*M* = 15.55, *SD* = 5.07).

This scale has demonstrated high internal consistency estimates of reliability, ranging from .81 to .86 (Frost & Meyer, 2009; Lehavot & Simoni, 2011; Rostosky, Riggle, Horne, & Miller, 2009). The Internalized Homophobia Scale also demonstrated good construct validity, convergent evidence with measures assessing for distress, and divergent evidence with measures that assess for both personal and collective self-esteem (Frost & Meyer, 2009; Wright et al., 1999). The internal consistency estimate of reliability for the current study was .79.

Outness (OI; Mohr & Fassinger, 2000). The degree to which a GLB-identifying individual has disclosed his or her sexual orientation to others was assessed using the Out to the World subscale of the Outness Inventory. This instrument asks the participant to rate how out he or she is to sexual minority friends, heterosexual friends, co-workers, and health care providers (Meyer et al. 2002; Mohr & Fassinger, 2000). Reponses are rated on a four-point Likert style scale designated by "none," "some," "most," or "all," and summed to calculate a total score. Possible scores on this subscale ranged from 4 (minimum) to 16 (maximum), with an average total score of 13.70 (*SD* = 3.18). The average item score was 3.42, similar to the average item score of 3.31 (complete scale) reported by Frost and Meyer (2009). High scores indicate a greater degree of outness. Mohr and Fassinger (2000) and Mohr and Kendra (2011) provide support for the 3-factor

structure of this construct, as well as internal consistency estimates of reliability ratings ranging from .78 to .79 for the Out to the World subscale. Brewster and Moradi (2010) reported an internal consistency estimate of reliability rating of .87 for the full 10-item scale. Scores on the Out to the World subscale have also been demonstrated to be inversely related to a measure of sexual orientation privacy (Mohr & Fassinger, 2000), and positively related to a measure of connectedness to the GLB community (Balsam & Mohr, 2007). No test retest it is reported for this scale, and this is a potential limitation of its use. Using only the subscale of the full-scale instrument is also a limitation. The internal consistency estimate of reliability for the current study was .79.

Heterosexist Harassment, Rejection, & Discrimination (HHRDS; Szymanski, 2006). Harassment, rejection, and discrimination was assessed using the Heterosexist Harassment, Rejection, and Discrimination Scale. This is a 14-item measure with item rated along a 6-point Likert-type scale, ranging from 1 (never) to 6 (almost all the time). Responses are summed, and high scores indicate more harassment, rejection, and discrimination experiences. Possible scores range from 14 (minimum) to 84 (maximum), with the average total score in this study being 32.1 (*SD* = 17.09). The average item score was 2.3, comparable to the average item score of 1.65 reported by Szymanski (2009). An example of an item from this scale is, "How many times have you been treated unfairly by family members because you are LGB?" The full-scale measure is comprised of three subscales, one each measuring harassment, rejection, and discrimination. Structural validity has been supported by factor analysis, and construct validity is supported by correlational studies between the HHRDS and measures of psychological distress (depression, anxiety, somatization, and obsessive compulsiveness).

Internal consistency estimates of reliability for the full scale is .90 (M = 1.63; SD = .70) and .89, .84, and .78 for each of the subscales, respectively (Szymanski, 2006). Studies by Lehavot and Simoni (2011) and Feinstein, Goldfried, and Davila (2012) also found internal consistency estimates of reliability of .90 and .94, respectively. There is little evidence of test-retest reliability, which is a potential limitation of its use in this study. The internal consistency estimate of reliability for this study was .91.

Dependent Measure

Grief (ICG; Prigerson et al., 1995). Grief was assessed using the revised version of the Inventory of Complicated Grief Questionnaire. The Inventory of Complicated Grief is described as a 19-item measure that assesses for the presence of complicated grief, a cluster of symptoms that exist independently outside the classification of anxiety, depression, or post-traumatic stress that have been demonstrated to predict long-term dysfunction following the death of a committed intimate partner (Neria et al., 2007; Prigerson et al., 1995; Shear, Jackson, Essock, Donahue, & Felton, 2006). Examples of grief-specific symptomatology include preoccupation with thoughts of the dead, searching and yearning for the deceased, disbelief about the death, being stunned by the death, and failure to accept the death (Prigerson et al., 1995). An example item from the Inventory of Complicated is, "I find myself longing for the person who died." Responses are rated on a 5-point scale, ranging from "never" to "always." Possible scores range from 19 (minimum) to 95 (maximum), with the average score for this study being 47.78 (SD = 13.38).

The initial study by Prigerson and colleages (1995) found that a score of 25 or higher on the ICG six months post-loss predicted both negative physical and mental

health outcomes, while Shear and Shair (2005) report using a score of 30 or above to indicate chronic, problematic grief. Although the ICG was originally developed with the assumption that what qualifies as "normal" grief responses are qualitatively different from complicated, or traumatic, grief responses, later research conducted by Holland, Neimeyer, Boelen, and Prigerson (2009) suggests an alternative structure underlying the grief construct. Instead of discrete, categorical distinctions, Holland et al. (2009) found evidence to support a more continuous grief structure, suggesting that instead of distinguishing normal grief from problematic grief, the ICG can be utilized to measure the severity of grief experiences along a continuum. In this way, scores on the ICG are summed, with higher scores reflecting greater experiences of more severe, problematic grief.

A meta-analytic view of problematic grief conducted by Lobb et al. (2010) revealed that the ICG was one of the two most frequently used instruments to assess problematic grief. Upon development, the internal consistency estimate of reliability for the ICG was high (α =.94), and test-retest reliability was determined to be 0.80 (Prigerson et al., 1995). Concurrent validity was demonstrated by strong correlations with the Beck Depression Inventory (r =.67, p < .001), the Texas Revised Inventory of Grief (r =.87, p < .001), and the Grief Measurement Scale (r =.70, p < .001) (Prigerson et al., 1995). There have been many recent studies in the empirical literature where The Inventory of Complicated Grief was implemented successfully. Notably, Fiegelman, Gorman, and Jordan (2009) used this measure to investigate the relationship between stigmatized death (child suicide) and grieving difficulties. Kramer, Kavanaugh, Trentham-Dietz, Walsh, and Yonker (2011), Feigelman et al. (2009), and Rosner, Lumbeck, & Geissner (2011),

each calculated alphas of .90, .89, and.87, respectively. The internal consistency estimate of reliability for the current study was .92.

Procedures

Similar to the methodology employed by D'Augelli and Grossman (2001), participants were recruited through contacting GLB groups and grief groups for survivors of spousal or partner death who have an online presence. Examples of such groups are The National Resource Center on LGBT Aging, the National Gay and Lesbian Task Force, and the "WidowNet" Yahoo Group. Participants were also recruited from local organizations, including the GLB community center and GLB affirming places of worship. Recruitment notices and announcements took the form of internet postings on listservs, discussion boards, and email to these groups and organizations. The researcher first emailed the organization with an explanation of the study and a link to the online survey (Appendix A). Once the contact person had responded and agreed to participate, this author asked the group or organization to further disseminate the link to the survey via postings to listservs, discussion boards, etc. Participation in this study was voluntary and based on self-report. Because it was difficult to estimate the demographic nature of the population of interest, and because most of the research on this population has been conducted with Caucasian males, there was a concentrated effort to acquire a diverse sample (race, age, socioeconomic status, etc.) (Green & Grant, 2008). Online groups or organizations specifically oriented toward GLB-identifying individuals who are also members of other demographic minority groups (e.g. race, ethnicity, older adults) were targeted for participation.

Before beginning the information-gathering section of the survey, participants were directed to an informed consent webpage. This page described the general purpose of the research, assured voluntary participation and termination without penalty, and denoted the limited risks and some benefits to participation. This portion of the survey also contained the eligibility criteria for participation, an estimate of the time needed to complete the survey, an assurance of anonymity of data, as well as the contact information for the researcher and department advisor should the participant have concerns. Additionally, participants were informed that in lieu of direct incentive, the researcher will donate one dollar to the local GLB community center for every participant who begins the questionnaire (up to $250). At the bottom of the informed consent page, participants were asked to click on a button marked "Continue," which directed them to the remainder of the survey.

Participants were asked to complete the demographic information page first, followed by the Inventory of Complicated Grief, The Internalized Homophobia Scale, the Heterosexist Harassment, Rejection, and Discrimination Scale, and the Out to the World subscale of the Outness Inventory. Upon completion, participants were directed to a final page which thanked them for participation, as well as provided a listing of national resources that may be useful for the bereaved (Appendix H).

Data Analysis

Preliminary analyses included checking that the data met the assumptions necessary for multiple regression, an analysis for risk of multicollinearity and potential outliers, and calculating frequency and descriptive data for the control variables included in the first step of analysis (age, nature of the death, time since loss, and social support).

The same statistics were gathered for the variables commitment status, ethnicity, gender, and sexual orientation. This information is included in Table 1.

This study utilized hierarchical multiple regression analyses to determine if sexual minority stress (measured by The Internalized Homophobia Scale, The Heterosexist Harassment, Rejection, and Discrimination Scale, and the Outness Inventory) as a cluster of factors predicted the experience of problematic grief (measured by the Inventory of Complicated Grief) for GLB-identifying adults who have lost a committed, intimate partner.

There were a few variables the researcher identified as potential confounds in this study. Age of the surviving partner, the amount of time post-loss, the nature of the loss, and social support have each been supported in the empirical literature as meaningful factors that affect the grief process. In order to control for any shared variance, the researcher specified the use of hierarchical multiple regression in the analysis, whereby the control cluster of variables (age, time since loss, the nature of the loss, and social support) were entered as the first step. The minority stress cluster of variables were entered into the regression analysis as the second step to explore how their influence as a cluster of factors predicted unique variance in the criterion variable, grief severity. It was hypothesized that those surviving partners who have experienced comparatively greater amounts of minority stress would experience increased dysfunction post-loss as well as more grief-specific symptomatology than those who experienced lower levels of minority stress.

Results were initially checked to have met the assumptions of normality, independence, and homoscedasticity, as well as to verify no problems with

multicollinearity and potential outliers. *F*- statistics were utilized to determine if the predictor variables explained a significant amount of variance in the criterion variable. R^2 was used to determine the percentage of variance explained by each of the steps taken in the regression, and t-values were examined to determine which predictors explained a significant amount of variance independently. Beta statistics were subsequently used to indicate the relative magnitude of the effects of significant predictors.

Chapter 4

Results

Preliminary Statistical Analyses

A hierarchical multiple regression was used to assess the influence of minority stress on the experience of grief related to the loss of a committed partner beyond the effects of age, social support, the nature of the death, and the number of years since the loss. Minority stress as a construct was assessed through the measurement of internalized homonegativity (TIHS), heterosexual harassment and discrimination (HHRDS), and the degree of sexual orientation disclosure (OI). Grief was assessed through the use of The Inventory of Complicated Grief (ICG).

Preliminary analyses were conducted to examine the data for accuracy, missing values, correct ranges of scores, frequency distributions, and that the assumptions for linear regression were met. All variance inflation factors were less than 2.0, suggesting no evidence for multicollinearity. Examination of the residual statistics suggested no evidence of influential data points. Visual inspection of the histogram and the P-plot of regression standardized residual suggested a generally normally distributed dependent variable. Review of the scatterplots revealed no apparent organization. The results of the preliminary analyses indicate no threats to the assumptions of linear regression.

Hierarchical Multiple Regression Analysis

In order to control for the effects of age, social support received, the nature of the death, and the amount of time post-loss on the experience of grief, hierarchical multiple regression was chosen as the appropriate data analytic tool. These control variables were entered as the first block of the regression model. The minority stress cluster of predictors

were entered together as the second block. Sample means, standard deviations, and correlations are reported in Table 1.

Control Variables. Literature suggests that the amount of time since the loss, the nature of the loss, and social support are important factors in predicting grief outcomes (Carnelley et al. 2006; Currier et al. 2008; Lobb et al. 2010). This cluster of variables, along with age of the participant, was entered into the regression as the first block. Theoretical reasoning and past empirical evidence suggests that these variables may explain a significant amount of variance in the dependent variable, and thus were entered into the analysis first as controls. Regression results revealed that the set of control variables explained 17.9% of the variance, $F(3,137) = 7.40$, $p < .001$. Of the four covariates, two (years since loss and age of the participant) displayed unique significance (β = -.310, -.184; see Table 2).

Table 1

Means, Standard Deviations, and Correlations

Variable	M	SD	1	2	3	4	5	6	7	8
1 Age	54.07	9.94	--	0.128	.252***	0.169*	-0.261***	-0.088	0.044	0.113
2 Social support	1.37	0.48		--	0.149*	-0.005	-0.154*	0.211**	0.085	-0.274***
3 Nature of death	1.61	0.49			--	0.095	-0.131	-0.071	0.239	0.062
4 Years since death	7.28	7.70				--	-0.344***	0.030	-0.033	0.031
5 Complicated grief	47.78	13.38					--	0.154*	0.239**	0.111
6 Internalized homophobia	14.97	4.45						--	0.042	-0.474***
7 Discrimination	32.09	17.09							--	0.011
8 Outness	13.7	3.18								--

*p<.05. **p<.01. ***p<.001.

Table 2

Results of Regression for First and Second Step in Analysis

Covariate Variable	b	β	t	R^2
Step 1				0.179
Nature of death	-1.007	-.037	-.453	
Social support	-3.489	-.126	-1.599	
Age	-2.48*	-.184	-2.252	
Years since death	0.538***	-.310	-3.922	
Step 2				0.310
Internalized homophobia	0.822***	.273	3.303	
Discrimination	0.185***	.237	3.266	
Outness	0.984**	.234	2.779	

*p<.05. **p<.01. ***p<.001. ΔR^2 = .131.

Sexual Minority Stress Variables

The sexual minority stress cluster of variables was entered as the second block in the hierarchical regression analysis. This step was composed of summed scores on The Internalized Homophobia Scale (TIHS), Heterosexist Harassment, Rejection, & Discrimination Scale (HHRDS), and the Out to the World subscale of the Outness Inventory (OI) (Mohr & Fassinger, 2000; Szymanski, 2006; Wright et al. 1999). The addition of the sexual minority stress cluster of variables to the model increased the proportion of variance explained by .131, $F(6,134) = 8.54$, $p < .001$. In the second block in the regression model, five variables demonstrated significant unique influence (see Table 2). In order of importance, they were years since the loss (β =-.316), internalized homophobia (β =.273), discrimination (β = .237), degree of outness (β = .234), and age of the participant (β =-.194).

Summary

The results of the hierarchical regression analysis support the hypothesis that sexual minority stress has a significant relationship with the experience of grief for those gay, lesbian, and bisexual individuals who have experienced the loss of a committed partner. As hypothesized, sexual minority stress demonstrated significant additional influence after accounting for the influence of the control variables. Further analysis revealed the relative influence of each individual variable in each step of the regression, with years since loss emerging as the variable with the most unique influence in the explanation of variance in grief in both steps of the regression model.

Chapter 5

Discussion

The purpose of this study was to explore what, if any, influence identifying as a sexual minority has in coping with the grief after losing a committed partner. Results reveal that gay, lesbian, and bisexual individuals who experience higher levels of sexual minority stress also experience high levels of problematic grieving. These results were found to be significant after accounting for the influence of control variables that have been previously demonstrated to be related to or impact the grief process. The following is a discussion of the results of this study in the context of existing research. First, the emergent factors that influence the experience of grief will be discussed, followed by the limitations of this study, clinical implications, and directions for future research.

Sexual Minority Stress

Results of this study support the hypothesis of this study, suggesting that minority stress is an important aspect of the grieving process for those individuals who identify as gay, lesbian, or bisexual. The cluster of minority stress variables (internalized homonegativity, discrimination, and degree of outness) explained a significant percentage of the variance in grief scores, above the influence of the control variables (age, nature of death, time since death, and social support). This suggests that the experience of occupying a marginalized space in society, specifically with regard to sexual orientation, may significantly negatively impact the grieving process following the loss of a partner. Interestingly, follow-up analyses of the sexual minority stress predictors were significant and exhibited very similar degrees of magnitude in the regression, suggesting that all three of the sexual minority stress factors were comparable in importance when

explaining variance in grief. This finding may continue to support the inclusion of each of these three components into our understanding of minority stress as a construct.

A small, negative correlational relationship emerged between the outness and social support variables. This effect was unexpected, as literature generally reports positive relationships between sexual minority status self-disclosure and social support (Frable, Platt, & Hoey, 1998; Schrimshaw, Siegel, Downing, & Parsons, 2013. This effect may be due to the influence of grief. The more self-disclosed one is to his or her community, the more stigmatized his or her loss may be. As a result of either anticipated or actual stigma, the bereaved may be less likely to seek social support. It may also be that the more out the bereaved was in the community, the less he or she had to actually go out and seek support. Perhaps because the loss of someone with a disclosed sexual minority identity might be better known to the community, his or her social support may have reached out in support to the bereaved. More research is warranted to further understand this effect.

The results of this study connect what is already empirically understood about the construct of minority stress to grief and loss, an event in life that many encounter. These findings add to the growing body of contemporary grief research that focuses on the social, environmental, and contextual factors that influence the grieving process. For example, researchers are currently exploring the role of race, attachment styles first developed in childhood, trauma experiences, physical health status, cultural themes, and the role of spirituality in adjusting to the loss of a loved one (Laurie & Neimeyer, 2008; Neimeyer & Burke, 2011; Prigerson & Maciejewski, 2006; Vanderwerker, Jacobs, Parkes, & Prigerson, 2006). As suggested by the results of this study, grief related to the

loss of a partner may be quite different for certain groups of people in society. Even though this study did not compare the grief experiences of heterosexual and homosexual individuals, the additive influence of sexual minority stress above other variables in the analysis suggests that the impact of occupying a marginalized space in society is important to understanding grief experiences. The complexity increases as even within the GLB sample, social, environmental, and contextual factors (the control variables) influenced the grief experience.

Control Variables

The researcher identified four empirically supported variables that could potentially influence or misrepresent the amount of variance explained if not controlled for in the regression model. Therefore, the age of the participant, the nature of death, the time since death, and if social support was sought were entered into the regression model as the first step to control for their effects on explained variance in the grief experience. When considered outside the effects of the sexual minority stress variables, time since the loss emerged as the most influential significant predictor, followed by the age of the participant (see Table 2). In this sample, the median number of years since loss was five, however, it is notable that the percentage of participants who had experienced their loss within the last 12 months was the largest in the sample (22%). Time since the loss was negatively correlated with scores on the Inventory of Complicated Grief, suggesting that those individuals who had recently experienced their loss endorsed more problems in grieving. This result supports other related empirical findings, suggesting that problematic grief tends to gradually lessen as time passes (Carnelley, Wortman, Bolger, & Burke, 2006).

The age of the participant was the only other variable among the control variables that emerged as a significant predictor of grief (see Table 2). The median age in this sample was 55 years, with the age distribution among the sample being remarkably even (the mean age almost equaling the median age). Interestingly, the regression results demonstrated a relationship between the age of the participant and scores on the ICG, suggesting that younger individuals experienced higher levels of grief than their older counterparts. This result seems unexpected, given the assumption that older gay, lesbian, and bisexual individuals might not feel as comfortable with their sexual identity, and may lack significant social support (Fenge & Fannin, 2009). It may be that older individuals have experienced multiple losses before the loss of their intimate partner, such as parents, family members, friends, and even previous partners. Older GLB individuals, particularly gay-identified men, may have experience in losing friends and partners to HIV/AIDS (Green & Grant, 2008; Sikkema et al., 2006). Due to the nature of living a longer life, older participants may have incurred a grieving "practice effect," whereby, with experience, they have learned about their own grieving style and developed resources. An older individual who had experienced the loss of an intimate partner long ago may also have had the benefit of time to progress through grief and make new meaning from his or her loss.

However, the age of the participant was significantly and positively correlated with nature of death, which, given how the nature of death was coded for this study, suggests that older participants tended to experience losses that were categorized as "expected/natural," while younger participants tended to experience more unexpected or traumatic losses. Research suggests that problems in grieving tend to increase as the

severity of the trauma surrounding the loss also escalates (Currier et al. 2009; Lobb et al. 2010). The results of this study are consistent with the results of previous research, and suggest that, for this sample, the level of trauma associated with the loss may be a mediating variable.

It should be noted that time since the loss emerged as the most important single factor in both steps of the analysis. Even with the addition of the sexual minority stress factors, time since loss had the largest unique contribution to explanation of variance in grief of all significant variables. Research suggests that although bereavement is an individual experience that varies from person to person, that the magnitude and severity of grief generally lessens as more time passes post-loss (Carnelley et al. 2006; Feigelman et al. (2009). While this study's results are consistent with prior research, it is notable that the immediacy of the loss accounted for the most explained variance even in the presence of sexual minority stress variables. This effect may in fact denote the importance of this factor in understanding the grief process, or may have been a consequence of the sample characteristics. Individuals who had lost their partner within the past 12 months constituted 22% of the sample, the largest single amount of time represented (the next largest being 2 years post-loss, at 10.6%). Given the nature of recruitment, it may be have difficult to find a sample in which the majority of the participants hadn't very recently lost their partner. As noted previously, individuals tend to experience fewer problems in grieving as time passes, therefore those individuals may not have as strong an online presence on grief and bereavement-related websites. However, the potential influence of these grievers should be considered when interpreting the data.

Clinical Implications

The results of this study highlight the additive impact of social stressors, specifically minority stress, on the grieving process. In clinical work with bereaved individuals who identify as gay, lesbian, or bisexual, practitioners may wish to address how, if at all, their client's self-understanding as a sexual minority impacts his or her grief experience. As demonstrated in this study, younger clients and those who have recently experienced a loss may be especially at risk for problematic grief.

As previously noted, the average score on the Inventory of Complicated Grief (Prigerson, et al., 1995) for this study was 47.78 (*SD* = 13.38). This score is considerably higher than average scores reported in other studies. For example, Prigerson and colleagues (1995) found a mean score of 17.74 (*SD* = 12.42), and Holtslander and McMillan (2011) found a mean score of 18.10 (*SD* = 11.6). At first glance, this elevated average grief score may seem to reflect the relatively high number of recently bereaved participants included in this study. However, comparatively, the average time since loss cited in the study by Prigerson and colleagues (1995) was 2.8 years (*SD* = 1.3), and all of the participants included in the study by Holtslander and McMillan (2011) were bereaved for only three months. However, it should be noted that the bereaved participants in Prigerson's study were classified as "elders," and those who participated in Holtslander and McMillan's study were caregivers, not exclusively spouses or intimate partners. Such an elevated mean grief score could be the result of utilizing online data collection methods. Participants who use GLB and grief-oriented discussion forums, listservs, and email groups may be less likely to seek out other types of support, including individual and group psychotherapy, as well as general social support. As a result, online data

collection may have accessed a more "clinical" sample of individuals with greater symptomatology. This high score may be a product of the general findings of the study, in that the stress of being a sexual minority was associated with increased severity in grief symptoms. In this case, that the elevated score may reflect the additive effect of minority stress. Additional research is needed to further understand this disparity, however, clinically speaking, the results of this study suggest that practitioners should be aware of potentially severe grief experiences when working with GLB-identified clients.

Clinicians should also remember that social stigma of any kind could prevent many people from seeking help. In the case of sexual minority identities, some clients may only disclose information regarding their grief, and may feel unsafe about revealing their sexual identities to a clinician. Clients may fear re-traumatization from the therapist, who they may anticipate to have an unaccepting attitude of minority sexual identity. Clinicians should attempt to make the therapeutic space as safe as possible, where the client feels comfortable talking candidly about his or her grief. Relatedly, research demonstrates that psychotherapeutic bereavement-related interventions are most effective when they are specifically and intentionally targeted for individuals who display a marked difficulty in dealing with grief (Currier et al. 2008). In this way, clinicians could maximize their effectiveness by assessing for symptoms of problematic grief early in the therapeutic process.

Both bereavement and identifying as a sexual minority can be isolating for some individuals. The loss of social connections and reclusion from normal activities can be common for those who are grieving, while those who identify as gay, lesbian, or bisexual may be ostracized from their communities. Considering these risk factors, clinicians

could focus on helping the client develop a positive social support network, or develop alternative forms of social support such as GLB-centered grieving groups. Outreach to local GLB community centers and organizations on the topic could help the larger GLB community better understand the specific needs of those who identify as gay, lesbian, or bisexual who are grieving.

Limitations

Although a concerted effort to reach racial and ethnic minorities was made throughout the data collection process, the majority of participants identified as Caucasian. Therefore, the results of this study may not easily be generalized to members of racial and ethnic minority groups. No data regarding social economic status, religious affiliation, education level, or geographic location was collected, thus any generalization of the results to these particular groups is cautioned. Participants were self-selected, thus precluding the researcher from collecting data from individuals who declined participation due to disinterest or other factors. Due to the high degree of face validity of many of the measures, and because data was gathered through participant self-report, social desirability may have been an influential factor in participant responses. Last, because this study utilized multiple regression as the principal data analytic tool, no assumptions with respect to causation can be made.

A second limitation to this study was the subjective categorization regarding the nature of death. Research suggests that the extent to which the death was anticipated as well as the trauma associated with the manner of death influence the survivor's grieving process (Currier et al. 2006). Generally, deaths that are unexpected or particularly violent (homicide, suicide, accident, war, or natural disaster) are associated with longer, more

complicated grief (Kristensen et al. 2012). Participants in this study were asked to explain the nature of their partner's death, which was then coded as either "expected/natural" or "unexpected/traumatic." Although the researcher utilized inter-rater reliability statistics to ensure accuracy in coding, researcher subjectivity and interpretation of any kind is a notable limitation.

Future Research

Due to the demographic limitations described above, future research should focus on gaining more specific knowledge as to how these factors may impact the relationship between sexual minority stress and the grief process found in this study. Other minority identities (racial, ethnic) may be important in continuing to understand the impact of social stress on the grief process for sexual minority groups. Research focused on multiple minority stressors (e.g., co-occurring sexual and racial minority identities) and their relationship to the grief process would broaden and deepen the understanding of this phenomenon.

Kuyper and Fokkema (2011) suggest that despite the increased empirical attention given to exploring minority stress and the risk and resilience factors for sexual minorities as a large, integrated group, little is known about potential difference between sexual orientation groups (e.g., gay compared to bisexual). Additionally, while much of the empirical knowledge regarding "gay grief" is focused on gay men, little is known about the grief experience of lesbian women and bisexual individuals. For example, a study by Sikkema et al. (2006) revealed that the rates of multiple loss can be quite high among gay men, however it is unknown if multiple partner loss is as prevalent or profound among

lesbian women. Future research may seek to understand how the grief experience may be different between these groups.

Third, this study did not compare the grief experiences of heterosexual and GLB individuals. Thus, statements comparing the grief experiences between these two groups cannot be made. To more fully understand the impact of minority stress on the grief experience for those who identify as a sexual minority, future research should include comparison studies of the bereavement experiences of both heterosexual and homosexual groups.

The degree of trauma associated with the death of a partner (evidenced by the nature of the loss variable) emerged as a potentially mediating factor in understanding the relationship between age of the surviving partner and the degree of problematic grief. Although other research has demonstrated a similar effect, it seems likely that for this sample, social isolation and discomfort with one's sexual orientation (sexual minority stress) may have had greater impact on the grief experience for older participants. Future research should attempt to achieve greater understanding of this relationship.

Results demonstrated that the time since the loss occurred uniquely accounted for more variance in grief than any other single variable in both steps of the analysis, even in the context of the sexual minority stress factors. These findings are consistent with previous research and may reflect a phenomenon of the grief process, or may be the result of additive effects of minority stress in bereavement. Future research should seek to clarify the relationship between these variables.

Degree of outness emerged as an unanticipated variable of interest in this study. In this sample, bereaved individuals who were open to their communities with respect to

their sexual minority status tended to seek out less social support. It may be that the more out an individual is to his or her community, the more stigmatized the loss and the less he or she is likely to seek social support. Alternatively, self-disclosed individuals may have such a strong social network, seeking out additional support is not necessary. Future research should focus on further understanding of this relationship. Additional research may also focus on self-disclosure or "outness" with regard to bereavement. Even though an individual may not conceal his or her sexual minority status with friends, family, and community, an individual may not be "out" about his or her loss, especially if it was a stigmatized loss (such as a death due to HIV/AIDS).

Finally, qualitative studies may help further broaden and deepen our understanding of the grief experience for those who identify as gay, lesbian, or bisexual. Given that the grief process is so complex and individualized, qualitative methodologies could help researchers gain a more contextual understanding of the relationship between bereavement and sexual minority status.

Summary and Conclusions

The major result of this study indicated that the social stigma associated with occupying a marginalized space in society (in this case, sexual minority stress) influenced the grief process following the death of a committed partner. More specifically, sexual minority stress emerged as a significant predictor of problematic, complicated grieving. These results maintained their significance even in the context of other grief-related variables previously shown to impact the bereavement process. Of these, time since the loss and age of the participant demonstrated importance in predicting the degree to which grief was problematic. It seems that gay, lesbian, and bisexual individuals who are young

and those who have recently experienced a loss of a partner were most at risk for problematic grief.

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Appendix A

Dear _____,

My name is Alison Hickman, and I am writing to request your participation in recruiting participants for a research study focused on the grief and bereavement experiences of gay, lesbian, and bisexual (GLB) individuals who have lost a committed partner. There are no foreseeable risks for participating in this study. In fact, participants might find some benefits, such as reflecting on their grief process and their relationship with their partner, as well as contributing to affirming GLB research.

Participants should identify as gay, lesbian, or bisexual, be over the age of 18, live in the United States, and have lost a committed partner (all lengths of time since the loss are encouraged to participate). A committed partner is defined as a significant other with whom you shared a monogamous relationship, and is not limited to those who are legally married.

I would greatly appreciate your help in connecting willing and appropriate participants to this study. Forwarding this email, posting the link below to listservs, discussion groups, newsletters, or a website (or any other way that you and your agency disseminate information) would be very helpful. Please know that anyone you refer is ensured anonymity, and that you are helping to contribute to responsible research in the GLB community.

I understand that talking about grief and loss can be a very delicate topic to reflect on, and I want to be sensitive to the questions and concerns of anyone who is considering participation. I have included my contact information on the first page of the online survey.

Sincerely,

Alison Hickman, MA
Doctoral Candidate
The University of Memphis

Appendix B

Informed Consent

Principal Investigator: Alison L. Hickman, MA
Doctoral Student, The University of Memphis

Description of the Study:
This study is focused on exploring the grief and bereavement experiences of gay, lesbian, and bisexual individuals who have lost a committed partner. Participants in this study will be asked to complete a survey that is expected to take 15-20 minutes. This survey is anonymous, does not require any identifying information, and any published research resulting from this study will be reported as aggregate data. The researcher will donate $1 for each survey initiated to the Human Rights Campaign, up to $250. Terminating this survey does not preclude a donation.

Qualifications:
Participation in this study is limited to gay, lesbian, or bisexual adults over the age of 18, who are living in the United States, and have experienced the death of a committed partner. Committed partnership is defined (for this study) as an intimate, exclusive relationship between two individuals who identify as gay, lesbian, or bisexual.

Risks:
There are no foreseeable risks involved in participating in this study. Participants may experience discomfort recalling memories of the deceased and reflecting on this relationship.

Benefits:
Participants may benefit from this study by developing a greater sense of awareness related to their own individual grief process, as well as feel satisfaction knowing they have contributed to gay, lesbian, and bisexual affirming research.

Confidentiality:
All responses will be kept anonymous, as participants are not asked for their names, dates of birth, or other individually identifying information. Data will be kept electronically, and password protected. All data will be held for a period of 12 months, and then disposed.

Questions:
If you have questions or concerns related to this study, please contact Alison L. Hickman at (901) 581-7635 or at alison.hickman@memphis.edu. You may also contact her faculty advisor Dr. Douglas Strohmer at (901) 678-2841. Questions related to your rights as a research participant may be directed to Chair of the Committee for the Protection of Human Research Participants of The University of Memphis at (901) 678-2533.

Terminating the Study:
Participation in this study is completely voluntary. Beginning this survey does not obligate the participant to complete the study. Participants may decline participation at any point with no consequences.

Agreement for participation:
By clicking on the button below, I acknowledge that I am at least 18 years old, have read and agree to the statements detailed above, and I agree to take part in this study.

Appendix C

Demographics Questionnaire

1. What is your gender?
    a. Male
    b. Female

2. What was your partner's gender?
    a. Male
    b. Female

3. How do you identify your sexual orientation?
    a. Gay
    b. Lesbian
    c. Bisexual

4. How did your partner identify his/her sexual orientation (to the best of your knowledge)?
    a. Gay
    b. Lesbian
    c. Bisexual

5. What is your age (years)?

6. What is your race/ethnicity?
    a. African American
    b. Caucasian
    c. Asian/Pacific Islander
    d. Hispanic
    e. Native American
    f. Biracial
    g. Multiracial

7. What was your partner's race/ethnicity?
    a. African American
    b. Caucasian
    c. Asian/Pacific Islander
    d. Hispanic
    e. Native American
    f. Biracial
    g. Multiracial

8. What was your commitment status with your partner?
    a. Married
    b. Civil union

c. Domestic partnership
d. Commitment ceremony
e. Other (please explain)

9. Time (in years) since you lost your partner (if less than one year enter "0").

10. Please explain the nature of your partner's death. (open response)

11. Have you sought help to deal with this loss?

    a. Yes
        i. If yes, please explain (open response)
    b. No

Appendix D

Inventory of Complicated Grief

1. I think about this person so much that it's hard for me to do the things I normally do…
   Never rarely sometimes often always

2. Memories of the person who died upset me…
   Never rarely sometimes often always

3. I feel I cannot accept the death of the person who died…
   Never rarely sometimes often always

4. I feel myself longing for the person who died…
   Never rarely sometimes often always

5. I feel drawn to places and things associated with the person who died…
   Never rarely sometimes often always

6. I cannot help feeling angry about his/her death…
   Never rarely sometimes often always

7. I feel disbelief over what happened…
   Never rarely sometimes often always

8. I feel stunned or dazed over what happened…
   Never rarely sometimes often always

9. Ever since s/he died it's hard for me to trust people…
   Never rarely sometimes often always

10. Ever since s/he died I feel like I have lost the ability to care about other people or I feel distant from people I care about
    Never rarely sometimes often always

11. I have pain in the same area of my body or have some of the same symptoms as the person who died…
    Never rarely sometimes often always

12. I go out of my way to avoid reminders of the person who died…
    Never rarely sometimes often always

13. I feel that life is empty without the person who died…
    Never rarely sometimes often always

14. I hear the voice of the person who died speak to me…
Never rarely sometimes often always

15. I see the person who died stand before me…
Never rarely sometimes often always

16. I feel that it is unfair that I should live when this person died…
Never rarely sometimes often always

17. I feel bitter over this person's death…
Never rarely sometimes often always

18. I feel envious of others who have not lost someone close…
Never rarely sometimes often always

19. I feel lonely a great deal of the time ever since s/he died…
Never rarely sometimes often always

Appendix E

The Internalized Homophobia Scale

1. I have a positive attitude about being gay/lesbian/bisexual.
Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree

2. I feel uneasy about people who are very open in public about being gay/lesbian/bisexual.
Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree

3. I often feel ashamed that I am gay/lesbian/bisexual.
Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree

4. For the most part, I enjoy being gay/lesbian/bisexual.
Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree

5. I worry a lot about what others think about my being gay/lesbian/bisexual.
Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree

6. If feel proud that I am gay/lesbian/bisexual.
Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree

7. I feel that being gay/lesbian/bisexual is a sin.
Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree

8. I wish that I weren't attracted to the same sex.
Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree

9. I feel that being gay/lesbian/bisexual is a gift.
Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree

Appendix F

Heterosexist Harassment, Rejection, and Discrimination

Please think carefully about your life as you answer the questions below. Read each question and then check the number that best describes events in the PAST YEAR, using these rules.
Circle 1—If the event has NEVER happened to you
Circle 2—If the event happened ONCE IN A WHILE (less than 10% of the time)
Circle 3—If the event happened SOMETIMES (10–25% of the time)
Circle 4—If the event happened A LOT (26–49% of the time)
Circle 5—If the event happened MOST OF THE TIME (50–70% of the time);
Circle 6—If the event happened ALMOST ALL OF THE TIME (more than 70% of the time).

How many times have you been treated unfairly by teachers or professors because you are GLB?

1 2 3 4 5 6 n/a

How many times have you been treated unfairly by your employer, boss, or supervisors because you are GLB?

1 2 3 4 5 6 n/a

How may times have you been treated unfairly by your co-workers, fellow students, or colleagues because you are GLB?

1 2 3 4 5 6 n/a

How many times have you been treated unfairly by people in service jobs (by store clerks, waiters, bartenders, waitresses, bank tellers, mechanics, and others) because you are GLB?

1 2 3 4 5 6 n/a

How many times have you been treated unfairly by strangers because you are GLB?

1 2 3 4 5 6 n/a

How many times have you been treated unfairly by people in helping jobs (by doctors, nurses, psychiatrists, caseworkers, dentists, school counselors, therapists, pediatricians, school principals, gynecologists, and others) because you are GLB?

1 2 3 4 5 6 n/a

How many times were you denied a raise, a promotion, tenure, a good assignment, a job, or other such thing at work that you deserved because you are GLB?

1 2 3 4 5 6 n/a

How many times have you been treated unfairly by your family because you are GLB?

1 2 3 4 5 6 n/a

How many times have you been called a heterosexist name like dyke, lezzie, or other names?

1 2 3 4 5 6 n/a

How many times have you been made fun of, picked on, pushed, shoved, hit, or threatened with harm because you are GLB?

1 2 3 4 5 6 n/a

How many times have you been rejected by family members because you are GLB?

1 2 3 4 5 6 n/a

How many times have you been rejected by friends because you are GLB?

1 2 3 4 5 6 n/a

How many times have you heard anti-GLB remarks from your family members?

1 2 3 4 5 6 n/a

How many times have you been verbally insulted because you are GLB?

1 2 3 4 5 6 n/a

Appendix G

Outness to the World

1. How out are you to your new heterosexual friends?
   None some most all

2. How out are you to your work peers?
   None some most all

3. How out are you to your work supervisors?
   None some most all

4. How out are you to strangers?
   None some most all

Appendix H

Resource Page

Thank you for participating in this study. I consider your thoughts and feelings to be extremely valuable, and I plan on handling them with care. Grieving loved ones is one of the most difficult experiences of our lives, so through participation in this study, you might have reflected on some memories or feelings that were difficult for you to handle. If you should feel that you would like to receive additional help and support, I encourage you to seek counseling in your area. Here is a list of other resources that you might find helpful.

National Grief Recovery Hotline	800-445-4808
National Suicide Hotline	800-suicide
Suicidehotlines.com	Listing of nationwide hotlines by area
Griefnet.org	Comprehensive website with online support groups
APA.org	Find a therapist