# CONVERSATIONAL DIFFERENCES BETWEEN HOMOSEXUAL AND HETEROSEXUAL COUPLES COPING WITH BREAST CANCER: A QUALITATIVE ANALYSIS

By

Katherine Emily Hague

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APPROVED

Dr. Megan Robbins
Department of Psychology

Dr. Richard Cardullo, Howard H Hays Jr. Chair
University Honors

ABSTRACT

This observational study explored the conversational similarities and differences between homosexual and heterosexual couples undergoing breast cancer treatment, to determine whether their communication methods and daily interactions suggest an increased ability for illness coping given the gender of the partner. Gender has been shown to influence how individuals cope with illness, but this has not been extensively studied in the context of homosexual and heterosexual couples and their dyadic approaches. Understanding alternative approaches to illness coping among different identity groups is significant for clinical settings and may offer increased insight for medical professionals as to the needs of their patients. Transcripts of patient and partner conversations were collected from an earlier study using the Electronically Activated Recorder (EAR) (Robbins et al. 2014) and were analyzed in this study using the qualitative method of Thematic Analysis (Braun & Clarke, 2006). Findings from this study indicated that homosexual and heterosexual couples did exhibit differences in their communication habits and in the content of their conversations, and supported the theory that gender of both patient and partner can influence the illness experience. Women, and therefore homosexual couples, were often more emotionally disclosing, more engaged with treatment decisions, and more explicit with regard to medical symptoms than men. Homosexual couples also exhibited increased partner to patient caregiving and had less concerns over physical appearance with increased emotional intimacy when compared to heterosexual couples.

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TABLE OF CONTENTS

## Introduction

It is well established that people around us, specifically romantic partners, have the ability to affect how we cope with stressors, such as illness and disease (Hagedoorn et al., 2008). As such, communication methods between patients and their partners are of great importance to psychological research given their potential therapeutic applications. Gender differences have been thought to contribute to the communication habits of individuals, and thus, have been discussed frequently in studies conducted on cancer patients (Dindia & Allen, 1992; Umberson, 2016; Wheldon, 2019). However, there has been little exploration of how the gender of the partner affects the illness experience. The individual adjustment of heterosexual and homosexual patients with illness-related stress has been considered, but how this translates to the couple has not been thoroughly explored. This study focuses specifically on breast cancer patients and their partners, to qualitatively determine whether the gender of the partner influences daily conversations, and in turn, suggest how that may influence emotional well-being.

## Background

Approaches to coping with illness have been shown to vary based on gender and have been studied extensively within the context of romantic relationships. Initially, interactions and coping mechanisms within couples were considered a function of role (patient versus caregiver) rather than gender. However, gender has been increasingly shown to influence interactions and coping mechanisms, irrespective of patient or caregiver role (Hagedoorn et al., 2008). More specifically, the gender of the patient and partner dictates how each person in the couple is able to take on these patient and partner roles. Self-report data in past studies has shown that men often adopt a process of illness minimization, in which their adjustment to illness involves downplaying the illness and a decreased role in caregiving, whereas women adopt an immersive

approach to illness coping, in which they participate in significant emotional disclosure and prioritize the caregiving role (Umberson et al., 2016). Additionally, improved adjustment outcomes have been shown in female patients whose partners also participated in increased emotional disclosure (Allen & Dindia, 1992; Manne et al., 2014; Robbins et al., 2014). It has been suggested that these improved outcomes are not necessarily associated with illness immersion being preferential to illness minimization, but instead that the illness association strategy is concordant within the couple (Umberson et al. 2016). A concordant approach, and thus, a unified coping strategy, aligns with the notion of dyadic coping within a couple, which has been consistently shown to improve couple relationship satisfaction and overall adjustment in the context of coping with illness (Karan et al., 2016; Umberson et al., 2016; Robbins et al., 2014).

Consequently, it is reasonable to suggest that female patients, such as those undergoing breast cancer treatment, would have significantly improved outcomes in the presence of a female partner versus a male partner. The illness experience of homosexual patients compared to heterosexual patients has been explored but vary rarely within the context of the couple's daily interactions. Self-report data from homosexual and heterosexual female patients coping with breast cancer has revealed striking differences. Firstly, women in homosexual couples have been shown to have higher levels of self-disclosure, in contrast to heterosexual women, who disclosed at a lower rate that was more closely correlated with heterosexual and homosexual men (Allen & Dindia, 1992). In addition, homosexual women have also been shown to have less cancer-related thought suppression than heterosexual women, and fewer concerns over relationship intimacy stemming from body issues and sexual concerns (Arena et al., 2007). Finally, homosexual women were more likely to express appreciation for caregiving performed by their partner than

heterosexual women, given that their relationship dynamics are more likely to be more egalitarian in division of care work, and thus, their female partner is more likely to participate in caregiving than male counterparts (Umberson et al., 2016). All these findings suggest significant differences in how homosexual and heterosexual women coping with breast cancer navigate their relationship with their spouse, the manner in which is likely to suggest improved adjustment outcomes for female patients in homosexual relationships.

The ability for homosexual women to have increased adjustment to illness has also been studied from a life course perspective, in which their designation as a sexual minority may contribute to their ability to cope with stressors. Homosexual women are more likely to experience increased stress throughout their lifetimes as members of a heteronormative society and may have to deal with sexual discrimination or familial rejection. It is suggested that these factors contribute to an increased ability to cope with illness stress, as they have had many experiences that have given them the opportunity to develop healthy coping mechanisms (Arena et al., 2007; Wheldon et al., 2019). Furthermore, the rejection they may experience has also been shown to dictate the quality of relationships in which homosexual women chose to participate, indicating that relationships with partners or "chosen family' are more likely to be supportive and involve high quality interactions (Robbins et al., 2021). This notion, termed a honing framework, coupled with the differences in communication habits amongst homosexual and heterosexual patients, indicates a need for further research into the interactions of homosexual and heterosexual couples coping with illness.

Observational studies have been performed on couples coping with breast cancer, but very few with the intention of exploring gender differences and comparing heterosexual and homosexual patients. Modern technology has moved research away from self-report data, which

has the potential for recall or apprehension bias, to naturalistic observation which analyzes participants in an unobtrusive manner. One such technology is the Electronically Activated Recorder (EAR); a recording device that has been shown to collect reliable data with test-retest reliability to draw conclusions on the well-being of subjects, such as those coping with breast cancer (Mehl et al., 2001, 2012; Robbins et al. 2014). EAR studies on breast cancer patients and their partners have revealed a strong non-independence within couples, indicating a dyadic approach to coping, with spousal support being most evident in daily interactions rather than emotional disclosure (Robbins et al., 2018). While it has been suggested that gender may be a contributing factor to adjustment outcomes, none of the studies involving the use of the EAR have directly compared the experiences of heterosexual and homosexual couples to reveal gendered approaches. Using the data from an earlier EAR study (Robbins et al., 2014), this study aims to evaluate the conversations of homosexual and heterosexual couples to determine meaningful differences in the context of dealing with illness-related stress while undergoing treatment for breast cancer.

***Present Study***

Unlike previous quantitative studies performed with this data, a qualitative approach was applied to this study to better understand the detailed nuances of heterosexual and homosexual communication methods. Thematic analysis was the chosen qualitative method, as its flexibility allowed researchers to determine which conversations were important and relevant to the study of relationship differences amongst couples coping with cancer. This observational study was primarily exploratory and attempted to determine whether conversations would be different amongst heterosexual and homosexual couples, and if so, how their communication habits and discussion topics differed. This was specifically explored through the lens of coping with breast

cancer and its effect on relationships, with special focus on conversations pertaining to medical treatment, couple intimacy, and gender differences. We predicted there would indeed be gender-related differences in communication habits, with women, and thus, more often homosexual couples, having increased emotional disclosure, especially when discussing medical-related issues. Furthermore, we predicted that women in homosexual couples would be more likely to engage in conversations pertaining to feminine issues, especially when it came to conversations about breast cancer, such as hair loss or mastectomies, given that they had a female partner who was going to be more attuned to the female experience. Finally, we also anticipated that homosexual couples were going to exhibit more concordant and dyadic coping mechanisms than heterosexual couples, and thus, be more sympathetic towards their spouses needs and reflected in caregiving actions and emotional support.

## Methods

Data for the present study was collected during an earlier experiment, in which 56 breast cancer patients and their partners participated in an Electronically Activated Recorder (EAR) study over the period of one weekend (Robbins et al., 2014). The patients were recruited for the study during their regular visits to the oncologist at the Arizona Cancer Center. Patients were considered eligible if they had a Stage I, II, or III breast cancer diagnosis, were receiving treatment in the form of radiation or chemotherapy, lived with their partner in a marriage-like relationship, and spoke primarily English at home with their partner. The patient and their partner's conversations were recorded for 50 seconds every 9 minutes using the EAR device, which was strapped to their waistband throughout the waking hours of their day. Approval for the original study was given by the University of Arizona Institutional Review Board (BSC B06.207).

Of the 56 couples selected for the 2014 study, 8 couples were part of a homosexual relationship, with both the patient and partner being female, giving a total of 16 homosexual participants for the current study. To study only the similarities and differences between heterosexual and homosexual couples, 8 heterosexual counterparts, and thus, 16 total heterosexual participants, were matched to the homosexual couples based on demographic similarities, including but not limited to, age, length of relationship, stage of cancer, and ethnicity (see Table 1). Participants were mostly White, representing around 78% of the participant sample, with Hispanic, Black, and Native American participants representing 13%, 6% and 3%, respectively. With the interest of studying only non-trivial, or emotionally significant discussions between partners, audio files were filtered to include only conversations between patient and partner, and were limited to substantive or emotionally disclosing conversations. Previous studies using this data have outlined and coded substantive conversations to include non-emotional meaningful informational exchange, such as opinions on news or philosophical ideas, and emotional disclosure to refer to anything pertaining to an individual's personal feelings or emotions (Robbins et al., 2018). This resulted in a total of 32 participants for the present study, with a total of 648 sound files, equivalent to approximately 9 hours of audio.

Transcripts and audio files were studied using the Thematic Analysis framework, as outlined by Braun and Clarke (2006), in which themes and patterns are identified and organized to provide meaning to how particular topics, such as cancer, relationships, and gender, are talked about within distinct groups of people. Thematic Analysis is primarily exploratory in nature and was chosen for this study due to the varied nature of the transcripts themselves (i.e., taken from observations of everyday life, and not through focused interview questions). Furthermore, it provides opportunity for both an inductive approach, in which content of the transcripts reveals

themes to the researcher, but also a deductive approach, in which the researcher brings concepts and ideas, say about gender or caregiving, to the data set as a basis for analysis.

Thematic analysis, and therefore the procedure for this study, follows six distinct phases: familiarization with the data, generation of initial codes, search for themes, review of potential themes, defining of themes, and report writing (Braun & Clarke, 2013; Delahunt & Maguire, 2017). Phase 1 required multiple readings and listenings of all the substantive or emotional audio files for the 32 participants, with the intention of becoming familiar with the content of the data and developing initial analytical notes. In Phase 2, audio files relevant to the field of study were coded based on their content and separated into heterosexual or homosexual categorical groups. Not every audio file or transcript was given a code, however, some files fit into multiple coding groups. For example, the statement "I think your hair looks cute, Dearest" from Couple 40, was coded as Pet Name from Partner, Compliment from Partner, and Patient Medical Symptoms, given that the conversation was centered around cancer-related hair loss. This step further reduced the data set from a total of 648 audio files to 195 pertinent audio files. Phase 3 required searching for patterns and themes within the data, to determine how certain codes may be linked to one another and what they reveal about the data set as a whole. These connections between codes were reviewed in Phase 4, to determine whether they indicated a larger theme rather than just a code, whether there was sufficient evidence for said theme, and ultimately, if these themes said anything significant about the data. Finally in Phase 5, themes were finalized and defined as a collection of distinct codes so that they did not overlap, with specific audio clips collected to represent each theme (see Table 2 for an example of these distinctions). The evidence of these themes, in the form of transcripts and audio clips, was then reported in Phase 6, to develop a

coherent narrative regarding the experiences of heterosexual versus homosexual couples coping with breast cancer.

## Results

From the conversations of both heterosexual and homosexual couples, six distinct themes emerged: Medical Talk, Affection and Intimacy, Conflict, Physical Appearance, Relationships and Family, and Culture. Each of these themes arose differently in homosexual and heterosexual couples, both in relation to the manner in which they presented themselves and their relative proportion in daily conversations.

### *Medical Talk*

Although cancer-related talk was very rare in previous studies of the entire data set (Robbins et al., 2014), this sub-sample of participants discussed cancer, and indeed other medical ailments, frequently. This may have been in part due to the filtering out of all non-substantive conversations, but may also reflect the increased proportion of homosexual, and thus, female, participants in the sample.

Homosexual and heterosexual couples discussed medical treatment in similar proportions, yet within heterosexual couples, the patient (i.e., the female spouse) mentioned medical treatment most frequently. When male partners did discuss medical treatment, it was often logistical or less emotional:

*Partner HT[1] (Couple 33): We didn't leave any pills, I thought we had taken them down… Well, how are you going to check what's in the house?*

*Partner HT (Couple 46): Aspirin is a wonder drug… You take so you don't have a heart attack.*

[1] Heterosexual couples indicated by abbreviation HT. Homosexual couples indicated by abbreviation HM.

*Partner HT (Couple 40): So, I bet you're looking forward to having uh the last treatment on Tuesday, huh? It gets to be a hassle going down there every day and staying there.*

As seen above, male-partner medical conversations were directed toward patients, and were rarely self-reflective, with the use of "you" allowing male partners to separate themselves from the illness experience.

In contrast, women, in both heterosexual couples and homosexual couples, were far more involved in treatment decision making and more explicit in their discussions of symptoms pertaining to themselves and others:

*Patient HM (Couple 11): Is itching one of the symptoms?... It's almost like it's spreading, like first it was just on the top of my head, now it's my whole head including my face and down my neck and on my shoulders.*

*Patient HT (Couple 46): Got an upset stomach? A little bit gassy? Maybe take a half hour nap.*

Oftentimes, as seen in the examples above, women elicited responses from their spouses and spoke in ways that encouraged them to participate in patient and partner illness experiences. Furthermore, specifically homosexual couples often expressed the notion of managing the disease and treatment together, and encouraged equal participation in the medical experience:

*Partner HM (Couple 11): She wants to know what the problem was with the Tegretol. Let's go get your calendar and try to figure it out.*

*Partner HM (Couple 22): I think you could do it, but I think you really learned with me.*

These conversations work to establish dyadic coping in the homosexual couple in response to breast cancer diagnosis and may alter the way in which they exhibit caregiving or intimacy with each other.

***Affection and Intimacy***

Affectionate or intimate moments indicated a closeness or fondness between partners and often took the form of caregiving, pet names, or emotional support and disclosure.

Caregiving followed the trends of medical talk, where women were more likely to participate, which often resulted in the patient having an increased caregiving role in heterosexual couples compared to homosexual couples. Given that the partner was rarely experiencing illness, caregiving in heterosexual couples often took the form of household chores:

*Patient HT (Couple 46): I thought you didn't want your water? You got your pills, right? They're on your seat, grab them.*

*I need to trim your mustache, don't I?*

*Patient HT (Couple 50): I'll help you move the bed.*

*Patient HT (Couple 33): I'm going to get the laundry first.*

Both partners and patients in homosexual couples participated in caregiving, but overall, partner caregiving to patient was most common. Specifically, younger homosexual couples, in which the partner was less likely to be experiencing illness as well, exhibited a greater proportion of partner to patient caregiving:

*Patient HM (Couple 23): Can you get me another bottle of water please? Thank you.*

*Partner HM (Couple 23): I'll be in to do your hair in a bit. Alright baby.*

*Patient HM (Couple 11): I was just looking out for you and your safety.*

*Partner HM (Couple 11): I think I need to pour that water in for you.*

Couple 11, aged 64 and 55, participated in equal amounts of caregiving, whereas Couple 23, aged 42 and 43, exhibited almost exclusively partner to patient caregiving.

Pet names also varied greatly between homosexual and heterosexual couples, and also different generational groups. Heterosexual couples almost exclusively used 'Dear,' 'Dearest' or 'Honey,' regardless of age group. On the other hand, older homosexual couples used similar pet names, like 'Honey' or 'Lovey,' but younger homosexual couples only used 'Baby' or 'Babe'. Despite these differences, both heterosexual and homosexual couples used pet names at similar rates. Not every couple used pet names, but when they did, they used the same one frequently in almost every conversation with their spouses. Additionally, in both heterosexual and homosexual couples, the pet name primarily used by one spouse was often the same one used by the other spouse.

Women, and more specifically, the patients, tended to be more emotionally disclosing, and often discussed fears or negative emotions with their partners:

*Patient HM (Couple 11): I don't want to be so abnormal.*

*Patient HT (Couple 42): I always get scared getting up to go to work. Well, anxious. Then I get so anxious that I start to shut down, and I go oh I don't care, I just don't care.*

Female partners showed more emotional support than their male counterparts, and their emotional support was often aimed at alleviating the emotional concerns of their spouses. Male partners showed affection and emotional support differently, often making more typically romantic statements, instead of comforting their spouse's specific concerns:

*Partner HM (Couple 22 - Female): It'll all work out… I think you're in much better shape.*

*Partner HT (Couple 40 - Male): We're holding hands, gazing into each other's eyes over our beautiful dinner. I love you.*

***Conflict***

Conflict, or arguments between the spouses, mostly occurred in heterosexual couples (in approximately five different heterosexual couples) and were most often associated with a discord in caregiving expectations. Male partners were seen to get most frustrated when having to perform caregiving duties:

*Partner HT (Couple 29): Well, that stuff has medicine in it, so. Too late now, don't take it off.*

*Partner HT (Couple 33): Why do you need me to go over there and help you pack up your stuff?*

Additionally, heterosexual female spouses also became frustrated when their desires for caregiving were not met:

*Patient HT (Couple 33): Are you going to lay down on the couch all day? You know you remember all of this when I was going through chemo and sleeping half the day away, like you're doing now.*

*Patient HT (Couple 46): Ugh I hate that… you forgot to remind me.*

Only one homosexual couple argued during the recordings, Couple 41, and while the argument did pertain to expectations around household chores, it was apparent that the disagreement was mostly centered around minor name-calling, in which the partner branded the patient as acting immature:

*Patient HM (Couple 41): Please straighten that out, I'd expect that from a little kid… you just acted like [you were] five.*

*Partner HM (Couple 41): You know… I'm not five. Do I look five right now opening this bag up? Absolutely not.*

***Physical Appearance***

In another indicator of couple satisfaction, the way in which couples talked about their own and their spouse's physical appearance varied amongst the different couple types. Heterosexual women were far more concerned about their appearance, and more specifically their weight, than homosexual women. They would often talk about dieting or worries about not fitting into clothes:

*Patient HT (Couple 42): I think I'm going to start making rice and vegetables again.*

*Patient HT (Couple 46): I just got a pair of pants to work out in. I think they'll fit…*

*Patient HT (Couple 43): Do you feel afraid to say [what you want for dinner] because I'm really struggling with my weight?*

Homosexual women would also comment on their own bodies, but these comments were rarely negative and never referred to weight loss. Their comments were more informational, such as discussing where they wanted to get a new tattoo, or about recent athletic performance:

*Partner HM (Couple 32): I would like to swim better… But what I feel is, aerobically, I'm good.*

In response to this, male partners were more likely to give physical compliments than female partners, possibly as a response to heterosexual women's negative talk about their bodies. Furthermore, men and heterosexual women commented more frequently on the physical appearance of other women than homosexual couples, and often in a negative way:

*Patient HT (Couple 30): Yeah, very intelligent woman though… Damn she had a big butt.*

*Patient HT (Couple 46): Oh, look how short she is.*

*Partner HT (Couple 30): Yep, that was her. The older woman.*

Neither couple type made comments on the physical appearances of other men. Interestingly, male partners complimented the patient's hair the most, seemingly with the effect of overcoming negative thoughts that heterosexual women had regarding their cancer-related hair loss. This was especially interesting given that female partners, who theoretically would be more attuned to the importance of hair with regards to feminine identity, rarely complimented the patient's hair. Homosexual couples did discuss their hair more, but it was not in the form of compliments and was mostly logistical. The compliments given by homosexual couples were often non-physical and related more to mental well-being:

*Patient HM (Couple 23): I always walk with my head down.*
*Partner HM (Couple 23): [fondly] You're in your own little world.*

*Partner HM (Couple 32): You are so freaking brilliant. I wrote that in the survey.*

Homosexual women also mentioned their own natural aging process more than heterosexual women, but again, these conversations were not negative in nature:

*Patient HM (Couple 11): It's natural, it's natural. How much is it the aging process, how much of it was chemo, how much is it the epilepsy…*

***Relationships and Family***

As to be expected, the ways in which homosexual couples discussed family life differed to that of heterosexual couples. Heterosexual couples often talked about their parents, specifically about their mothers and birth:

*Patient HT (Couple 40): That's what happened to my mom when she gave birth to H— and when my grandma gave birth to B—.*

*Partner HT (Couple 50): I'm too much my mom, I guess.*

*Partner HT (Couple 40): You know, every time lately that I've seen your mom she just looks so much more frail to me each time. Do you think the same?*

Homosexual couples rarely talked about their parents or motherhood, but when they did, it was either in a negative way or it was about themselves:

*Partner HM (Couple 32): I'm not an amazing mom.*

*Patient HM (Couple 32): We don't talk about things. So, I think I threw her when I reached puberty.*

Couple 32 was not the only homosexual couple that discussed puberty and reproduction. Surprisingly, even though homosexual couples talked less about their parents and family, they spoke more about children and reproductive issues than heterosexual couples, who rarely talked about it at all:

*Partner HM (Couple 11): We are a thinking people; we basically believe that God gave us a brain and expects us to use it. We believe in birth control.*

*Partner HM (Couple 41): I'm on my period too remember, I'm bleeding heavily.*

Regardless of the apparent openness of homosexual couples, these couples seldom talked about their own relationship with each other and spent significant time discussing and criticizing the relationships of peers and family members. On the other hand, heterosexual couples talked far more about their own relationship than the relationships of others, discussing how they felt about the relationship and what they believed others thought about their relationship:

*Patient HM (Couple 5): How are A—- and H—-? Are they still arguing?*

*Patient HT (Couple 42): They're going to think, "Isn't this the quietest couple ever?"*

### *Culture*

Finally, the last difference discovered in the conversations of heterosexual and homosexual couples is how they discussed cultural identity, with emphasis on ethnicity, religion, and sexuality. These topics were only discussed by the homosexual couples, with one exception: the sole Black heterosexual participant, the Patient of Couple 30, discussed the prejudice faced by Black Americans with her partner on multiple occasions:

> *Patient HT (Couple 30): So, it is ok for Blacks to achieve, but we are still just like that picture… they go back home, and they are treated like dirt!*

All other participants who discussed ethnicity, religion, or LGBTQ+ issues, were part of the homosexual couples. Most of the time, these discussions pertained to the social identity groups in which each participant belonged. For example, the Partner in Couple 41, who was both Hispanic and part of a homosexual relationship, talked about being a Latina at Pride, but Couple 11, where both patient and partner were Christian and White, only talked about their church group and did not participate in any ethnic conversations:

> *Partner HM (Couple 41): He's like Y— said that you can do the [Pride] panel… I need a Latina. I already told them I can't.*

## Discussion

Overall, it is evident from the conversations between homosexual and heterosexual couples that gender does contribute to conversational differences and suggests, at least in this sample, a gendered approach to illness and spousal support. Contrary to what was expected, the significance of a breast cancer diagnosis, compared to a non-gender-specific cancer such as lung or skin cancer, did not encourage discussions pertaining to femininity or a feminine cancer experience, and instead, focused on coping and illness more broadly.

Even though illness conversation content was rarely gender-focused, the proportion and nature in which individuals discussed the illness experience did concur with expected gender approaches. The tendency for women, both patient and partner, to be more engaged and explicit with the illness experience and decision-making process than men, aligns with the theory of illness immersion by women and illness minimization by men (Umberson et al., 2016). This further explains the increased conflict between heterosexual partners compared to homosexual partners, especially when it pertained to illness-related caregiving, given that their gendered approach to illness was not concordant. For the homosexual couples, the ability for both partner and patient to be equally engaged with cancer and the illness experience allows for a potential decrease in detrimental thought suppression, and an increased opportunity for dyadic coping with beneficial therapeutic effects (Arena et al., 2007; Robbins et al., 2014).

Additionally, it was evident that gender differences in caregiving and emotional disclosure also followed expected patterns, not only due to the predisposition of women to be more immersed in the illness experience, but also the tendency of women to be more likely to express their feelings and desires (Allen & Dindia, 1992). This difference amongst men and women was further amplified by the same-sex female couple conversations, in which support given by the spouse was much more tailored to the emotions of their partner. The propensity for women to be more aware of their emotions and the emotional needs of others allowed them to deliver emotional support and caregiving at an increased rate to men. While outward expressions of appreciation by patients for partner caregiving were rare for both couple types, the increased caregiving role of homosexual partners aligned with predetermined notions that women in homosexual couples are often shown to be more appreciative of caregiving gestures (Umberson et al., 2016). Altogether, these findings concur with pre-established societal stereotypes, in which

women perform most of the caregiving duties in the home, whether that be for children, or in this context, for spouses.

The focus on physical appearance by heterosexual women is also closely linked to this notion of illness awareness and couple discord. Past research has shown that heterosexual women diagnosed with breast cancer are more likely to have concerns over body image and sexual intimacy than homosexual women (Arena et al., 2007). Furthermore, this has been directly related to cancer-specific awareness, with couples who experienced more awareness (i.e., same-sex female couples) reporting greater intimacy and relationship satisfaction (Manne et al., 2014). This is reflected in the current study, with homosexual couples exhibiting far less preoccupation with body image and significantly less conflict within the couple. The fact that homosexual couples opted for less physical compliments and focused more on complimenting personality traits and intellectual strength, further illustrates this idea. These outcomes are correlated in both this study and previous studies, however given the observational nature of these studies, it is still unclear whether these factors have a causal relationship.

The observed patterns, in which homosexual couples experienced more emotional spousal support and less couple discord, could also be linked to the quality of relationships outside of their partner. In this study, homosexual couples discussed family far less frequently than heterosexuals, and when they did, it was often to describe negative relationships with family or to offer criticism of their family members relationships. This finding is consistent with the notion of a honing framework, in which homosexuals are more likely to have higher quality relationships with selected members of their social groups (i.e., spouses), given that they are more likely to distance themselves from low quality relationships in which they may experience sexual prejudice (i.e., family members) (Robbins et al., 2021). In homosexual couples, both

partner and patient are likely to have experienced discrimination, and therefore, the need to eliminate certain social connections, which may contribute to a mutual understanding of increased spousal support. This further explains the decreased conflict among homosexual couples and is likely to reflect the improved coping mechanisms seen in homosexual couples, given that their sexual minority status has forced them to confront many life stressors in the past (Weldon et al., 2019; Arena et al., 2007).

Finally, this idea that past discrimination can influence the quality of one's social connections, and therefore, one's ability to develop healthy coping mechanisms, may translate to other examples of discrimination outside of sexual minority, such as ethnicity. This may explain the increased presence of ethnic conversations amongst the homosexual couples, given that they are more likely to be aware of how their social identities contribute to their experience. This supports the theory of intersectionality, in which multiple social identities contribute to an individual's experience of prejudice, and may influence their social structures (Bowleg, 2012). While intersectionality may be a contributing factor in explaining the increased presence of ethnic conversations amongst homosexual participants, it is unclear whether this unique and nuanced experience of discrimination contributed to an increased ability to cope with stressors, as it may also create conflicting approaches and discord amongst couples. Given that the majority of the participants in this study were white, it may be useful to conduct further studies with greater ethnic diversity to determine the net effect of multiple interacting social identities on conversation characteristics and coping mechanisms.

***Limitations***

This study was performed on a relatively small scale, and as such, was open to potential biases. While the small sample size was necessary for this type of qualitative study, as analysis of

audio files one by one would be unmanageable in a large sample size, there is still a potential for sampling biases. The patterns and themes in the current data may not be representative of heterosexual or homosexual couples coping with breast cancer globally and may just be present in the small group we selected. This could be attributed to the similarity in recruitment location, the predominance of white participants, or the presence of generational differences. Furthermore, the methodological choice to filter the conversations to only include substantive or emotional conversations may have left out data that could have potentially influenced results (such as pet names being used in informational or small talk). Finally, given that the analysis of results was only conducted by one person, and reviewed by one other person, the interpretation of the data is somewhat subjective and unavoidably built upon predetermined ideas or biases, regardless of intent to remain impartial.

## Conclusion

This study provides evidence to support that gender does influence how patients cope with illness, not only with regards to themselves, but also in terms of the gender of their partners. Homosexual couples exhibited decreased conflict and increased concordance in their illness approaches, resulting in increased spousal support and dyadic coping compared to their heterosexual counterparts. While it is suggested that concordant illness approaches, honing frameworks, and sexual minority designations may influence these results, future studies should be designed to confirm these theories. Increasing sample size and varying sample demographics will help determine the validity of these conclusions, but it is perhaps most important to expand participant groups to include homosexual male relationships. If these improved coping mechanisms are indeed a product of same-gendered approach to illness, rather than just an outcome of increased emotional disclosure and illness participation, reduced conflict should also

be observed for homosexual male couples. Furthermore, it would be beneficial to analyze these conversational differences within the context of psychological adjustment scales, such as those that may indicate depression or relationship satisfaction, to confirm whether seemingly healthy coping mechanisms and couple interactions actually improve the psychological adjustment of the patient and their partner. Finally, it may be important to further establish these trends in other forms of cancer (i.e., not breast cancer) or other long-term illnesses, given that the breast cancer diagnosis itself had no real significance to the conversation habits of these participants. Ultimately, how patients interact with their illness and medical treatment is a byproduct of social experience, personal identity, and cultural background. In order for clinical care teams to effectively communicate and administer treatment, it is important for them to understand the nuances of these social backgrounds to ensure improved patient outcomes.

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| Table 1: Heterosexual and Homosexual Participant Matches and Demographics | | | | | | |
|---|---|---|---|---|---|---|
| **Match** | **Couple Type** | **Age** | **Ethnicity** | **Relationship Length (years)** | **Number of Children at Home** | **Stage of Cancer** |
| Couple 40 Partner | Hetero | 60 | WHITE | 15.00 | 0 | 1 |
| Couple 40 Patient | Hetero | 64 | WHITE | 15.00 | 0 | 1 |
| Couple 5 Patient | Homo | 62 | WHITE | 15.00 | 0 | 2 |
| Couple 5 Partner | Homo | 66 | WHITE | 15.00 | 0 | 2 |
| Couple 38 Partner | Hetero | 59 | WHITE | 23.25 | 1 | 2 |
| Couple 38 Patient | Hetero | 50 | WHITE | 23.25 | 1 | 2 |
| Couple 11 Patient | Homo | 64 | WHITE | 19.00 | 0 | 1 |
| Couple 11 Partner | Homo | 55 | WHITE | 19.00 | 0 | 1 |
| Couple 33 Partner | Hetero | 63 | HISPANIC | 43.00 | 0 | 3 |
| Couple 33 Patient | Hetero | 62 | HISPANIC | 43.00 | 0 | 3 |
| Couple 22 Patient | Homo | 68 | WHITE | 18.92 | 0 | 3 |
| Couple 22 Partner | Homo | 67 | HISPANIC | 18.92 | 0 | 3 |
| Couple 29 Partner | Hetero | 39 | WHITE | 4.08 | 5 | 3 |
| Couple 29 Patient | Hetero | 38 | WHITE | 5.00 | 2 | 3 |
| Couple 23 Patient | Homo | 42 | NATIVE AMERICAN OR ALASKAN NATIVE | 4.42 | 1 | 2 |
| Couple 23 Partner | Homo | 43 | WHITE | 4.42 | 1 | 2 |
| Couple 46 Partner | Hetero | 77 | WHITE | 37.33 | 0 | 1 |
| Couple 46 Patient | Hetero | 60 | WHITE | 35.58 | 0 | 1 |
| Couple 31 Patient | Homo | 72 | WHITE | 37.00 | 0 | 3 |
| Couple 31 Partner | Homo | 65 | WHITE | 37.00 | 0 | 3 |
| Couple 42 Partner | Hetero | 34 | WHITE | 12.75 | 0 | 1 |
| Couple 42 Patient | Hetero | 49 | WHITE | 12.75 | 0 | 1 |
| Couple 32 Patient | Homo | 45 | WHITE | 11.75 | 0 | 1 |
| Couple 32 Partner | Homo | 39 | WHITE | 11.75 | 0 | 1 |
| Couple 30 Partner | Hetero | 67 | WHITE | 7.00 | 0 | 3 |
| Couple 30 Patient | Hetero | 59 | BLACK | 6.42 | 0 | 3 |
| Couple 41 Patient | Homo | 36 | BLACK | 4.92 | 1 | 2 |
| Couple 41 Partner | Homo | 37 | HISPANIC | 4.92 | 1 | 2 |
| Couple 50 Partner | Hetero | 64 | WHITE | 10.83 | 0 | 1 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Couple 50 Patient | Hetero | 50 | WHITE | 17.00 | 0 | 1 |
| Couple 55 Patient | Homo | 49 | WHITE | 17.75 | 0 | 2 |
| Couple 55 Partner | Homo | 59 | WHITE | 17.75 | 0 | 2 |
| **Homosexual Averages** | | **54** | W **75%** - H **13%** - B **6%** - NA **6%** | **16.10** | **0** | **2** |
| **Heterosexual Averages** | | **56** | W **81%** - H **13%** - B **6%** - NA **0%** | **19.45** | **1** | **2** |
| **Total Averages** | | **55** | W **78%** - H **13%** - B **6%** - NA **3%** | **17.77** | **0** | **2** |

Table 2: The Organization of Themes and Codes Example

| Theme: | Affection/Intimacy - *Conversations suggest a closeness or fondness between patient and partner.* | | | |
|---|---|---|---|---|
| Code: | Homo - Caregiving by Patient | Hetero - Caregiving by Patient | Homo - Pet Name from Partner | Hetero - Pet Name from Partner |
| Transcript: | *"I'll go for you babe, you are gonna relax..."*<br><br>*"Are you hurting?"* | *"I need to trim your mustache, don't I?"*<br><br>*"You got your pills, right?"* | *"I know, Lovey. You can hardly take any kind of medication."*<br><br>*"Babe, do you want anything?"* | *"I know it honey; it's getting bad here."*<br><br>*"Good stuff, dear."* |
| Theme: | Medical - Conversations pertain to the medical treatment of a patient or partner. | | | |
| Code: | Homo - Patient Medical Symptoms | Hetero - Patient Medical Symptoms | Homo - Partner Medical Symptoms | Hetero - Partner Medical Symptoms |
| Transcript: | *"I'm nauseous"*<br><br>*"Is that why I'm freezing?"* | *"That's why I have such problems when I lay down like that."*<br><br>*"Ouch, my knee again…"* | *"That's what Percocet does for me. I itched so bad all over."*<br><br>*"My energy level is so low today."* | *"I know you've got really sick because of it!"*<br><br>*"Were you getting car sick?"* |