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Role Strain Among Lesbian, Gay, Bisexual, Transgender, Queer Couples Diagnosed with Cancer

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Abstract

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MA, New Mexico State University, 1992

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

In society, individuals tend to be socialized into roles that take on characteristics of masculine and feminine. Studies exist on the role strain experienced by heterosexual couples dealing with a life-threatening illness due to this characterization. The scholarly literature lacks studies on the understanding of roles, as well as possible role strain, in lesbian, gay, bisexual, transgender, and queer (LGBTQ) couples when dealing a life-threatening illness. The purpose of this qualitative case study was to explore the role strain experiences of LGBTQ couples who are living with cancer diagnoses of a partner. Biddle's role strain theory provided the conceptual framework for this study. The study included interviewing five LGBTQ couples with a partner having a first-time diagnosis of Stage II or III cancer. Face-to-face, individual, semistructured interviews were used to collect the data, and an open coding method to analyze the data. The themes identified were the significance of fluid roles prior to cancer diagnoses, adjustment to role change, relationship since cancer diagnoses, chosen or determined roles, and society's views of roles. Finding were LGBQT couples roles were chosen or determined based on the task they enjoy or like to do instead of stereotypical view of masculine and feminine. LGBTQ couples did not report experiencing role strain related to assuming additional roles due to their partners' illness. Positive implications for social change resulted from the ability to inform healthcare providers how LGBTQ couples manage when supporting a partner diagnosed with Stage II or Stage III cancer.

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Dedication

June 26, 2016, same-sex couples finally won the battle to marry legally in all 50 states. To the heartfelt and arduous battle for society to acknowledge your relationships to be equal to heterosexual relationships; this doctoral study is dedicated. The day that the Supreme Court voted to legalize same-sex marriage, it was truly a happy day for you.

To the entire dyslexic community, encouraging every one of you to identify the learning tools that best fit you in your daily academic, social, and work environments. Despite the challenges that you may face, you can achieve your dream and goals. This dissertation is an example of what you can accomplish.

A loving family who never let quit enter the picture when feeling that there was no more energy to carry on. Jerry Aaron, loving father who passed away before seeing the completion of this journey. Both parents, Jerry and Linda Aaron were a driving force of their daughters getting college educations. Telling us from the time we could walk we would go to college for a degree. Parents that guided a child who was not confident that she could achieve a college degree, at a time she was unable read a book all the way through.

Chip Thomason a loving husband, who encouraged and supported continuing the Ph.D. program. Chip, you provided strong, loving encouragement throughout as well as love during this strenuous journey. The completion of this project is an example of our teamwork.

Tina New, my younger sister who listened when I was lost and did not know where to go in the writing of this doctoral study. Unknowingly, the guidance provided kept the project on track. The understanding of this challenging subject added validity to the importance of its completion.

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I am thankful to all my love ones and friends who provided compassion, inspiration, and comfort through the journey and the completion of my Ph.D.

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Chapter 1: Introduction to the Study

Introduction

Researchers have examined the influence of family members' roles who have had members diagnosed with cancer, as well as other medical conditions including stroke, brain injuries, and diabetes (Fife, Weaver, Cook, & Stump, 2013). In the structure of a relationship, each member family demonstrates distinct patterns of behaviors (Macionis, 2011). LGBTQ couples have different modes of behavior within the context relationship (Macionis, 2011). According to Erickson (2015), heterosexuals view LGBTQ couples' roles within their relationship as similar to their roles as providers and caregivers.

Researchers explored the role strain experienced by heterosexual couples living with a loved one with a significant or terminal illness (Erickson, 2015; Hoyt, Stantion, Irwin, & Thomas, 2013; Mooney, Knox, & Schacht, 2013). However, scholars have not examined the role strain experiences of LGBTQ couples with a partner with significant or terminal illness. In this qualitative study, I focused on LGBTQ couples' perceptions of how role strain influences their roles within their relationship when one partner receives a diagnosis of Stage II or III cancer. In this study, I explored how their roles change during one partner's illness and whether this leads to them experiencing role strain.

I employed a case study approach that included conducting face-to-face interviews. I used semi structured, open-ended interview questions to gather data and to analyze participants' lived experiences concerning how they coped with changes in their roles when one partner received a diagnosis of Stage II and III cancer. In this chapter. I provide the background on this topic, as well as clarifying terms, and discuss the basis and structure employed to conduct the research.

Background

Socialization begins in infancy (Mooney et al., 2013). The agents of socialization are family, peer groups, schools, and the mass media (Iantaffi & Bockting, 2011; Mooney et al., 2013). The socialization process provides an individual with the behaviors and knowledge to function in society, social positions, status, and roles (Eaton & Rose, 2011; Mooney et al., 2013). Status refers to social position (ie., race, job title, education, or gender; Eaton & Rose, 2011; Mooney et al., 2013). Each person learns a set of behaviors referred to as his or her role (Eaton & Rose,2011; Mooney et al., 2013). As individuals, some of these roles include employee, supervisor, student, church member, club member, caregiver, brother, son, husband, partner, boyfriend, mother, sister, wife, daughter, and girlfriend. In someone’s lifetime, the possible roles are endless; however, at any given time an individual is only performing one or two roles (Iantaffi & Bockting, 2011; Mooney et al., 2013).

Li, Shaffer, and Bagger (2015) asserted that role strain occurs when challenges or difficulties develop into multiple roles, creating stress for an individual. The pressure may be due to the individual’s lack of skills, time management, or desire to perform a new role. The added role of caregiver for an ill parent is an example role strain. Role strain is stress or anxiety individuals experience due to inconsistent behavior, expectations, or obligations in their current role (Henslin, 2015). In many cases, couples have to alter their roles when changes like receiving a diagnosis of cancer occur in their relationship. The couple may need to adjust their previous role to dedicate more time to the new role of caretaker or patient (Lim, Brown & Kim, 2014). The adaptation process can cause stress (Raikla et al., 2013).

White and Boehmer (2012) focused on women and female partners support system during and after the recovery from breast cancer, not on the structure of their same-sex relationships. Hoyt et al. (2013) examined outcomes related to gender roles for both heterosexual and gay men concerning their gender roles and feelings of masculinity after a prostate cancer diagnosis. Minimal empirical evidence exists on the roles that LGBTQ couples choose in their relationship (Iantaffi & Bockting, 2011; Mooney et al., 2013). Also, scholars have not explored how the experience of role strain affects LGBTQ couples having a partner diagnosed with cancer

There have been studies on various heterosexual population's experiences of strain and being overburdened when a family member receives diagnoses of cancer (Faguendes et al., 2012; Kim, Carver, Rocha-Lima & Shafer, 2013; Mazanec et al., 2011; Papadopoulos et al., 2011). Role reassignment within the context of their relationships occurs, in an attempt to maintain the daily functions. Individuals not only have to perform their usual roles but learn the skills of the added role, caregiver. During treatment planning, physicians were not only concerned about the physical and mental health of their patient but also their caregivers (Kim et al., 2013; Li et al., 2015).

In previous studies, the sample populations were single parents, caregivers, and adult children (Mazanec et al., 2011; Railka et al., 1013; White & Friesen, 2013). Researchers found that these populations reported role strain, based on the additional roles they assumed (Li et al., 2015; Mazanec et al., 2011; McQueen, Kreuter, Kalesan, & Alcaraz, 2011). The participants experienced role strain, which caused anxiety, depression, fatigue, and insomnia (Li et al., 2015; Papadoppoulos et al., 2011; Railka et al., 2013). Additionally, heterosexual couples developed dissatisfaction in their relationships due to the role strain (Li et al., 2015; Papadoppoulos et al., 2011; Railka et al., 2013).

Gap in Knowledge

Although studies exist concerning the effect of role strain on heterosexual couples, no empirical investigations were found on LGBTQ couples' perceptions of role strain (Hoyt et al., 2013; Kim et al., 2013; Li et al., 2015). There is a gap of knowledge in this area of research (Hoyt et al., 2013; Kim et al., 2013; Li et al., 2015). In respect to LGBTQ couples' perceptions and experiences of role strain, LGBTQ and heterosexual couples' role structures are the same (Hoyt et al., 2013; Mooney et al., 2013).

According to American Cancer Society (2016), 1,685,210 people are diagnosed with cancer, of them 841,390 are males and 843,820 are females. The cancer registry, where all diagnoses of cancer are logged and tracked, only records individuals as male or female but does not document their sexual orientation (Bishop et al., 2014). In 2014, the U.S. Census Bureau (2014) reported 530,861 LGBTQ households in the country; it is unknown how many have cancer. I was able to locate only two studies related to gay couples who experienced a partner receiving a cancer diagnosis. Higgins (2005) reported on gay partners experiencing prostate cancer and revealed patterns indicating that gay men were twice as likely to receive this diagnosis when compared to their heterosexual counterparts.

Before the United States Supreme Court's ruling on LGBTQ marriages, only 20 states, as well as the District of Columbia, had legalized LGBTQ marriages (Henslin, 2015). There is a need for extending the body of knowledge regarding LGBTQ' relationships, and roles within their relationship. Little is known related to how gay LGBTQ couples differentiate themselves in the context of their relationship (Hoyt et al., 2013; Mooney et al., 2013). People outside of their community often view LGBTQ couples as having one person who fulfills the role of "the husband" and the other "the wife" (Rhoads & Rhoads, 2012). LGBTQ couples do not feel bound by these role expectations (Hoyt et al., 2013; Mooney et al., 2013). When beginning a relationship, LGBTQ couples discuss and decide what roles each partner will perform (Iantaffi & Bockting, 2011; Mooney et al., 2013). Unlike typical heterosexual couples, LGBTQ couples can choose the roles they play in their relationship (Iantaffi & Bockting, 2011; Mooney et al., 2013).

Throughout this study, I focused on changes in their relationships when one partner receives diagnoses of Stage II or Stage III cancer. I explored LGBTQ couples' perceptions of changes made in their partnerships to meet the needs of the household and whether the adjustments create strain for the caretaking partner. The intent was to contribute to the knowledge base concerning LGBTQ couples' roles, as well as providing insight into the effects of role strain.

Problem Statement

In 2015, there were 26,840 new patients diagnosed with cancer (American Cancer Society, 2016). Cancer not only affects the patient but the family as well (Biddle, 2013). Family members alter their roles to ensure the structure of the household remains balanced (Biddle, 2013). As the role adjustment occurs, the individual required to perform different tasks is challenged to acquire new skill sets (Biddle, 2013). The balancing of old roles into new ones can create role strain (Iantaffi & Bockting, 2011; Mazanec et al., 2011; McQueen et al., 2011). Although researchers have examined the experiences of role strain by heterosexual couples caring for a loved one with a significant or life-threatening illness, scholars have not focused on role adaptation in same-sex relationships or on the of role strain experienced by LGBTQ couples dealing health issues. There is a disparity in the understanding of roles as well as role strain in LGBTQ couples when dealing with the same situation. I explored these issues by documenting the lived experiences of LGBTQ couples confronted with these life changes.

Purpose of the Study

The purpose of this study was to explore LGBTQ couples' roles in the context of their relationships to glean an understanding of whether they experience role strain when dealing with a partner diagnosed with Stage II and Stage III cancer. To investigate LGBTQ couples' roles and intuitive experiences of role strain, I interviewed five LGBTQ couples who had a partner diagnosed with Stage II or III cancer, using a case study approach. During this inquiry, I provided LGBTQ couples with the opportunity to verbalize the role they perform in the context of their relationship and to explain if these roles changed, once a partner received a diagnosis of Stage II or III cancer. I will use the outcomes of the study to provide a foundation to begin to understand LGBTQ couples' roles and their experiences when a significant illness occurs, potentially altering the way they relate to one another. There was a body of knowledge regarding how role strain affects heterosexual relationships, along with individual family members or friendships when they assume caretaking responsibilities (Faguendes et al., 2012; Mazanec et al., 2011; McQueen et al., 2011). The results of this study will assist in providing information related to LGBTQ couples' roles within their relationship and offer suggestions to health care providers who provide treatment to ill partners. Policymakers can use the outcomes of this study to evaluate and develop policies and procedures within the healthcare field.

Research Paradigm

Consistent with qualitative research approaches, interpretivists seek to understand the meaning people attach to their experiences. Interpretivists explore the lived experiences of a population to inform academia of their unique perspectives (Barnham, 2015; Madill, 2015). In analyzing their data, researchers attempt to clarify and describe the data offered by their study participants (Barnham, 2015; Humprey, 2013). Interpretivists co-create with their research participants (Madill, 2015). Within this framework, researchers connect people's experiences with how they express them based on their worldview (Madill, 2015).

In this qualitative case study, I described the influences of role strain experienced by LGBTQ couples while a partner battles with cancer. The goal is to bring light to same-sex couples' perceptions of role strain. The illumination is likely to provide insight into LGBTQ couples' roles and motivations needed in dealing with a partner diagnosed with cancer.

Research Questions

To describe the perceptions of LGBTQ couples' roles within their relationship, and the influence of dealing with a partner diagnosed with Stage II or Stage III cancer has on their relationship, I posed the following questions:

RQ1. How do LGBTQ couples decide their roles within their relationship?

RQ2. How are LGBTQ couples' roles influenced when a partner is diagnosed with Stage II or Stage III cancer?

RQ3. What are LGBTQ couples' concerns and perceptions regarding their relationship with a partner diagnosed with Stage II or Stage III cancer?

In the development of the research questions, I incorporated elements of role theory as it aligned with the purpose of this investigation. This inquiry provided opportunities for LGBTQ couples to explain their roles both before and after a partner receive a diagnosis of cancer.

Theoretical Framework

I applied the theoretical framework of role theory as described by Biddle (2013) to undergird my study. The theory's origins are in sociology and social psychology (Biddle, 2013). Biddle defined role theory as behavioral actions people perform within a context. Role theory has also been used to examine and explain the various roles experienced throughout an individual's lifetime (Sluss, van Dick, & Thompson, 2011). The framework is used to understand individuals' roles and the associated skill sets used to perform expected behaviors in social settings (Sluss et al., 2011).

Role theory has six major propositions. In the first, throughout life, individuals interact with individuals, groups, and organizations (Biddle, 2013). Within these interactions, individuals hold distinct positions (Biddle, 2013). The positions they hold requires the performance of a role by the individual, functioning within the group or organization (Biddle, 2014). The expectations of the role within a group or organization are formalized norms, including rewards and punishments for performing the role successfully or unsuccessfully (Biddle, 2014). According to the final proposition, individuals primarily conform to the expected roles as well as the norms attached to the roles (Biddle, 2014). Biddle (2014) suggested that other group members hold one other accountable to conform to the norms and the role performed.

A role is an expected behavior, attitude, or interaction of the person within a particular status (Mooney et al., 2013). Biddle (2014) described roles as changing depending on the situation. The application of this theory was significant to this study as it related to the status, role, and role strain for LGBTQ couples dealing with a partner diagnosed with cancer. Because LGBTQ couples have the ability not to conform to expected roles, I used the theory to understand the nature of the relationships and their perceived changes when unexpected events cause their roles to change (Sluss et al., 2011). I provide a detailed description of role theory in the next chapter.

Nature of the study

Rationale

I conducted a qualitative, descriptive, bounded case study. In using this method, I sought to gain an understanding the roles performed by LGBTQ couples within their relationship and to explore whether any changes, such as performing caretaking responsibilities, creates role strain (Henslin, 2015). The goal was to allow LGBTQ couples to discuss the roles they perform daily in their home, as well as any changes that occurred after a partner received a Stage II or Stage III cancer diagnoses. I inquired as to whether same-sex couples experience role strain in the cases requiring reassignments of roles (Henslin, 2015).

A descriptive, bounded case study was the most suitable design to explore the lived experiences of LGBTQ couples because the design supports the research process used to investigate a phenomenon within the context of everyday life (Yin, 2013). Data were collected using purposeful sampling techniques and the identification of themes or categories based on the participant's descriptions (Yin, 2013). In Chapter 3, I provide a more detailed discussion of the research methodology.

Key Concepts

I focused on the functioning of LGBTQ couples' roles within their relationship and how it evolves and changes following one partner receiving a diagnosis of Stage II or III cancer. LGBTQ couples had the opportunity to describe the routine roles each performed before the diagnose of a partner's cancer and discuss how they experienced any changes after the diagnose of cancer was determined. For the couples who experienced role changes, I explored whether they experienced strain related to learning the skills in the new roles.

Methodology

Data collection occurred between treatment cycles for the partner diagnosed with cancer for this study. I collected data using semi-structured, open-ended questions to guide face-to-face interviews. With the permission of the participants, I audio recorded the interviews while taking handwritten notes, and upon concluding the collection process, I transcribed the data verbatim by hand. By employing an open coding methodology, I identified repetitive codes or phrases during the first read-through of the data. In the second reading, I used a highlighter to mark words demonstrating behaviors related to the identified verbiage.

Definitions

Ascribed status: Involuntary, for example, male, female, mother, father, White, African American, a teenager, or an orphan (Mooney et al., 2013).

Achieved status: Earned, for example, full-time student, social worker, teacher, or thief (Mooney et al., 2013).

Cancer: Any of various malignant growth or tumor invading tissue in one part of the body or metastasizing into additional body sites (American Cancer Society, 2016). Individuals diagnosed with cancer are assigned a Stage from 0 to IV depending on the extent of the disease. The Stage of the cancer is determined using Tumor Node Metastasis (TNM) staging system (American Cancer Society, 2016). The determination of the Stage includes if there is a tumor, or if it is in the lymph nodes or whether it has spread to other organs (American Cancer Society, 2016). Physicians use the results from the TNM staging system to diagnose the Stage of cancer in each patient. In some cases, Stage 0 is combined with one of the other Stages (American Cancer Society, 2016). Stage 0 indicates the cancer is in the original location and has not grown into other locations (American Cancer Society, 2016). Stage I, also known as the early Stage of cancer, means that there is a small amount of cancer or tumor that has not embedded in the tissues or spread to the lymph nodes. Stage II and III is when a larger amount of cancer or tumors has grown deeply into the tissue, spreading into lymph nodes (American Cancer Society, 2016). Stage IV is advanced or metastatic cancer, indicating the spread of cancer to other organs or parts of the body (American Cancer Society, 2016).

Family caregiver: Husband, wife, parent, or adult child providing care for an individual with an illness (Kim et al., 2013; Kim, Shaffer, Carver, & Cannady, 2014).

Gender: Behaviors and attitudes for males, females; masculinity or femininity proper in society (Henslin, 2015).

LGBTQ: Acronyms for lesbian, gay, bisexual, transgender and queer or questioning (Stinton, 2016).

LGBTQ couple: Marriage or committed relationship between two individuals of the same sex; a person who is attracted to both same-sex and opposite-sex; or a person who identifies with the opposite sex they were born or identifies with both male and female (Stinton, 2016). The relationship can take many forms, from romantic and sexual, or nonromantic (Stinton, 2016).

Master status: The status carrying the most important for a person's identity. This status is either a person's ascribed or achieved status, which holds exceptional significance to a person's identity, for example, Ph.D., lawyer, MD, mother, being blind, or a Kennedy (Mooney et al., 2013).

Role: A set of behaviors expected of a person who holds a particular status (Mooney et al., 2013).

Role conflict: Occurs due to tension between the roles of two or more (Mooney et al., 2013).

Role strain: Stress or strain individuals experience due to inconsistent behavior, expectations, or obligations of roles (Henslin, 2015).

Status: A person's social position directly tied to social identity and defines relationships to others (Mooney et al., 2013).

Assumptions

In this study, I assumed that all participants provided truthful responses to the interview questions. I anticipated that participants might be experiencing some level of stress because they are coping with medical issues related to the cancer treatments. I did not collect medical information on the partner not diagnosed with cancer but assumed they were in good physical health.

Scope and Delimitations

The focus of the study was on the role that LGBTQ couples establish in the context of their relationships, along with how they experience their separate roles. I highlighted the changes they express when one partner receives a diagnosis of cancer. In this context, I inquired about whether the altering of previous patterns of behavior creates strain for the partner in the caretaking role. I conducted face-to-face interviews with five same-sex couples meeting the study criteria. The criteria included being in a committed LGBTQ relationship, with one partner diagnosed with Stage II or III cancer. I conducted the data collection portion of the study in between treatment cycles. Heterosexual couples did not participate in the study. Other exclusions included the first-time Stage I or IV cancer diagnosed individuals; patients receiving treatment for brain, eyes, nose and throat cancer; and those with second cancer diagnoses at any Stage. I did not engage the couples in discussion regarding the influence of the disease process

Limitations

The sample size of five LGBTQ couples limits the transferability of the study's outcomes to other populations. The excluded populations also limit the generalizability of the outcomes (Suri, 2011). Another limitation was the possible hampering of the ability of participants to verbalize their experiences because they may be coping with the differing levels of depression and anxiety connected to cancer. Finally, the participants' self-reporting presents the possibility of distorted or erroneous responses.

The bias influencing the outcomes of the study are the systemic error, interviewer bias, and misclassification of data (Manen, 2014; Vagle, 2014). The reduction of systemic errors will occur through professorial review of the research process (Manen, 2014; Vagle, 2014). Practicing with the interview questions on a nonsample population will assist in minimizing interviewer bias (Siedman, 2013). Documenting the trail of data during the analysis process decreases the occurrence of misclassification of data (Vagle, 2014).

Significance

Studying the role that LGBTQ couples perform within their relationship, and any possible changes based on role strain among same-sex couples with a partner diagnosed with Stage II or Stage III cancer, is unique due to addressing an underresearched population (Lim et al., 2014). Understanding role strain among LGBTQ couples affected by dealing with a partner with cancer will add to the body of knowledge related to LGBTQ couples' roles within their relationships. I identified themes or categories that describe the experiences of role strain has on LGBTQ couples dealing with a partner diagnosed with cancer (Hancock & Algozzine, 2011). The insight I developed from conducting this study can be used to inform health care providers who examine the treatment of LGBTQ couples, and decision makers who evaluate policies and procedures within the field. I plan to disseminate the information at conferences and by publishing articles in relevant academic journals to assist future researchers investigating similar populations.

Summary

Throughout the chapter, I discussed the lack of research on the roles LGBTQ couples' relationships and how they experience changes in these roles when one partner receives a diagnosis of Stage II and III cancer. I examined whether the diagnosis changes the role previously held by each partner and whether it creates strain for either partner. In posing the research questions, I reviewed literature highlighting the gaps in these areas of study. I presented the theoretical framework underpinning this investigation, offering definitions for unfamiliar terminology, along with highlighting the significance of my research.

In Chapter 2, I present literature related to LGBTQ couples' role strain, along with details concerning the conceptual framework used to undergird my investigation. The central phenomenon of this study was LGBTQ couples processing their experiences of role strain. The case study method was selected to describe the experience of role strain among LGBTQ couples dealing with a partner with cancer in a treatment setting because it provides a glimpse into the structural change in a partner’s role. I recruited five LGBTQ couples with a partner having a first-time diagnosis of Stage II or III cancer to participate in the study.

Chapter 2: Literature Review

Introduction

In this qualitative case study, I addressed the problems related to the disparity in treatment services for LGBTQ couples, based on a lack of the understanding of roles, as well as role strain when they are adjusting to one partner's diagnoses of Stage II and II cancer. The purpose of the study was to explore LGBTQ couples' roles in the context of their relationships to glean knowledge of whether they experience role strain when dealing with a partner who faces a potentially terminal illness. The outcomes of the study can provide information related to how LGBTQ describe their roles, as well as whether they experience role strain based on one partner's cancer diagnosis, which alters previous relationships. I will also use the results of the study to inform policymakers who develop and evaluate policies and procedures within the health care field. The information can also assist health care practitioners currently providing services to LGBTQ couples, coping with oncology issues.

Within the structure of a couple's relationship, each member demonstrates distinct patterns of behaviors. These different patterns of behavior define how the couple interacts with their relationship. For couples, the interactions can be both positive and negative (Macionis, 2011). Each within the relationship performs roles like wife, husband, sibling, Mr. Fixit, clown, organizer, mediator, budgeter, or caregiver depending on the structure of the relationship. When events like a partner receiving a diagnosis of cancer occurs, the structure of the relationship adjusts to new roles, which could cause role strain (Fife et al., 2013).

Although studies exist on role strain impact on single parents, caregivers, and heterosexual couples, scholars have not examined the perceptions of role strain experienced by LGBTQ couples. Throughout this chapter, I discuss the literature search strategies used and the theoretical concepts used in the study. I include an examination of the literature on related topics such as single parents, caregivers, and heterosexual couples' personal experiences when providing support for ill loved one. Additional issues presented reflect the influence of role strain during the treatment of cancer.

Literature Search Strategy

For the literature review, I searched the concepts of role theory, role strain, affect, family dynamics, gay and lesbian couples, cancer, and family for peer-reviewed journal articles and textbooks. I searched the following libraries: New Mexico State University, Northeast State Community College, and Walden University. Search engines included EBSCO and Google Scholar. Using the search terms listed, I performed reviews of salient articles published in the last 5 years in the following databases MEDLINE, CINAHL, PsycINFO, ProQuest, SocINDEX, and LGBT Life. The search terms used individually or in combination were as follows: *role strain, stress, anxiety, impact, family, cancer, gay, lesbian, homosexual, gays diagnosed with cancer, burden, caregivers for cancer patients, partners with cancer, the effect on relationships, and role theory system approach.*

During the process of the literature review focusing on LGBTQ couples' experiences with role strain, I was unable to find sources on LGBTQ couples who have a partner diagnosed with cancer as a sample population. In narrowing the focus to LGBTQ couples' experiences with cancer, I found two articles. Hoyt et al. (2013) researched the effects prostate cancer had on gay men's masculinity. White and Boehmer (2012) explored the support available to female partners within a same-sex relationship when caring for a female partner diagnosed with breast cancer. White and Boehmer also related results concerning the emotional and physical treatment options available for gay men diagnosed with prostate cancer. Due to the gap in the background literature available on LGBTQ couples' experiencing role strain, I broadened the search criterion. In the expanded inquiry, I found articles on single parents, caregivers, and heterosexual couples' experiences of role strain while caring for a spouse or parent receiving treatment for cancer.

Theoretical Foundation

The origins of role theory are sociological and psychological, beginning in the 1920s. In the mid-1930s, Mead, Moreno, and Linton developed the first theoretical framework interrogating the concept of role expectation and performance within a social setting (as cited in Biddle, 1986). Mead's theoretical framework is symbolic interactionist role theory (Biddle, 1986). Mead viewed individuals as actors when interacting within a social setting (as cited in Biddle, 1986). Mead believed that actors were consciously aware of normative behavior required within the different settings (as cited in Biddle, 1986). The actors learned the required behavior by imitation, basically as if playing a game (Solomon et al., 1985). Mead documented that no one person knew who he or she was because the script he or she performed changed from one setting to the next (as cited in Dionysiou & Tsoukas, 2013).

Function role theory represented the work of Linton, but it was not recognized until 1951 by Parsons (Biddle, 1986). The focus of this theory was on individual characteristic behaviors (Biddle, 1986). The behaviors are referred to as roles, meaning shared expectations, explaining why and how individuals behave (Biddle, 1986). Within the social system, individuals occupy social positions. Solomon et al. (1985), suggested viewing individuals as actors within these social positions. As actors, they conform to normative behavior as defined by their social systems (Solomon et al., 1985). In 1975, the theory was expanded to include social structures as the main category of social positions (Solomon et al., 1985). With this expansion, theorists explained that there are different behaviors or roles required for different social positions (Solomon et al., 1985).

Cognitive role theory is the theoretical framework of Moreno created in 1934 (as cited in Biddle, 1986). Moreno focused on role-playing, meaning individuals seeking a desired outcome of acceptance in a social setting imitate the behaviors of others (as cited in Solomon et al., 1985). Children performed roleplay easier than adults, as it comes natural to them (Solomon et al., 1985). Moreno believe that roleplay could be adapted to educational and therapeutic settings (as cited in Biddle, 1986). Moreno applied roleplay as a means to change inappropriate behavior into acceptable and expected behavior as cited in (Solomon et al., 1985). I the role theory, Biddle (1986) adopted the concepts from symbolic interaction, function, and cognitive role theories

I applied Biddle's (1989) role theory as a framework to understand and analyze the process and outcomes of my study. The study of roles began when researchers questioned whether roles were learned patterns of behavior or natural parts of cultural (Li, Shaffer, & Bagger, 2015). Biddle (1989) stated that researchers could consider social issues using role theory as a conceptual framework. The application of role theory in studying human behavior in various societies provided researchers the possibility of generalizing their outcomes (Li et al., 2015). According to Biddle (1989), investigators in the fields of sociology, psychology, and anthropology used their understanding of roles to integrate fundamental concepts into their field studies.

According to Biddle (2013), patterns of behavior or social life roles are the foci of role theory. In role theory, there is a connection between roles and social positions, and an expectation of actions of oneself and others (Biddle, 2013). Individuals behave differently in different social situations that connect to their social identities; therefore, their roles become more like performances. Biddle (2013) stated that the performance of roles were "parts for which scripts were written" (p. 68).

To understand individuals through their behavior, researchers use role theory to define the effects of behavior in given contexts and the processes they are expected to demonstrate in a particular manner (Biddle, 2013). Within social position and roles performed in these social situations, there is an expectation of behavior (Biddle, 2013;

Mooney et al., 2013). Researchers can use role theory to analyze these behaviors occurring in social positions (Merton, 1996). Role theorists began to develop a desire to understand what caused individuals to develop role conflict and role strain when having to interact in a social context (Biddle, 2013; Mooney et al., 2013). Society uses the process of socialization as a means for individuals use to learn their social position, status, and roles needed to function within society (Mooney et al., 2013; Railka et al., 2013). Through the socialization processes, individuals learn the expected behavior that is attached to a particular social position, status, and role (Klassen et al., 2012; Mooney et al., 2013). When individuals are unable to perform the expected behavior, it causes role conflict and strain, which leads to stress, anxiety, and depression (Mooney et al., 2013; Valdes- Stauber, Vietz, & Kilian, 2013).

Individual Roles and Status

In society, individuals are socialized into roles that take on characteristics of obligations and expectations connected with status (Mooney et al., 2013). People's behavior is guided by the role that they are performing (Mooney et al., 2013). As a male, some of these roles include a brother, son, husband, partner, boyfriend, employee, supervisor, student and, caregiver. Throughout a lifetime, the possible roles are endless; however, an individual at any given time is only performing one to two roles (Mooney et al., 2013). An individual's roles require them to obtain skills to perform various functions. The skills are gained through observations, trial and error, and education (Mooney et al., 2013). There may be times that a particular role only occurs in an individual situation (Mooney et al., 2013). In life, there may be times that roles overlap, or one role that demands more time, creating role strain (Macionis, 2011; Mooney et al., 2013).

Status, which connects roles in society, is demonstrated by the position within a social group a person holds (Mooney et al., 2013). Macionis (2011) identified three types of statuses: ascribed, achieved, and mastered. There are social positions assigned to an individual at birth that the individual has no control over, like sex, race, ethnic, and socioeconomic background (Macionis, 2011). Achieved status is the social position assigned to a person based on characteristics or behaviors, such as student, spouse, parent, banker, or prison inmate (Macionis, 2011). The social identity a person develops, which is likely to shape a person's life, is the master status, like a doctor, lawyer, or educator (Macionis, 2011). At any given time in life, a person is functioning within one or all three status sets, simultaneously.

Role Strain

Role strain occurs when challenges or difficulties develop into multiple roles, which create feelings of stress (Kaplan, Alderfer, Kaal, & Bradley, 2013). Placing more saliency in one role, or creating less time for other roles, can cause role strain (McCutcheon, 2015). The spouse or daughter typically assumes additional roles when a family member receives a diagnosis of cancer (Kaplan et al., 2013; McQueen et al., 2011; Reblin et al., 2016; Wellisch, Sumner, Kim, & Spillers, 2015). Kaplan et al. (2013) and Reblin et al., (2016) indicated that parents, husband, and daughters who take on the role of caretaker once a family member became ill, felt role strain, and burdened by performing the duties associated with their new role.

The caregiver's ability to care for a family member is affected by family conflicts leading to role strain (Kramer, Kavanaugh, Trenthan-Dietz, Walsh, & Yonker, 2011). Caregivers with a high level of family conflict and role strain experience lower psychological wellbeing, resulting in a decline in family function (Kramer et al., 2011). In the cases where a husband has to assume the roles of his wife, the increased responsibilities create role strain, which lead to marriage dissatisfaction (Kim et al., 2013; Kim et al., 2014; Reblin et al., 2016). Kaplan et al. (2013) agreed that role strain occurs in families with a cancer patient due to the changes in roles, along with increased frequency of critical events. As roles change these families, shifts in individual identity also occur in the context of marital relationships (Fife et al., 2013).

Literature Review Related to Key Variables

Cancer Influences on Relationships

Diagnoses of cancer affect the individual patient in varied ways. There is the emotional stigma attached to being diagnosed with neck, lung, and prostate cancer (Thomas et al., 2013; Wong et al., 2013). There are societal beliefs that only individuals who smoke or use smokeless tobacco become diagnosed with neck and lung cancer. Therefore, a person could have prevented their illnesses (Wong et al., 2013).

Along with the physical and psychological effects on individuals diagnosed with cancer, the family faces the similar challenges (Kaplan et al., 2013; Wellisch et al., 2015).

Families have described cancer as a threat to their livelihood. Hearing the diagnoses of cancer from medical professionals was equal to experiencing a violent crime (Francis et al., 2015; Kaplan et al., 2013). Family members reported they feared the worst but held on to hope (Kaplan et al., 2013; Wellisch et al., 2015).

Relationship problems begin between wives and their spouses, and other children in the homes, because they may feel that they are not getting the attention they desire (Reblin et al., 2016). For couples who are already having marital problems, the increased pressures can lead to separation or divorce (Gottlieb, Maitland, & Brown, 2014). Mothers reported an increase in feelings of stress, fatigue, and depression (Gottlieb et al., 2014; Reblin et al., 2016). Researchers also reported patient and caregivers experiencing different levels of depressive symptoms (Gottlieb et al., 2014). Husband caregivers reported ill health while caring for their wives receiving chemotherapy treatments (Gottlieb et al., 2014; Reblin et al., 2016). As the caregiver develops a sense of burden providing care for a family member, their health can also be negatively affected (Gottlieb et al., 2014). Caregivers with low psychological wellbeing experience a decline in family function (Gottlieb et al., 2014: Kramer et al., 2011; Reblin et al., 2016). The other changes that occur are financial (ie., the caretaker had to quit or decrease work hours to balance the demands of supporting their home while one person received treatments; Reblin et al., 2016). The role strain caused by dealing with the adjustments necessary to cope with a partner diagnosed with cancer affects not only the individual but also the relationship (Reblin et al., 2016). Researchers found that heterosexual couples experiencing role strain also suffer from anxiety, depression, fatigue, insomnia, and dissatisfaction in their marriage (Kim et al., 2013; Kim et al., 2014; Reblin et al., 2016). Role strain among LGBTQ couples with a partner diagnosed with cancer remains an underresearched topic.

Kaplan et al. (2013) reported a shift in roles of spouses as they attempted to keep their home functional. During the cancer treatment, the families tried to keep everything as normal as possible, but their regular daily routine was disrupted by treatments and the after-effects of the treatments (Kaplan et al., 2013; Reblin et al., 2016). Family members need support to deal with the stress; however, family caregivers reported that their support came mostly from the family member battling cancer (Wood, Gonzalez, & Barden, 2015). Even when they received support, the person felt role strain and depression when it came to attempting to balance traditional roles with a new role as a family caregiver (Kim et al., 2013; Kim et al., 2014; Reblin et al., 2016; Wood et al., 2013).

Researchers documented that heterosexual couples, and caregivers of cancer patients, experienced anxiety, depression, fatigue, insomnia, and dissatisfaction in their marriage while supporting their loved ones (Badr et al., 2016; Gottlieb et al., 2014; Reblin et al., 2016). According to Deniz and Inci (2014), caregivers experienced higher incidents of headaches and higher blood pressure upon taking on the role of caregiving for a family member diagnosed with cancer. Caregivers’ anxiety, depression, fatigue, and insomnia developed from the stress of balancing their roles as they provided care for spouses, parent, or children (Dionne-Odom et al., 2016). The stress for both the patient and caregiver influenced their future quality of life (Richardson, Morton, & Broadbent, 2015). Due to the life-threating illness, the couples' roles had to be adjusted to maintain daily activities (Fife et al., 2013). Fife et al.'s (2013) determined that females are more amenable to making a change in healthy relationships than were their male partners. Communication and openness to adjust were key to the couples' success in dealing with their relationship when faced with a life-threatening illness (Fife et al., 2013).

Badre et al. (2016) postulated that the disease causes stress in relationships because of the unknown influence the outcomes have on their body, career, and the creation of financial hardships. The couples described the diagnoses of cancer as a traumatic life event, leaving them unsure how to cope with their futures (author, year). The couples with strong communication skills and the ability to discuss the need for adjustments in their relationship were able to maintain marital satisfaction (author, year). However, the couples who supported traditional family roles and lacked the ability to communication were unable to deal with altering previous roles, thereby developing depression and marital dissatisfaction (author, year).

Kim et al. (2013) reported depression in family caregivers who were experiencing stress and lack of social support. Cancer patients had lower reported incidences of depression, headaches, and blood pressure problems than their caregivers (Deniz & Inci, 2015). Family caregivers reported that they had a strong sense of family loyalty, which pushed the family caregiver to move forward (Kim et al., 2013). The patients' survivor ability also plays a part in the family caregivers' depression. There are few support programs available to the family caregiver during the treatment progress. Therefore, they are left alone to find a way to deal with their depression (Kim et al., 2014).

Martial dissatisfaction depended on the structure of the relationship before the diagnosis with an illness (Badr et al., 2016; Granek et al., 2014). Some couples who reported having marital problems like poor communication continued to have problems after the diagnoses (Badr et al., 2016; Granek et al., 2014). According to Stenberg et al. (2014), the diagnoses of cancer affected a couple less physiologically when they have good communication skills, which allowed them to discuss the needed adjustments to their lifestyle. In a strained relationship, caregivers felt emotional stress affecting how they felt about the partnership (Fagundes, Berg, & Wiebe, 2012; Sautter et al., 2014). Couples with a child diagnosed with cancer who reported being in healthy marriages before the diagnoses stated they experienced problems with poor communication based on lengthy periods of separation causing marriage conflict and struggles with other members of the family (Granek et al., 2014). Studies reported couples with a child battling illness who had previous marital conflict had an increase in divorce (Granek et al., 2014). As couples attempt to share the role of caregiver for their ill child, stress within their relationship occurred as a result of the father's unsureness when it came to caring for a sick child (Granek et al., 2014).

Chow and Ho (2015) reported older Asian couples who maintained their cultural status during the illness of the spouse, experienced continued harmony and marital satisfaction. The opposite was true for wives with husband diagnosed with prostate cancer, who were no longer able to perform intimately and reported dissatisfaction with their marriage (Vines & Demissie, 2013). The husbands with wives receiving cancer treatment who were no longer able to perform their daily roles and the husband had to become the caregivers also reported discontent within their marriage (Meta, Chan, & Cohen, 2014). The husbands connected having to take on more of the wives' role, like, cleaning, shopping, vacuuming, laundry, cooking, and taking care of her daily needs like bathing and dressing, with their disgruntlement (Liang, 2015; Meta et al., 2014). Spouses who were required to take on more of the daily roles of their spouse, due to illness, found it required decreasing their personal and social activities (Meta et al., 2014). By having to reduce the things they enjoy, they become increasingly stressed, tense, and emotionally upset (Meta et al., 2014). For some couples in the studies, the martial dissatisfaction led to divorce (Liang, 2015; Meta et al., 2014).

When adult children are required to adjust their role within their immediate family, they experienced role strain (Honda et al., 2013). These adult children reported feeling overwhelmed in balancing their role as an employee with the demands of the role of a caregiver (Honda et al., 2013). As a result of attempting to maintain their work-related duties to ensure continued income and not neglecting the emotional and physical needs of their elderly parent, the adult children reported developing depression (Honda et al., 2013). Along with the development of depression, they also became dissatisfaction with their employment (Honda et al., 2013).

LGBTQ Couples

In 2013, the United States Census Bureau reported there were approximately 726,600 same-sex couple households in the country (U.S. Census Bureau, 2015). On September 26, 2015, the United States Supreme Court ruled states could no longer deny same-sex couple marriage licenses (Amiel, Goltz & Wenker, 2015). LGBTQ couples have been socialized from infancy into the same roles as heterosexual couples (Mooney et al., 2013). Hoyt et al. (2013) and Mooney et al. (2013) argued LGBTQ couples are not bound to gender roles within their relationship, instead, as a couple, they can decide which roles they will perform within their relationship. LGBTQ couples are presently fighting to have their relationship recognized the same heterosexual couples (Mooney et al., 2013). There is a need for extending the body of knowledge regarding LGBTQ couple's relationships. In conducting the literature review, I was unable to locate research regarding LGBTQ couples. I was also unable to identify studies regarding the structure of LGBTQ couple's relationships or their experiences of role strain when caring for a partner diagnosed with a significant or possible terminal illness.

Sutphin (2013) conducted a quantitative study explored 49 same-sex couples' relationship structures for caring for children (Sutphin, 2013). The 49 same-sex couples were both gay and lesbian couples with children either from a prior relationship or donor insemination, adoption, foster care, and surrogacy. The caregiver roles for most couples was egalitarian (Sutphin, 2013). In heterosexual couples' children conceived prior to the relationship, the biological and non-biological parents shared the role of caregiver

(Sutphin, 2013). In a small number of the couples, they negotiated childcare responsibilities due to having one partner more equipped to handle the role than the other (Sutphin, 2013). The limited number of gay couples who participated in this study highlighted the need for increased studies on gay couple's parental roles (Sutphin, 2013)

High-Risk Behaviors

LGBTQ are more likely to engage in high-risk behaviors causing cancer than heterosexuals (Rosario et al., 2014). The high-risk behavior includes tobacco use, drinking alcohol, using tanning booths, and vomiting for weight loss (Rosario et al., 2014). Using tobacco places individual an increased risk of lung, colon, oropharyngeal, and esophageal cancers (Blashill & Safren, 2014; Rosario et al., 2014). Rosario et al. (2014) reported lesbians are more likely than gay men, and heterosexuals to smoke cigarettes. The reason given by lesbians for smoking is a desire to reduce stress (Rosario et al., 2014). Tobacco use has a cancer mortality rate of 30 % to 40 % (Blashill & Safren, 2014; Rosario et al., 2014).

Obesity has become an increasing problem in the United States (Blashill & Safren, 2014). Healthcare professionals linked being overweight or obese with 30 % of cancer diagnoses (Blashill & Safren, 2014). Overweight or obesity contributed to between 15 % to 20 % of cancer-related deaths (Blashill & Safren, 2014). Blashill and Safren (2014) have indicated that gay men participate in vomiting behaviors as a means to lose or maintain their weight at higher rates than lesbians or heterosexuals.

The use of tanning booths or outdoor tanning is another high-risk behavior performed by gay and bisexual men in an attempted to increase their body satisfaction (Blashill & Safren, 2014). Forty percent of gay or bisexual men are at increased risk of being diagnosed with skin cancer based on their use of using tanning booths or outdoor tanning (Blashill & Safren, 2014). Compared to women, gay and bisexual men have a 100 % increase in the chance of dying from skin cancer (Blashill & Safren, 2014).

LGBTQ experience with Medical Care

Healthcare providers tend to approach providing care to LGBTQ with negative perceptions (Elliason, Dibble, & Robertson, 2011). Based on the deleterious sensitivities, healthcare providers deny LGBTQ treatment because of what Elliason et al. (2011) described as fear. The healthcare profession who felt all illness developed by the LGBTQ patients was due to sexual orientation choice, caused patients to feel stigmatized (Elliason et al., 2011). Patients would switch healthcare providers and chose not to disclose their sexual identity to the new provider (Elliason et al., 2011).

Coren, Coren, Pagliaro, and Weiss (2011) reported LGBTQ lacked feeling comfortable while in healthcare settings due to their experiences of disparities and barriers to receiving services needed to treat their illnesses. The patient's unwillingness to openly share causes problems with the treatment of their illness (Coren et al., 2011). Additionally, LGBTQ couples experience stress in their relationship because of the how their families do not support them during periods of illness (Coren et al., 2011).

LGBTQ experience with Cancer

Cancer occurs in the body when malignant growth or tumors invade normal tissue within a particular part or parts of the body (American Cancer Society, 2016). In our society, an estimated 1,658,370 people living with a diagnosis of cancer cases in 2015, and 589,430 men and women will die within the next year (American Cancer Society, 2016). The death ratio for an individual with cancer diagnoses is two out of every three (American Cancer Society, 2016). Heart disease is the leading killer, followed by lung cancer (American Cancer Society, 2016). The second leading cause of cancer deaths is prostate and colon for men; breast and colon for women (American Cancer Society, 2016). Statisticians do not document sexual orientation when recording the prevalence and incidences of cancer (Rosario et al., 2016). Therefore, the specific number of LBGTQ cancer deaths is unknown. Health care professionals treating LGBTQ cancer patients estimate between 420,000 to 1,000,000 falls into LGBTQ demographic populations (Kamen et al., 2015; Rosario et al., 2016).

White and Boehmer (2012) reported, female partners often have separate health concerns while caring for their companion during breast cancer treatment. Although the female was able to provide emotional and physical support for their partner during the treatment, they did not receive support for themselves at this time (White & Boehmer, 2012). As the lack of support continued, they can develop a feeling of their partner being a burden (White & Boehmer, 2012). The ability to maintain the relationship after their counterpart recovered from breast cancer, the couple needed to address feelings of stress, burden, and lack of support (White & Boehmer).

Thomas, Wootten, and Robinson (2013) found gay males faced stigma after receiving a diagnosis of prostate cancer as consistent with those diagnosed with HIV/AIDS. Within health and non-health care providers, some believe a change in lifestyle could have prevented the diagnoses of prostate cancer for gay males (Thomas et al., 2013). No medical evidence connecting the two diseases seems to reduce the patient's experiences of stigma while being treated (Thomas et al., 2013). Thomas et al. (2013) and Wong et al., (2013) agreed a cancer diagnosis alters an individual's self-concept, and individuals with a negative self-concept, tend to distance themselves from others during the treatment progress.

Janson and Kamen (2016) found cancer patients who are satisfied with the care provided by their healthcare professional, had positive outcomes and survival rates. Unfortunately, LGBTQ cancer patients reported dissatisfaction with their care (Janson & Kamen, 2016). They connected the dissatisfaction of care to LGBTQ's experiencing stigmatization based on their sexual identity, and gay-related stress stemming from the belief of some healthcare professional that the cancer is directly a result of HIV/AIDS (Janson & Kamen, 2016).

Scope of Study

With this qualitative, descriptive, bounded case study, I focused the study on the role LGBTQ couples establish in the context of their relationships, along with how they experience their separate roles. I have also highlighted how the couples experience changes when one partner receives a diagnosis of cancer. The face-to-face interviews with five LGBTQ couples provided an opportunity for each person to describe any alteration of previous patterns of behavior that created strain for the partner in the caretaking role. The disease process was not inquired about or discussed during the interviews. Candidates in committed LGBTQ relationships, with one partner diagnosed with Stage II or III cancer, meet the criterion to participate in this study. I excluded people who are in heterosexual relationships, the first-time Stage I or IV cancer diagnosed individuals, patients receiving treatment for brain, eyes, nose and throat cancer, and those with second cancer diagnoses at any Stage.

The bias influencing the outcomes of the study are the systemic error, interviewer bias, and misclassification of data (Manen, 2014; Vagle, 2014). The reduction of systemic errors occurred through professorial review of the research process (Manen, 2014; Vagle, 2014). Practicing with the interview questions on a non-sample population assisted in minimizing interviewer bias (Siedman, 2013). Documenting the trail of data during the analysis process decreased the occurrence of misclassification of data (Vagle, 2014).

Strengths and Weaknesses

Of the 54 studies used in the literature review, similar strengths and weaknesses were determined to exist. Some of the strengths of these studies were their sampling procedures and populations, the reliability of the instruments, the establishment of data collection procedures, and generalization of results. (Francis et al., 2015; Gottlieb et al., 2014; Railka et al., 2013). An inherent limitation of qualitative research is small sample sizes. The limitations of the studies were the lack of researcher's knowledge concerning the effects of chemotherapy and radiation treatments. Additionally, the definition of family was limited to heterosexual families, married couples, married couples with children, or adolescents with aging family members (Francis et al., 2015; Gottlieb et al., 2014; Railka et al., 2013).

Relationship to Current Study

The studies related to the research questions were the ones exploring role strain experienced by the caregivers of cancer patients in heterosexual families. These studies reported on the impact cancer has on the roles of the caregivers along with their feelings of role strain and burden while caring for family members with cancer (Klaassen et al., 2012; Mazanec et al., 2011; White & Boehmer, 2013). Study results indicated that caregiving contributed to developing both emotional and physical issues like fatigue, anxiety, insomnia, depression and in some cases dissatisfaction within their marriages (Francis et al., 2015; Gottlieb et al., 2014; Railka et al., 2013).

For this study qualitative, descriptive bounded case study approach was the selected methodology. This method was used to investigate a phenomenon in the context of real life (Yin, 2013). The use of qualitative descriptive bounded case study was to explore LGBTQ couple's experience of role strain while dealing with a partner diagnosed with Stage II or Stage III cancer (Yin, 2013).

Summary and Conclusions

No one is untouched by the changes that occur in relationships upon receiving a diagnosis of cancer (Railka et al., 2013; Kaplan et al., 2013; McQueen et al., 2011; Reblin et al., 2016; Wellisch et al., 2015). As roles change, there is also a shift in individual's identity within the context of a committed, intimate relationship (Fife et al., 2013). When a family caregiver attempted to balance prior roles with the new roles of caregiver, it led to stress, depression, anxiety, and role strain (Kim et al., 2013; Kim et al., 2014). The literature review highlighted studies focusing on heterosexual couples, parents, and adult child as their sample population. There was a gap in the literature on LGBTQ couple's experience of role strain while dealing with a partner diagnosed with cancer. Wellisch et al.'s (2015) research indicated the need for additional research regarding the alternations of roles in LGBTQ couples under similar circumstances. Mooney et al. (2013) agreed LGBTQ couples do not fit into traditional roles, as they can discuss and decide which roles they will perform within their relationship.

The objective of this research was to investigate directly five LGBT couples dealing with first-time Stage II or III diagnoses of cancer. The goal was to gain knowledge related to LGBTQ couples' perception of role strain while dealing with a partner diagnosed with cancer. I have presented the methodological strategies used to investigate this unknown phenomenon, along with the procedures used to analyze the outcomes of the data collected.

Chapter 3: Research Method

Introduction

In this qualitative case study, I explored role strain in relationship to LGBTQ couples' experience with cancer. Throughout the chapter, I explain the rationale for using a case study, along with the instrumentation and mode of analyzing the data. I also convey my role and responsibilities, which are consistent with my ethical obligations. Methods used to establish internal and external validity are also covered, in addition to the limitations. I discuss the informed consent process and issues demonstrate how I protected the participants' confidentiality.

Research Design and Rationale

The qualitative approach used in this study was the open-ended interview method, which leads to the unpredictability of the themes that can emerge during the process (Gill, 2014). Qualitative researchers focus on attitudes and feelings of the participants (Gill, 2014). There are various types of qualitative designs with different data collection methods suited to investigate a participant's experience with a given phenomenon (Gill, 2014).

I sought to understand the role strain experienced by LGBTQ couples caring for a partner diagnosed with Stage II or Stage III cancer. I explored the phenomenon of role strain occurring in the caring for a partner with cancer. By using a case study as the qualitative research design, I provided the LGBTQ couples the opportunity to voice their shared experiences of role adjustment and role strain in their caretaking role.

I chose case study design to develop a deeper understanding of the roles and possible experience of role strain of LGBTQ. A case can represent a person or group of people the researcher identifies (Gill, 2014). For this study, I sought to gain a depiction of LGBTQ couples' roles in the context of their relationships, along with how they experience role strain. The intent was to describe the influences of role strain experienced by LGBTQ couples while a partner battles with cancer and to bring light to their perceptions of role strain (Manen, 2014; Vagle, 2016).

Social constructivism was chosen as the lens to view the perceptions of changes in the family dynamic. I used this framework to understand how families experience the effects of cancer. While participants provided descriptions of how cancer is impacting their family, I also observed their interactions. The foundation of social constructivism stems from an epistemological perspective (Ralph, Birks, & Chapman, 2015). Interpretive in its nature, researchers from this orientation spend time with participants to understand how they develop their worldview in relationship to their experiences (Ralph et al., 2015).

Research Questions

To describe the perceptions of LGBTQ couples' roles within their relationship and the influence of dealing with a partner diagnosed with Stage II or Stage III cancer has on their relationship, the following questions were posed:

RQ1. How do LGBTQ couples decide their roles within their relationship?

RQ2. How are LGBTQ couples’ roles influenced when a partner is diagnosed with Stage II or Staged III cancer?

RQ3. What are LGBTQ couples’ concerns and perceptions regarding their relationship with a partner diagnosed with Stage II or Stage III cancer?

Conceptualization

The central phenomenon of this study was LGBTQ couples’ experiences of role strain based on changes in their role functions when a partner receives a diagnosis of cancer. In this study, I offered LGBTQ couples an opportunity to describe the roles each performed in the couples’ relationship before the diagnosis, as well as any changes experienced in roles following the onset of the disease process. Also, I inquired into whether the reevaluating of roles with a desire to provide for the household needs during treatment created role strain in the LGBTQ couples’ relationship.

Research Tradition

I conducted this study using a bounded, case study approach. When researching a phenomenon like role strain occurring in the context of real life, a case study is an appropriate approach to answering the research questions (Yin, 2013). According to Yin (2013), the purpose of a case study is to explore a phenomenon within the context of people’s lived experiences. Researchers use case studies to gain a comprehensive account of the phenomenon as it provides a means to examine and gain insight into experiences of the population (Yin, 2013). Scholars collect data and detail them into a narrative, providing specifics of the experiences of the phenomenon within the real-life context (Punch, 2014). Case study investigations allow the researcher more freedom in the designing of his or her study. However, it is important to be open-minded during the process (Yin, 2013). Case study samples are typically small, thereby limiting the generalization of findings to larger groupings, but theoretically are generalizable (Yin, 2013).

Yin (2013) revealed the six types of case studies: descriptive, exploratory, explanatory, bounded, single, or multiple cases. For the six types of case studies, several types could be applicable for use in this study. I chose to conduct a descriptive, bounded multiple case study. Researchers use descriptive studies as a means for collecting data that demonstrate relationships and describe the phenomenon in a real-life context (Yin, 2013). In using a descriptive, bounded case study, I attempted to glean information from LGBTQ couples with a partner diagnosed with cancer as it relates to the phenomena of role strain. Additionally, I wished to identify themes or categories based on their description of their experiences of role strain. The desired goal was to expand the knowledge base for health care providers working with LGBTQ couples to inform the development and implementation of training programs, policies, and procedures and to provide baseline data for future researchers.

With many different research method approaches, a qualitative case study method was suited for this research, as it supports articulating the participants' authentic voices regarding their perceptions and emotions, previously unheard. In describing role strain from the LGBTQ couples' experiences, a deeper understanding of the issues related to this complex problem cannot be accomplished using quantitative data analysis. Other qualitative methodologies were not deemed appropriate for answering the research questions in this study. If the scholar wishes to focus on an individual describing his or her meaning of life, a researcher would use the narrative approach (Treloar, Stone, McMillan, & Flakus, 2015). Case study researchers desire to investigate a phenomenon of a particular segment of the population (Punch, 2014). Phenomenologists examine an individual or group's constructed reality (Punch, 2014). Due to this, phenomenology approach was not well suited. Grounded theorists seek to develop new concepts (Punch, 2014). In this study, I intended to provide a descriptive account of LGBTQ couples' experiences, using an established theoretical framework, thus excluding grounding theory (Johnson, 2015). Researchers desiring to explore individuals' relationship between their behavior and culture use ethnography (Punch, 2014). The research population of this study was LGBTQ couples, which are a social group. Thus, ethnography was not appropriate.

Role of the Researcher

In this study as the researcher, I was an observer. I gathered objective data through semi-structured, open-ended interview questions, paying attention to the participants' behavior and interactions, noting their conduct and then presenting the findings in a clear, concise, and unbiased manner. As the researcher, consideration was given to the ethical issues related to both professional roles and responsibilities to LGBTQ couples. I adhered to the role and accountability for the maintenance of participants' anonymity, confidentiality, and privacy (Petrova, Dewing, & Camilleri, 2016).

I had no personal or professional relationships with the participants of this study. During the research process, I remained aware of the possibility of both conscious and unconscious biases that could occur. Reflective in nature, researchers employ the use of journals to reduce biases (Peredarvenko & Krauss, 2013). I recorded personal thoughts and observations in a journal to identify perceptive beliefs, assumptions, and preposition of LGBTQ couples to minimize research biases.

I recognized the LGBTQ as experts on their experiences and treated them with dignity and respect throughout the process. I deferred to their insight and knowledge, which assisted in creating an equalized balance in the power relationship. The LGBTQ couples were not offered or given incentives to participate to avoid any perceptions of influence, coercion, or corruption of responses.

Methodology

Upon approval from Walden University's Institutional Research Board (IRB), I conducted an Internet search for local oncology physicians. I made appointments and visited those who agreed to assist me. At the time of the meeting, I provided recruitment flyers for posting on information boards, as well as copies they could leave in their waiting room. LGBTQ couples desiring to participate used the contact information included on the flyer and called or e-mailed, based on their preferred method of communication. After ensuring the couples met the inclusion criteria, I discussed the informed consent process and scheduled a convenient interview appointment at a private location, such as a local coffee shop, family waiting room, or study room at a local library. At no time were the interviews scheduled or held in the homes of the participants. Participant interviews occurred outside the treatment environment to avoid interfering with the partner's treatment. I assigned a fictional name to each participant after the completion of the phone call.

In preparation for the meeting, I prepared copies of the informed consent, interview protocol, notebook, and audio recorder. Once they arrived, greetings and introductions occurred. After engaging in small talk to create a relaxed atmosphere, I began reviewing the informed consent and consent to audio tape, and I answered all of their questions. Once they memorialized the documents, I reminded them of their ability to withdraw from participation at any point in the process, and I offered them a list of free or low-cost local and Internet-based mental health providers. After turning on the audio recorder, I began posing questions, following the interview protocol, making handwritten notes throughout the meeting. At the end of the interview, participants could ask questions, which I answered. To conclude the interview, I disengaged the audio recorder and thanked the participants for their time and the information they shared. I secured both audio recorder and notes in a briefcase and locked them in a file cabinet in the home office until the transcription process was completed. In Chapter 4, I provide a detailed description of the study environment during each interview, which includes the time and length of the interviews.

Participant Selection Logic

The U.S. Census Bureau (2015) stated that 58,229 LGBTQ individuals were living in the state of Mississippi. The recruitment and selection of participants were focused on the central portion of the state, locating a total of five LBGTQ couples with a partner diagnosed with Stage II or Stage III cancer. The participants meeting the criteria of being in a committed LGBTQ relationship, with one partner currently receiving treatment, were accepted. If the initial purposeful selection did not yield the number of participants required to reach saturation, I asked those who did participate if they know any LGBTQ couples willing to volunteer for the study. Researchers refer to this method of recruiting as snowballing (Palinkas et al., 2015).

Sampling Strategy

When using qualitative research, establishing boundaries is key to balancing the sampling strategy and determining the sample size (Dworkin, 2012; Sanjari et al., 2014; Yin, 2013). The ability to select a sample without using a randomization is a technique referred to as purposeful sampling (Yin, 2013). Researchers using purposeful sampling cannot demonstrate statistical significance (Dworkin, 2012; Yin, 2013). Scholars use purposeful sample to collect data from a sample population experiencing a phenomenon (Yin, 2013). For this study, criteria for participant required that I focus on the group of individuals who experienced being in a committed LGBTQ relationship with a partner receiving treatment for Stage II or III Cancer.

Within qualitative research, there are some factors to consider, such as the purpose of the research, possible risk, accessible resources, and the benefits conducting the study (Dworkin, 2012; Robinson, 2014). The size of the sample is determined by ensuring that the participants are representative of the population (Dworkin, 2012; Robinson, 2014). A researcher should consider the demographics, time mandates, and financial issues when determining the sample size (Dworkin, 2012).

Inclusion/Exclusion Criteria

This study selection process consisted of the following criteria: LGBTQ couples with a partner diagnosed with a first-time diagnosis of Stage II or III cancer who is in between treatment cycles. Based on the information provided at the time the participant calls to set up their interview, I identified whether they met the study criteria by asking them directed questions. If participants reported the following information: heterosexual couples, first-time diagnosis of Stage I or IV cancer, being treated for brain, eyes, nose, or throat cancer, or having a second diagnosis of cancer at any Stage, I thanked them for their willingness but excluded them from the study.

Sample Size

Researchers using case studies methodology tend to focus on smaller groups. However, the sample size should be significant enough to provide the perspective of the broader population (Palinkas et al., 2015). In a study exploring stress related to taking on the role of caregiver for adult parents, I interviewed 14 adult caregivers. In exploring the caregivers' level of support throughout the treatment progress, White and Boehmer

(2012) interviewed 15 female caregivers for their female parent diagnosed with breast cancer. Five LGBTQ couples, totaling 10 individuals, was consistent with the sample size of other studies regarding similar populations.

Recruitment

Using Internet search engines, I identified local oncology physicians and contacted their office by telephone to request their assistance by posting recruitment flyer (Appendix A). I delivered the flyers to physicians who agreed to post it on their information boards or leave it on tables in their waiting areas. In the recruitment flyer, I offered information regarding the purpose of the study, along with the amount of time and meetings requested to gather their information. I also included information regarding the confidential nature of the study, along with details regarding remuneration for their involvement. The flyer provided my contact information including home, office, and cellular telephone numbers, along with e-mail addresses on the invitation, and I asked them to contact me if they are interested in volunteering.

I asked the couples offering to participate if they were in an LGBTQ committed relationship, the diagnosis of cancer, and where they were in their treatment cycle. After answering the questions, and ensuring the couple met the criteria, I conducted a review of the informed consent document for willing participants. In concluding the conversation, a convenient date, time, and location for the interview was arranged.

Saturation

Researchers must assure that the sample size and data collection produce reliable and confirmable outcomes (Fusch & Ness, 2015). To achieve these standards, they continue their investigative process until they reach the point where the data are redundant and repetitious, or they have reached saturated (Dwrokin, 2012; Fush & Ness, 2015). When analyzing the data obtained during semi-structured, open-ended questions, investigators reach saturation when no new information emerges from the interviews (Fusch & Ness, 2015). In most research, saturation occurs after four or more interviews but can be reached at any time during the data collection process (Dwrokin, 2012; Fush & Ness, 2015). This study had a sample size of five LGBTQ couples, or a total of 10 individuals who participated in 45-minute interviews. Saturation was achieved by the completion of the interview process consisting of the number of participants greater than the minimum required.

Instrumentation

I collected data using an interview guide, posing semi-structured, open-ended questions to the study participants. After receiving permission from the interviewees, I audio-taped the meetings and took handwritten notes for future reflection. I designed the interview questions to collect information to answer the overarching research questions, and I used the theoretical framework to inform their construct. During face-to-face meetings, LGBTQ couples were able to articulate the effect having a partner diagnosed with Stage II or Stage III cancer had on their relationship, and whether they experienced role strain. I posed follow-up questions based on the responses the participants provided and encouraged full disclosure, should they desire to offer additional information.

Data Collection

After identifying the participant pool, each couple selected a convenient time and place for the meeting. Options such as private meeting rooms at local libraries assured the confidentiality of the volunteers, while also allowing for audio taping to be clear, without background noise. I arranged for the meetings outside of the treatment environment to avoid interference with the partner's treatment and to avoid any potential Health Insurance Portability and Accountability Act (HIPAA) violations. If unable to interview a sufficient number of couples to reach saturation, I would have continued to recruit additional participants using snowballing techniques.

I scheduled 45-minute appointments with each partner involved in the study, using 15-minutes for the informed consent process and any questions, and the remaining 30-minutes for asking the questions. After documenting consent to audiotape, I recorded the session as well as took handwritten notes. No follow up was required for participants. During the telephone contact participants were initially advised of the informed consent process; however, I reviewed the document with them, answer any questions, and request their signature before posing the questions from the pre-established interview guide. Also, emphasizing their ability to stop the interview at any time, without fear of negative consequences. They received copies of the consent forms, along with a list of free or low cost local and internet-based mental health providers. Although there was minimal risk involved, the list was available to all participants, should they experience any discomfort based on recalling the information provided.

During the data collection process, I adhered to privacy and confidentiality procedures. After I collected the data, the creation of an encrypted, password-protected computer file to store the transcribed audiotaped interviews and handwritten notes to a single file.

Exit Procedures/Follow-up

At the end of the interviews, I asked the participants if they have any questions and provided responses to those posed. Copies of their transcript, either electronically or in written form was provided upon request. I thanked participants for their participation and offered them my contact information in case they had questions after we concluded the meeting. The study did not require follow-up meetings or any further contact. I did not offer any remuneration for their contributions.

Data Analysis Plan

I sought to explore the experience of role strain by LGBTQ couple with a partner diagnosed with Stage II or Stage III cancer. The data collected from interview questions three and four addressed research question one. Interview questions five, six, and eight collected data were responsive to research question two. For research question three, data was collected from questions one, two, seven and nine.

Once I completed the interviews, I hand transcribed the data, verbatim, and employed the method of open coding**.** The process entails reading through all transcripts before coding the data. In reviewing the transcripts, I began to identify codes or labels during the next reading and make notations in the border of the document (Myles, 2015). In the third reading, I used colored pencils to identify words or phrases demonstrating a relationship to the codes or labels. I did not use software programs in the analysis process, but hand-coded, based on the small number of participants (Saldaña, 2015). The analysis process used both concept mapping and open coding. I identified each code or label with a specific color and used concept mapping along with the open coding methods.

A key part of validity testing is identifying and analyzing discrepant cases (Erickson, 2012). If a discrepant case occurs in this study, it will be identified and reported in the findings (Erickson, 2012). I reviewed the case to determine whether a need exists for an in-depth analysis of the concept (Erickson, 2012).

Issues of Trustworthiness

Credibility

According to Seidman (2013), credibility occurs when the researcher uses a valid instrument or interview protocols and procedures. I developed the interview protocol for this study and posed the questions in the same order from one participant to the other (Seidman, 2013). They are straightforward, with the desired outcome to avoid any misinterpretation. Although follow-up questions may be necessary to clarify or obtain additional information, I only answered questions from the participant related to the questions and the research project.

For this study, engagement and rapport building started during the initial telephone call (Punch, 2014). In seeking to establish the credibility of this study, only participants willing to participant in the study were interviewed. I based this on their level of engagement throughout the initial steps. Throughout the study process, participants were given the opportunity to refuse to participate (White, Oelke, & Friesen, 2012). Participant's personal experiences are unique to their self and therefore cannot be replicated but do influence the validity of the study (Aravamudhan & Krishnaveni, 2015). As a researcher, the honesty of the participant must be taken in good faith. Reassurances of confidentiality and protection of participant's responses and privacy are likely to increase their willingness to provide an honest response. The process used in the identification of themes, patterns, and assuring data saturation also increases the credibility of the outcomes (Dworkin, 2012).

I used reflective journaling throughout the study. Journaling is a means of contemplating and re-examining my thoughts and feelings (Sanjari et al., 2014). First, I documented my experiences based on engaging in the various processes required to execute the study (White et al., 2012). Secondly, I journaled observations, perceptive beliefs, assumptions and concerns after any interactions with participants (Sanjari et al., 2014).

Additionally, I incorporated concept mapping. Concept mapping is a tool used by researchers to maintain their focus on meaning participants' attach to their experiences (White et al., 2012). I used concept mapping to assist in the identification, development, and visual formatting of the codes and themes (Saldaña, 2015). A visual tablet allowed me to highlight and mark words or phrases demonstrating the relationship and frequency of the codes and themes I identified (Saldaña, 2015).

Transferability

When the results and conclusion from a study can pertain to another population, researchers refer to this as transferability (Cope, 2014). Transferability occurs when another population is able to apply the processes and results of a study (Cope, 2014). I established limitations of five LGBTQ couples who have a partner diagnosed with Stage II or III cancer. These restrictions result in decreased transferability outside of the specific population. I did not focus on the cancer treatment process or the medical effects of the illness of the partner, also exclude end-of-life issues. Instead, I focus on recognizing LGBTQ couples' experiences and whether they had similar feelings and thoughts as heterosexual couples when dealing with cancer. I intend to inform health care providers, so that they can recognize the treatment needs of the couple, instead of the partner only.

In journaling the experience of the LGBTQ couples using rich narratives, I detailed the experiences of LGBTQ couples confronted with these life-changing circumstance (Houghton et al., 2012). Observations, description of participants, and interview settings were narrated in the journal, as well as in Chapter four (Suri, 2011). In the following chapter, I also used direct quotes from the interviews to describe the phenomenon experienced by LGBTQ couples in context (Houghton et al., 2012; Suri, 2011).

Dependability

For a researcher to increase dependability and establish their expertise requires flexibility, the ability to use the interview question suitably, an awareness of biases, and instituting steps to eliminate ethical issues (Punch, 2014). In a desire to reduce inaccuracy, I reviewed the transcripts, journal entries, concept mapping, and hand-coded documents (Yin, 2013). The performance of the reviews contributes to establishing the reliability of the outcomes of the study (Myles, 2015).

I also triangulated the data as a method of increasing the accuracy, thereby dependability of the analysis process (Houghton et al., 2013). Researchers use triangulation to achieve data confirmation, as well as completeness of outcomes (Houghton et al., 2013). It increases the dependability of the study when consistency is established between the different data collection and analysis methods (Houghton et al., 2013; Yin 2013). Data collected from perceptions of a specific phenomenon from multiples participants allows the researcher to construct a bigger, more complex picture through describing unique elements of individual experiences (Houghton et al., 2013; Yin 2013).

Confirmability

To ensure confirmability, researchers need to provide data-driven results (Cope, 2014). In addition to outcomes driven by the data, I described assumptions used to reduce biases and errors (Cope, 2014). I used reflective commentary in my journaling to assist in identifying preconceptions, further establishing the confirmability of my results (Berger, 2015; Yin, 2013).

Ethical Procedures

Prior to conducting this study, Institutional Review Board (IRB) approval was obtained (IRB approval number for this study is 12-09-16-0312823). The partners diagnosed with Stage II or III cancers represent a potentially vulnerable population. Because my ethical obligation to cause no harm, I conducted the interviews in between treatment cycles. These are periods when the participants are recovering from the effects of the treatments and most likely to be relaxed. Although there was minimal risk of harm, as previously described, I offered them a list of local and internet-based mental health providers to consult with should they experience any discomfort because of answering the interview questions. The intent of interviewing the couples separately contributes to reducing any stress related to express their feelings in front of one another openly.

During the data collection phase, I was sensitive to the emotional status of the LGBTQ couples. I treated the LGBTQ couples professionally, using caution when discussing sensitive topics. As a researcher, I am unable to predetermine the responses to the interview questions or the detail that may be provided by each participant. I encouraged them to be as accurate as possible when responding to the interview questions.

Due to confidentiality concerns, as the researcher, the utmost concern is maintaining participant's privacy. Throughout the study, I protected the participant's identities and information. Initially, participants were invited to call me, instead of the reverse. I conveyed the methods I used to protect their identity during the initial contact and face-to-face during the informed consent portion of the interview as described in the data collection section of this document.

To protect the identity of each participant, I assigned fictional names. In a separate file, I noted the actual matching names with those I assigned to protect them from exposure. I maintain the interview notes, correlating guide matching the real and fictitious names, transcribes, concept mapping, reflexivity journal, and hand-coded transcripts locked in a file cabinet at my residence. My computer is password protected and upon completion of the study, I downloaded all files to a USB device and stored it in the locked file, along with any other materials associated with the study. Except for my committee members and the Walden University's Institutional Review Board (IRB), no one else will have access to the cabinet. I will maintain all study-related information for a five-year period consistent with Walden University's IRB policies. After the five years elapse, I will destroy the data by incinerating it in a safe container.

Summary

Within this chapter, I have provided a detailed description of methodology, data collection, and analysis I employed while conducting a qualitative, case study. I reviewed issues related to the integrity and trustworthiness of my methods and analysis, along with discussing how I assured ethical conduct throughout the process. In the next chapter, I have provided details of the actual data collection and analysis. Also included the inductive process used to determine the resulting themes. Following the detailing of data analysis, I revisited issues related to trustworthiness to affirm the validity of the outcomes.

Chapter 4: Results

Introduction

The purpose of this study was to provide a descriptive analysis of role strain experienced by LGBTQ couples caring for a partner diagnosed with Stage II or Stage III cancer. I wished to explore the roles of LGBTQ couples within their relationship and whether any changes, such as performing caretaking responsibilities, creates role strain. LGBTQ couples described perceptions of their experiences with roles prior and once a partner received a diagnosis of cancer.

Research Questions

To describe the perceptions of LGBTQ couples' roles within their relationship and the influence of dealing with a partner diagnosed with Stage II or Stage III cancer has on their relationship, the following questions were posed:

RQ1. How do LGBTQ couples decide their roles within their relationship?

RQ2. How are LGBTQ couples' roles influenced when a partner is diagnosed with Stage II or Stage III cancer?

RQ3. What are LGBTQ couples' concerns and perceptions regarding their relationship with a partner diagnosed with Stage II or Stage III cancer?

In this chapter, I describe the setting for the interviews with a description of the five LGBTQ couples who participated in the study. Additionally, I describe the data collection process, data analysis procedures, and a description of evidence of trustworthiness. This chapter will include study results related to the research questions. Chapter 4 concludes with a summary of the results.

Interview Setting

Participants chose the setting to ensure their convenience of time and place for the meeting. All of the LGBTQ couples chose to meet in a private meeting room at the public library. This private meeting room was in a back corner of the library. The room had a windowed door, a wall at the entry of the room, and brick walls at the back. The room was soundproof. Individuals walking by could see into the room but were unable to hear the conservations in the room. All five LGBT Q couples were interviewed using this private room at various dates and times of the day. There was no observed discomfort from the participants during their interviews connected to this setting.

Participant Demographics

The study included five LGBTQ couples for a total of 10 participants. All participants were in a committed LGBTQ relationship. The participants reported being in a committed relationship between 2 to 15 years. One of the partners in two of the couples had Stage II cancer and three had Stage III cancer. All of the participants were between treatment cycles at the time of their participation.

Couple 1

Esther (a pseudonym) and Betty (a pseudonym) had been a couple for 12 years before to the diagnosis of cancer. Esther had Stage III breast cancer. Esther had completed her radiation treatment and oral chemotherapy. She was awaiting the second round of treatment. Ten years ago, Esther and Betty had a private ceremony in which they exchanged vows. At the time of this study, they had chosen not to marry, feeling their first vows demonstrated their commitment.   The couple had two children.

Couple 2

Elizabeth (a pseudonym) and Samantha (a pseudonym) had been a couple for 2 years before the diagnosis of cancer. Elizabeth had Stage II breast cancer and was awaiting her second round of treatment. Elizabeth had two teenage children. The couple was planning to marry once they have completed the treatment and are cancer free.

Couple 3

Cyrus (a pseudonym) and James (a pseudonym) reported to be a couple for the past 12 almost 13 years at the date of their next anniversary.   Cyrus had Stage III colon cancer and had completed his radiation treatment and oral chemotherapy. He had scheduled a date in the future to have surgery to remove the tumor along with the colon, after which he will begin his second round of treatment.

Couple 4

Mark (a pseudonym) and Jackson (a pseudonym) had been together for the past 8 years. They had both a civil union and a religious ceremony. Jackson had Stage III prostate cancer. He had undergone surgery and one round of chemotherapy. He was waiting to begin a new treatment plan, in which he will have both radiation and chemotherapy together for 24 weeks.

Couple 5

Charles (a pseudonym) and Kevin (a pseudonym) reported being a couple for the past 15 years. Charles had Stage II bladder cancer. Charles had completed his 6 weeks of radiation. He reacted and was having to wait a week to retake treatment.

Data Collection

In this study, I recruited participants through a recruitment flyer posted at two oncology offices, coffee shops, several organizations associated with the Pride, newspaper ads, and Facebook posting. Participates who called desiring to participate were asked the initial screening questions to ensure that they met the study criteria. The participants who met the criteria were then read the informed consent. After the participant agreed to participate in the study voluntarily, a convenient time to conduct the interview was set up. The recruitment and interview appointments followed the plan described in Chapter 3.

I collected data with interviews from the five LGBTQ couples between December 2016 to November 2017. The interviews were conducted using semi-structured, open-ended questions with the 10 individuals. I conducted all 10 interviews in person using a digital audio-recorder. Upon completion of the interviews, the recordings of all interviews were downloaded into an encrypted, password-protected computer file, entitled Dissertation Interview Data on a personal computer.

The individual 45-minute interviews were held in a private meeting room at a local library. The first 15 minutes of the interview, I read the informed consent to the participants, had them sign the informed consent, and answered any questions. A copy of the consent forms and list of free or low cost local and Internet-based mental health providers was provided to the participants.

Before beginning the interview, I started the digital audio-recorder. The digital audio-recorder was on during the data collection process. I interviewed all 10 participants following the interview protocol without any variations. The interview time frame ranged from 1 hour and 10 minutes to 47 minutes in duration.

The audio documents of the individual interviews were hand transcribed into an individual Word document. I randomly assigned the individual interviewees a pseudonym. I saved the documents into an encrypted, password-protected computer file, entitled Dissertation Interview Data on a personal computer.

Esther went over the 45-minute interview time. I attempted to stop the interview at the end of the 45 minutes, even though we still had one more question. Esther wanted to continue the interview until she had answered all the questions. No variations in data collection were experienced from the plan or any unusual circumstances during data collection.

Data Analysis

Upon completion of transcribing the interviews, the coding process began. Transcriptions were validated to rule out any transcription errors. The next reading of the transcriptions started with the identification of themes in the context of the interviews to develop the categories used in the analysis, as suggested by Myles (2015). On the third reading, colored pencils were used to identify words or phrases demonstrating a relationship between the categories initially identified. The results from the third reading were the identification of seven themes. This process reduced redundancy and produced an explicit representation of the concepts. A new page was created with the test separated by color and categories. This process allowed for the inductive development of the seven codes. This process assisted in the identification of the themes. A review was conducted of the information presented in the literature reviews (Chapter 2) to ensure alignment of the categorization of themes. An additional reading was performed to assure the themes reflected the LGBTQ couple communications. Table 1 describes the coding categories for the analysis of the interview data.

Table 1
Summary of Categories from the Interview Questions

Categories	Subcategories
Roles prior to cancer diagnoses	Use of society's label of role
Changes	None Emotional Physical Family issues
Adjustment to role changes	None Maintenance of role Desire to change role
Relationship since diagnose	Strong Stressed Communications issues Sexual issues Strained
Role chosen or determines	
Society views of roles	
Preparation for treatment	Internet Couple Friends/support group

Analysis of Themes

Roles Prior to Cancer Diagnoses

The participants described the roles they performed in their relationship prior to the diagnose of cancer as perceived by themselves or their partner. Eight of the participants interviewed defined their roles related to the task they performed. The examples provided were household chores or outside chores. Elizabeth stated, “I did more things around the house like cooking, clean and laundry.” Of the couples, only one couple used traditional labels to describe their roles. Esther stated, “I was the breadwinner, she was the housewife.” Besides describing the roles as a task, many used the term “doing the things I like to do” in connection with their role performance within their relationship. James stated, “I enjoy doing things in the house.” Samantha described her roles as “fitting her identity of herself.” Samantha stated, “I have always been more of a tomboy and like doing more activities that occur outdoor.”

Within the literature, there are gaps related to the LGBTQ couples’ role within their relationships. However, the roles performed within their relationships appear to mirror similar roles performed within heterosexual couples’ relationships, like household and outside task (Hoyt et al., 2013). The LGBTQ couples’ description of their role was consistent with the literature that their roles are chosen (Iantaffi & Bockting, 2001; Mooney et al., 2013).

Adjustment to Role Changes

Before the diagnosis of cancer, the individuals were performing roles within the relationship. Upon the diagnoses, the individual roles still needed to be performed to maintain the stability of the relationship and household. Adjustments within the structure of the relationship were made to maintain the stability of the roles. Cyrus expressed his definition of roles as well as his feelings connected to adjustment to his ability to perform his roles and as

> I would say my roles in the relationship are mine versus how society sees roles. My roles are based on my strengths verse what is expected. Even with that, I feel strongly about maintain the roles within my relationship. I feel uncomfortable not being about to do so.

This description is not consistent with Biddle's (2013) description of role theory. One of the theoretical propositions stated that individuals are required to hold positions in which they perform a role (Biddle, 2014). A second describes an expectation of the role within a relationship (Biddle, 2014).

In describing adjustments to individuals' roles, LGBTQ couples expressed feelings of concern and unhappiness in their inability to maintain their roles. Elizabeth stated, "Not happy with not being able to clean my house the way I like." Besides the adjustment to roles within the household, there were the changes in the participants' ability to work. Jackson stated, "I'm unhappy. I want to be at work with my husband."

The responses varied from the partner connected to the loss of the role and the need to have the role fulfilled. Samantha stated, "There has been a great deal of adjustments. I have assumed more roles than before in addition to working, attending appointments, handling the kids. I am uncomfortable with having to do the household chores."

In contrast, Mark stated, I haven't had to make any adjustments. I'm thinking about hiring a housekeeper again." In a desire to maintain the role, both Mark and James discussed that they would hire people to fulfill the gap in the roles. James reported,

> There hasn't been much of a change other than outside household stuff like yard work. I tend to help more or try to do. If I cannot, I ask one of our family members to do it. I hire someone to do repairs presently.

Most of the LGBTQ couples dealt with some form of role adjustment since the diagnose of cancer. For one LGBTQ couple, despite the stress, and limitation of abilities, their roles were maintained. Esther stated, "I'm maintaining my role as the breadwinner."

Role Chosen or Determined

Four of the five LGBTQ couples reported just falling into the roles in which they perform within their relationship. There were not conservation or expectation of who was going to perform a given role. Each just performed that tasks they enjoyed. Cyrus stated, "We just kind of fall into them. We just did the things we liked doing. The things that we don't like we discussed who was going to do or did do together."

James shared:

> We really didn’t discuss them. Once we were living together. We each began doing the things we had always done. Then notice we were having money issues. I had always paid the bills in other relationships, so I just took care of it. While sick we needed to work out a system, which we did. We sit down together on the weekends and paid bills together.

Charles described their role determination as “Basically, I just did what, I did before we were a couple. He did what he was doing. We really didn’t talk about. Everything just fell into place.” Kevin stated,” Just fell into place. I guess we just do things we like doing.”

For Mark and Jackson’s relationship role, the determination was made by maintaining the status quo for Mark. Jackson had to fit into Mark’s life. Therefore, his roles were determined by flowing more comfortably for Mark. Jackson stated, “While I just fit into Mark’s life. It was clear; I needed to just fall into place for our relationship to work.”

Two of the LGBT couples described role determination in their relationship based on income. When describing their role, both used traditional labels for the role each was performing. Esther stated,

> I think financial, honestly, because I had a college degree and I made the largest among of money. She was a blue-collar worker. I had small children, 2 and 4, when we got together so, it was decided I would support the family, and she would stay home and run the household.

Betty reported:

> While we were dating both of us worked. I worked at an office, and she worked at the hospital. She was making a lot more money than me. I also was coming into a relationship with children, who were young. She was managing to support her household well without my income, and the children needed more stable home life instead of daycare or sitters. It made more sense for me to stop working and stay at home.

Elizabeth shared this about her role determination in her relationship:

> I would say in my past relationships; my roles have been decided base on income. I made a good living and would take on the role of breadwinner. Our present relationship the roles are more equal. She makes more money than I do. I do more of the inside household tasks. I do not like the outside chores.

Samantha discussed their roles as equals. She stated,

> We are pretty much equal. We both make a good living. She has always considered herself to be a "girlie girl," whereas I am more masculine. I don't wear make-up at all. I believe we are probably equal in our relationship. During our relationship, there have been times when one of us has been the breadwinner or vice versa. I don't think we fall into the stereotype of one needs to be masculine and be the breadwinner. We are equals.

Relationship Since Diagnosis

Four of the five LGBTQ couples reported having a strong relationship prior to being diagnosed with cancer. Two of the four described their relationship as “we were a team, talking about everything.” Other words used were “strong,” “very close,” “very loving” and “being able to handle anything together.” One of the partners from the five LGBTQ couples shared: “Our relationship was strained.”

When asked for description of their relationship since receiving the diagnose of cancer, all of the LGBTQ couples expressed that cancer had impacted their relationship in both positive and negative ways. Three of couples expressed they were experiencing a positive impact. Elizabeth shared: “we are still very close. We are handling this as a team.” Samantha reported, “She is a very strong person, which appealed to me the most when we got together. Every day, we as a couple were growing closer. “Charles shared, “Since being diagnosed, he has changed. Spending more time, acting like he is concerned and loving.”

The other two couples shared they had experienced a negative impact on their relationship. Cyrus reported, “We seem connected and disconnected. We’re having to work at communicating; it’s like we are afraid of saying the wrong thing.”
James shared:

> I find myself feeling mad, thinking he should have seen the doctor when he first started feeling bad instead of waiting. I also think I’m not ready for him to die, or our life to be over. I feel he seems to be holding things back from me. He is

> getting more spiritual which makes me feel like he will wake up and decide we should not be together. Sometimes he acts like he is in this alone, which cause me to say things I regret. We do not really fight, but it is like pulling teeth to get him to discuss what he is feeling.

Mark reported, “We are still loving. I feel some strain due to physical changes that have occurred.” Jackson shared: “Our relationship had changed. We cannot close our shop, so I go to all my appointments alone or with my mother. There are days I feel lonely and like we aren’t as close as we were before.”

Changes

In responses, all participants verbalized the changes they had experienced whether it was emotionally, physically, or family related. Betty reported, “Nothing has really changed for me except feeling helpless or a burdened.” Elizabeth shared: “I am less physically strong. I cannot do as much. I have had to cut back on working.” Samantha reported, “I’m having to deal more with the children’s behavior without any support.” Cyrus shared, “I’m having some physical limitations. I cannot work. I have experienced some illness from the treatments.” Jackson reported, “physical strength as changed. I am limited in inmate functions. I don’t feel we are a team. “

Society Views of Their Roles

When asked how do you think society views your roles in relationship? Most responded with “not sure” or that they have “never been asked before.” Then as they responded in more detail to the question there appeared to be a trend of description related to gender. Kevin stated, “one is the man and the other the women.” Charles shared: “I have been asked “who is the wife or husband” in our relationship.” Elizabeth stated, “as masculine and feminine in our relationship.” Samantha reported, “in a same-sex relationship, someone is just confused about their identity.”

Two of the individuals reported experiencing a double standard, being accepted in their professional career as a member of the LGBTQ community, then rejection of their personal lives. Esther shares a situation that occurs at her work:

> I remember being at work and a nurse saying I just don’t understand my wife this, my wife that, I think she was trying to start something deliberately. I said you talk about your plans for the weekend, why don’t you allow me the same courtesies.

Mark shared: “When we had our civil ceremony, about 20 people refused to come because they did not believe in two men being together in a “marriage” It was ok for them to buy flowers from us but not accept us as a couple.”

Some discussed the lack of acceptance of their relationships by society. Jackson stated, “We live in an area which is unaccepting of same-sex couples. We love each other the same way heterosexual couples do.

Preparation for Treatment

The LGBTQ couples did not report any planning for the changes in roles. The key action taken in the preparation of cancer treatment was seeking out information related to cancer, treatment and possible changes to one’s body. LGBTQ couples sought out their information via the internet, friend or support groups. Charles reported, "I spoke to people who I knew had same cancer before."

Jackson shares: "I did some research on the internet to look about my cancer. I sought out a support group." James reported: the oncologist was not helpful in providing them with the information related to resources they desired. James states,

> There was little to no information given to us from the doctor's office. I asked about a social worker to help with information and connection to support groups. They said they used to have one, but it was not useful.

Discrepant Case

According to Yin (2014), case study research where data challenges the theoretical proposition is called discrepant data. The theoretical proposition of this study is the role and role strain for LGBTQ couples dealing with a partner diagnosed with cancer. Interviews supported the theoretical proposition due to LBGTQ couples describing their roles and experience related to adjustment or maintenance their roles connected to having diagnosed with cancer or a partner diagnosed with cancer.

Evidence of Trustworthiness

Credibility

To establish credibility, only willing participants interviewed for this study. During the recruitment, two couples volunteered for the study. However, they did not show for their interview appointment. One couple called stating they had changed their mind regarding participating. I honored their request, thanked them for their consideration, no further communication occurred. I made no attempt to reach out to the second couple, as their no-show to their interview appointment was concluded as their desire to no longer participant.

I used concept mapping to focus on meanings the participants attached to their experiences (White et a., 2012). Colored pencils were used to identify words or phrases demonstrating a relationship between the categories identified. This process provided me greater visualization, allowed for reduced redundancy and produced representations of the concepts throughout the analysis process.

To minimize researcher biases, I used reflective journaling. During the study, I journaled experiences throughout the execution of this study. Within the journal entries, I reflected thoughts, feelings, observations, perceptive beliefs, assumptions and concern related to participating during interaction was documented (Sanjari et al., 2014).

Transferability

Transferability is limited in a qualitative research study with a small sample size of five LGBTQ couples (Houghton et al., 2013). Geographically, this study was limited to the central region of Mississippi. The results of this study cannot generalize to the larger population of LGBTQ couples. The LGBTQ couples' various experiences demonstrated similarities and difference based on their relationship structure. However, with a small number of couples' interviews one cannot speculate into other similar populations. As described in chapter three, the researcher used journal entries to document observations, descriptions of the participants as well as the interview setting. I used journal entries during the data analysis process. Transferability is not created through journal entries; it is a tool that could be used in future exploration.

Dependability

Dependability of the analysis process occurred by the use of triangulation to compare the data, thereby increasing the accuracy (Houghton et al., 2013). Reflexivity occurred during the study at numerous points contributing to the dependability of the outcome. Within my journal, I documented my decision-making process throughout the data collection and analysis process.

Confirmability

In establishing conformability, the results of this study are data-driven (Cope, 2014). I used reflective commentary in my journaling to assist in identifying preconceptions, further establishing the confirmability of my results. Researcher bias was avoided in this study using detailed descriptions of my experiences and beliefs in journal entries.

Results

For this study, I analyzed the results concerning the research questions. Analysis of the research questions will be presented. At the end of each section, a table summarizing the results will also be presented.

Research Question 1

The first research question was: How do LGBTQ couples deciding their roles within their relationship? The LGBTQ couples shared different perceptions and descriptions of their experiences of individual role determination within their relationship. The roles within the relationship were described as a task performed inside and outside the homes. The terms used by the couples in their descriptions were household chores (cleaning, cooking and laundry) and outside tasks (yard work, repairs and maintained).

Three couples reported, “they just fell into” the role they were performing in their relationship. A few stated they were performing this relationship and continued once they became a completed couple. For these three couples, role determination appeared to be based on doing the “things they enjoyed doing.”

Role determination for the last two couples appeared to be determined by the structure of the relationship. The income of one couple was the determining factor to role performance in their relationship. Esther stated:

> I think financial, honestly, because I had a college degree and I made the largest among of money. She was a blue-collar worker. I had small children when we got together. So, my children were 2 and 4. So, it was decided I would support the family, and she would stay home, and run the household.

For the last couple, Mark and Jackson, Mark had an established business and daily routine. Mark expressed, “I just continued to do what I was doing before we became a couple. So, Jackson had to fit into my lifestyle.” Therefore, it appeared Jackson had to will conform to the roles available for this relationship to work. Table 2 summarizes the data analysis themes that were revealed during analysis.

Table 2

Summary of Results for Research Questions 1

Theme	Narrative coding
Role chosen or determined	• financial, honestly • the largest among of money • I would support the family and she would stay home and run the household. • both of us worked • making a lot more money than me • the children needed more stable • past relationships; my roles have been decided base on income

	• roles are more equal • more money than I do • maintain our household • pretty much equal. • times when one of us has been the bread winner or vice versa • We are equals. • did the things we liked doing • discussed who was going to do or did do together. • really didn’t discuss them • began doing the things we had always done. • I just continued to do what I was doing before we became a couple. • fit into my lifestyle • just fit into his life. • not very flexible. • like to do like cooking and cleaning Everything just fell into place. • Just fell into place. • do things we like doing.

Research Question 2

The second research question was: How are LGBTQ couples’ roles influenced when a partner is diagnosed with Stage II or Staged III cancer? All five LGBTQ couples reported cancer affected role performance within their relationships. The partner diagnosed with cancer indicated experiencing loss of abilities, and physical strength. Jackson shares: “My physical strength as changed.” With the physical changes occurring from cancer, four of the five diagnosed with cancer had either stopped working or dropped to part-time. Charles states, “I’m only working part-time.” Along with the reduction of work, their roles within their relationship also were impacted. Elizabeth reported, “Our house isn’t as clean, but it doesn’t seem to matter as much as before.”

With the changes in both their professional and personal activities, their roles still needed to be completed. The role fell to the partner without cancer to either assist in the task, do it themselves, or hire someone. Three of the five partners assumed the task that had been affected. Samantha who in the relationship before the diagnosis was responsible for outside tasks reported, “I’m doing some household chores, caring for the children, besides outside chores. I’m working.” To address the loss of income, both James and Kevin took on extra work in the attempt to maintain the household income level. Mark hired someone to clean the house for Jackson as he was no longer able to, as well as hired part-time help at their shop for the days Jackson did not have the strength to go in.

Despite Esther’s impacted physical abilities, Esther and Betty maintained their roles within their relationship. Esther shared:

“I am still the breadwinner. I honestly, I am in survival mode. I’m a typical Southern Women, and we either cope or don’t cope and not coping wasn’t an option. So, you do what you have to do. I’m being supporting. It probably would be a different situation, but I have to think about the kids. The children’s father died only 3 ½ years early. So, it isn’t choice to leave them. My focus is on getting through it alive. I have been given a five-year prognosis. So, my thoughts are to get as much done as I could during that time. “

Betty reported I can work, but for us, we did it based on what was best for our family." It appeared that Betty desired to adjust her role. Table 3 summarizing the data analysis themes that were revealed during analysis.

Table 3

Summary of Results for Research Question 2

Theme	Narrative coding
Adjustment to roles change	• Not happy it isn't something she likes or wants to do • missing work • stressed about missing work • affect our household income • doing more household chores, • helping with some of her personal care • deal more with the children's behavior without any support

Theme	Narrative coding
	• a great deal of adjustments • having to learn to do new things, • uncomfortable with having to do the household chores • Not happy with not being about to work • worry about the loss of income • I have hired out some of what I cannot do. • I want and need to work • I'm working more to off-set our income loss, • thinking about hire someone • stressed related to the loss of income. • Unhappy with changes • don't like doing the household stuff. Or helping him with personal care items. But I'm doing it. • Adjustment to doing more around the house having to pay more of the bills. • maintaining my roles as the bread winner. • attempting to maintain the household I wanted to maintain my ability to work

Research Question 3

The third research question was: What are LGBTQ couples' concerns and perceptions regarding their relationship with a partner diagnosed with Stage II or Stage III cancer? When the couples were asked about their relationships, and interaction with the diagnosed of cancer reported changes occurred. The couples indicated some perceptions the diagnosis increased the strength their relationship already had, some felt it was changing their relationship from strained to closer and others experienced strain in closeness and communication.

Two of the LGBTQ couples expressed fear that the relationship would not survive the changes that had occurred within the relationship dynamics. James expressed,

> "I worry that our love is not enough to get through the physical and emotional changes I see him going through and deal with. Along with the changes in our communication."

Mark and Jackson reported experiencing issues with their intimate relationship. Jackson expressed,

> "The physical changes have impacted our relationship. My concerned Mark will seek physical interaction outside our relationship if I continue to be unable to have sex with him. Really unsure what I'll do."

Three of the couples' expression little or no concern about their relationships. Theses couples indicated they were still strong or growing stronger in their relationship. Kevin shared: "strong as we have always been." Samantha perceptions as "Every day, we as a couple we're growing closer."

Structural changes in the relationship since the diagnoses of cancer, most of the LGBTQ couples perceived a change to roles as simple adjustments in their daily task. In describing the adjustment only two individuals used terms like "uncontrollable" or "have not chosen." Samantha was primarily responsible for outside chores and had to assume the household chores since Elizabeth's diagnosis. Samantha indicated she experienced, "great deal of adjustments," and "uncomfortable with having to do the household chores." In the case of Esther and Betty, Esther was concerned with doing everything in her power to maintain her role as "breadwinner" to ensure her family was taking care for. Esther's perception was "I'm still the breadwinner. It was not difficult to decide because she was not able to bring home the money. I did. So, I worked throughout all my treatment even though it was vicious." Table 4 summarizes the data analysis themes that were revealed during analysis.

Table 4
Summary of Results for Research Question 3

Theme	Narrative coding
Relationship since diagnose	• Communication between us seemed more one sided • Despite all the stress, illness and unknown I felt our love was still strong. • a burden and helpless.

	• We seem connected and disconnected • work at communicating • we are working at our relationship when it use to come more easily • I don’t feel we are as close as we were. • concern of who we will be after this and will we stronger or broken • We used to handle everything as a team • Now we are struggling with communication. • I feel think he seems to be holding thing back from me • he acts like he is in this alone • sometimes it feels like there is a divide between us • strain due to physical changes that have occurred. • discussed having a more open relationship. I love him • need more sexual activity than he has been able to give or might be able to give • physical changes have impacted our relationship • continue to be unable to have sex with him • Concerns of losing my husband, our house, our life • unable to discuss my feeling, fear

Summary

Chapter four includes the results of the data analysis connection to the research questions. For this study, the setting was a private study room at a local library. I have provided a description of five LGBTQ couples with a partner diagnosed with Stage II or Stage III cancer who participated in this study. A discussion of the data collection methods, timelines of recruitment and interviews appeared in this chapter. Through the data analysis, the following seven themes emerged: (1) roles prior to cancer diagnoses, (2) adjustment to role changes, (3) roles chosen or determined, (4) relationship since diagnoses, (5) changes, (6) society views of their role, and (7) preparation for treatment. Key findings from the data analysis about the research questions indicated that roles are chosen in LBGTQ couples relationship based on the things they like to do. LGBTQ couples' roles are influenced when a partner is diagnosed with Stage II or Stage III cancer. However, LGBTQ couples may be unhappy or uncomfortable with the changes yet appeared to adjust to the changes freely. LBGTQ couples' concept and perception of their relationships when having a partner with Stage II or Stage III varied from being a team, going strong, strained regarding communication, as well intimacy to unsure if they will survive as a couple.

In chapter 5, I will present an interpretation of the findings from the analysis of the data. I offer recommendations for future studies. I provide an acknowledgment and discussion of the study's limitation. The chapter concludes with a discussion of implications for social change and conclusion.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this study was to investigate LGBTQ couples' roles and intuitive experiences of role strain when dealing with a partner diagnosed with Stage II and Stage III cancer. In this qualitative investigation, I used a case study design. The case study design was appropriate because I attempted to glean information from LGBTQ couples with a partner diagnosed with cancer as it related to the phenomena of role strain. This study was conducted related to the gaps in the literature on the effect of role strain on LGBTQ couples with a partner diagnosed with cancer. Empirical investigations exploring LGBTQ couples' perceptions of role strain were unavailable (Hoyt et al., 2013; Kim et al., 2013; Li et al., 2015). In this study, I addressed the literature gap by exploring LGBTQ couples' roles in the context of their relationships to glean an understanding of whether they experienced role strain when dealing with a partner diagnosed with Stage II and Stage III cancer.

In this study, several key findings emerged during the data analysis related to the three research questions. In Research Question 1, I looked at LGBTQ couples' roles within their relationship. Three of the five couples indicated that the role determination in their relationship was chosen by the individual based on the tasks or chores they liked to do. One of the couples described their roles being based on income. For this couple, the roles performed in their relationship were viewed as more traditional roles: breadwinner and homemaker. In the case of Couple 5, the partner had to choose to assume the role available to become and continue to be a committed couple.

For Research Question 2, all couples described the influence the diagnoses with Stage II or Stage III cancer had on their relationship. For some couples, the influence was positive, whereas for others, it was negative. The LGBTQ couples reporting a positive effect from the diagnosis indicated feeling that their relationships continued to grow stronger. For the couples experiencing a negative influence, restraint in communication, diminished closeness, and issues with intimacy were reported.

In Research Question 3, I found that five LGBTQ couples were concerned with the change of the dynamic of their relations. Three couples were concerned with whether or not their relationship could survive the adverse changes that had occurred. These couples experienced a lack of communication, reduction in closeness, and isolation.

Individuals diagnosed verbalized their unhappiness with being unable to fulfill their roles. These individuals did voice experiencing guilt, stress or depression related to only being able to partially or not all perform their roles. One of the individuals diagnosed maintained her role during her treatment process. The maintaining of her role was due to her desire to ensure the family's stability of income. One partner described experiencing uncomfortableness in assuming new roles. The other partners did not discuss any discomfort or unhappiness with having to assume new roles. There were a couple of partners who expressed possibly hiring someone to help in filling the loss of the role.

Interpretation of the Findings

Research Question 1: Role Determination in LGBTQ Couples

Before this study, I was unable to find empirical investigations on LGBTQ couples' role determination (Hoyt et al., 2013; Kim et al., 2013; Li et al., 2015). Hoyt et al. (2013) and Mooney et al. (2013) reported that LGBTQ couples, unlike heterosexual couples, are not bound by societal role expectations. Within the literature, little was known regarding the roles performed in LGBTQ couples' relationship. Biddle (2013) used role theory to understand individuals through their behavior. Role theory is used to define behavior in the contexts and processes they are expected to demonstrate in a specific manner (Biddle, 2013). According to Biddle, roles and social positions are connected, thereby creating an expectation of actions of oneself and others. Individuals behave differently in different social situations related to their social identities; thus, their roles become more like performances.

I found that LGBTQ couples do not perform societally viewed roles within their relationship as male and female or husband and wife. The LGBTQ couples' role are not bound by gender, social positions, or expectation of behavior as set out in role theory (Hoyt et al., 2013; Mooney et al. ,2013). LGBTQ couples do have defined roles they perform within the structure of their relationships. LGBTQ couples' role performance was determined based on everyone doing what they enjoyed doing. From one LGBTQ relationship to the next, the structure is uniquely determined to meet the desire of the individual relationship structure.

Research Question 2: Roles Influenced by Cancer

I used role strain to explain how the challenges or difficulties develop multiple roles, which create feelings of stress. According to McCutcheon (2015), role strain occurs as an individual is required to spend more time learning a new role resulting in less available time for other roles. A heterosexual spouse or daughter typically assumes additional roles when a family member receives a diagnosis of cancer (Kaplan et al., 2013; McQueen et al., 2011; Reblin et al., 2016; Wellisch et al., 2015). For a heterosexual spouse, daughters and parents who take on the role of caretaker once a family member became ill felt role strain and were burdened by performing the duties associated with their new role (Kaplan et al., 2013; Reblin et al., 2016).

LGBTQ couples in this study did not report experiencing role stress when dealing with a partner diagnosed with cancer. The LGBTQ couples' roles appeared to be chosen based on the things they liked or strengths. Some LGBTQ couples seemed to have less stress adjusting to changes as the expected societal definition of roles does not apply to their relationships. With the absence of masculine and feminine roles, care of the partner was more important than role performance.

The LGBTQ couples described the societally viewed roles they perform within their relationship as male and female or husband and wife. The study findings build on Hoyt et al.'s (2013) and Mooney et al.'s (2013) findings that LGBTQ couples' role are not bound by gender. There are roles performed within the structure of LGBTQ couples' relationships. However, the roles within their relationship do not align with the gender, social positions, or expectation of behavior as set out in role theory. LGBTQ couples have more freedom in the structure of their relationships. LGBTQ couples' defined roles based on income or what they as individuals liked to do. In this study, the unique structure of LGBTQ couples' relationships appeared to be determined more by their desire to perform the task they enjoy verses filling a societal view of roles determined based on one's gender.

Research Question 3: Concerns in their Relationship

There was a gap in the literature related to LGBTQ couples' experiences of role strain and marital dissatisfaction when having to assume the role of a partner diagnosed with an illness. This study's findings differed from prior studies conducted on a heterosexual couple. Previous researchers indicated that heterosexual couples experience marriage dissatisfaction as a husband experiences role strain due to the increased responsibility as he assumes the roles of his wife (Kim et al., 2013; Kim et al., 2014; Reblin et al., 2016).

This study's findings differ from prior studies on heterosexual couple marriage dissatisfaction. I found that LGBTQ couples did not experience role stress or marriage dissatisfaction when dealing with a partner diagnosed with cancer. A possible reason these couples did not experience role stress and marriage dissatisfaction could be related to how roles are determined by their relations (Mooney et al., 2013). Some LGBTQ couples reported dissatisfaction associated with changes in their intimacy, communication, and lack of closeness. The changes appeared to be associated with the treatment of cancer or how the individuals were coping with the diagnosis and treatment of cancer. Heterosexual experienced marital dissatisfaction in connection with taking on spousal roles. LGBTQ couples' dissatisfaction was related to intimacy and communication changes as opposed to assuming spousal roles.

Limitations of the Study

This study sample size was limited to five LGBTQ couples with a partner with Stage II or Stage III cancer from Central Mississippi in the United States. Four of the LGBTQ couples were White, one couple was African American, and there were no Asian or Latino participants. The generalizability to similar populations is constrained. The results can only be a qualified representative of the LGBTQ couples in the regions where the interviewees resided.

The second limitation was the recruitment process. Of 15 oncology offices, only two were willing to post my recruitment flyer. The denial of access to the LGBTQ patients reduced my participant pool.

Recommendations

Future research is needed related to the results of this study and the gaps in the literature found during this study. As the subject of role determination among LGBTQ couples has not been investigated to the length of heterosexual couples, this study has provided an opportunity and foundation for further research. Within this study, multiple factors were discovered that influenced role determination. This would allow researchers to continue exploring role determination and role strain among LGBTQ couples with a partner diagnosed with cancer as established in this study. I found that role determination was based on the individuals doing the things they liked. Along with role strain experienced by participants, they attempted to maintain their roles versus taking on new role. This warrants further exploration in future studies for similarities.

Within the literature, there was a gap in LGBTQ couples' experience of role strain (Hoyt et al., 2013; Mooney et al., 2013). The LGBTQ couples in this study did not report experiencing role strain related to assuming additional roles due to their partners' illness causes. As this study's sample population was focused on LGBTQ couple with a partner diagnosed with Stage II or Stage III cancer, the results are not generalized to LGBTQ couples with a partner diagnosed with other serious illness or all LGBTQ couples. Future research is needed to add to the body of knowledge related to LGBTQ couples dealing with other serious illness and how they make adjustments to their roles without experience role strain.

Implications

Positive Social Change

Society continues to have a lack of understanding of how LGBTQ couples define their roles within their relationships. LGBTQ couples are aware of how society perceptive their roles within their relationships. The stereotyped view of their relationship one performing the "female" roles and the "male" roles. In fact, the roles being performed within their relationship are not connected to female or male but instead on enjoyment and like to do. The potential for positive social change begins by presenting the structure of LGBTQ couples role. This study provides an opportunity for society to understand that the LGBTQ couples roles are not based on a stereotypical view of masculine and feminine. The role is related more to task orientation as opposed to society defined roles. This provides an opportunity for society to understand that the LGBTQ couples do not appear to experience role strain as their heterosexual counterparts, as their roles fall more into task orientation as opposed to defined roles. This qualitative case study explored LGBTQ couples' roles in the context of their relationships to glean an understanding of whether they experience role strain when dealing with a partner diagnosed with Stage II and Stage III cancer. The identified population of LGBTQ couples did not indicate the experience of role strain occurrence with a partner diagnosed with Stage II or Stage III. They did articulate their role determination, the development of relationship issues since the diagnose, preparation for treatment and their belief of how society views their relationships.

In many instances, healthcare providers do not understand the role of the partner in an LGBTQ couple. The five LBGTQ couples shared their experiences in preparing for treatment. That data will be used to inform healthcare providers about LGBTQ couples preparation for treatment and healthcare providers will be able to evaluate their present services, policies, and procedures.

This information from this study may be presented in the healthcare setting as part of the annual cultural diversity module which is required annually as a Centers for Medicare & Medicaid Services (CMS) competency. This information will allow for better patient care by presenting additional knowledge of the support structure of the LGBTQ couples with a partner diagnosed with cancer. It might help define the support structure for heterosexual couples who experience role strain when caring for a partner diagnosed with cancer.

There is a disparity in the understanding of roles, as well as role strain, in LGBTQ couples when dealing a life-threatening illness. This study offers new knowledge based on LGBTQ couples' experiences of role determination and an adjustment of roles when dealing with a partner diagnosed with Stage II or Stage III cancer, as well as the lack of role strain when an adjustment to roles was needed. The dissemination of knowledge could assist in altering the comparison between heterosexual couples and LGBTQ couples' relationship structure. I plan to disseminate the information in varied of venues. First, as an instructor of Sociology when lecturing on socialization, roles, and role strain. I will share the results of this study. Secondly, I will submit a proposal to an educational conference.

Conclusion

On June 26, 2015, the United States Supreme Court ruled that same-sex couple relationships be legally recognized. Before this ruling, same-sex couples did not qualify as a "couple" when discussing healthcare matters. There is currently a disparity in the understanding of roles as well as role strain in LGBTQ couples when dealing with the same situation.

This study explored the role and role strain experiences of LGBTQ couples who are living with a cancer diagnoses of a partner. Biddle's (2013) role strain theory was the conceptual framework used in this case study methodology. The research questions provided perceptions of role strain and role expectations, along with how the experience their marital relationship during this potentially turbulent period of their lives. This data assisted in the development of a vibrant description of their experiences.

The approach of this study was to explore the role of LGBTQ couples within their relationship and whether any changes, such as performing caretaking responsibilities, creates role strain (Henslin, 2015). To achieve the purpose of the study, LGBTQ couples' perceptions of their experiences with roles prior to and once a partner received a diagnosis of cancer were described. Positive implications for social change resulted from the ability to inform healthcare providers regarding how LGBTQ couples experience their treatment when supporting a partner diagnosed with Stage II or Stage III cancer.

The purpose of this study was to provide a descriptive analysis of role strain experienced by LGBTQ couples caring for a partner diagnosed with Stage II or Stage III cancer. The results appreciated minimal if any role strain among the LGBTQ couples. This study provides an opportunity for society to understand that the LGBTQ couples do not have the same amount of role strain as their heterosexual counterparts. The outcomes support an opportunity for research on LGBTQ roles within the relationship as well as the evaluation of policies and procedures within the healthcare field.

References

Ard, K. L., & Makadon, H. J. (2012). Improving the health care of lesbian, gay, bisexual and transgender (LGBT) people: Understanding and eliminating health disparities. *Boston: The Fenway Institute*. Retrieved from http://fenwayhealth.org/the-fenway-institute/

American Cancer Society. (2016). Cancer facts and figures. Retrieved from http://www.cancer .org/downloads.STT/CAFF2010PWSecured.pdf

Amiel, G. E., Goltz, H. H., & Wenker, E. P. (2015). *Cancer and the LGBT community.* New York, NY: Springer.

Angen, M. J. (2000). Evaluating interpretive inquiry: Reviewing the validity debate and opening the dialogue. *Qualitative Health Research*, *10*(3), 378-395. doi:10.1177/104973230001000308

Biddle, B. J. (1986). Recent developments in role theory. *Annual Review of Sociology, 12*, 67-92. doi:10.1146.annurev.so.12.800186.000435

Biddle, B. J. (2013). *Role theory. expectations, identities, and behaviors.* New York, NY: Academic Press.

Badr, H., Herbert, K., Reckson, B., Rainey, H., Sallam, A., & Gupta, V. (2016). Unmet needs and relationship challenges of head and neck cancer patients and their spouses. *Journal of Psychosocial Oncology, 34*(4), 336-346. doi:10.1080/07347332.2016.1195901

Berger, R. (2015). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative Research*, *15*(2), 219-234. doi:10.1177/1468794112468475

Blashill, A. J., & Safren, S. A. (2014). Skin cancer behaviors among US men: The role of sexual orientation. *American Journal of Public Health*, *104*(9), 1640-1641. doi:10.2105/AJPH.2014.301993

Chow, E. O., & Ho, H. (2015). Caregiver strain, age, and psychological well-being of older spousal caregivers in Hong Kong. *Journal of Social Work, 15*(5), 479-497. doi:10.1177/1468017314549709

Cope, D. G. (2014). Methods and meanings: Credibility and trustworthiness of qualitative research. *Oncology Nursing Forum*, *41*(1), 89-91. doi:10.1188/14.ONF.89-91

Coren, J. S., Coren, C. M., Pagliaro, S. N., & Weiss, L. B. (2011). Assessing your office for care of lesbain, gay, bisexual, and transgender patients. *The Health Care Manager, 30*(1), 66. doi:10. 701097/HCM.0b013e3182078bcd

Deniz, H., & Inci, F. (2015). The burden of care and quality of life of caregivers of leukemia and lymphoma patients following peripheric stem cell transplantation. *Journal of Psychosocial Oncology*, *33*(3), 250-262. doi:10.1080/07347332.2015.1019660

Devine, K. A., Heckler, C. E., Katz, E. R., Fairclough, D. L., Phipps, S., Sherman-Bien, S., & Sahler, O. Z. (2014). Evaluation of the psychometric properties of the

Pediatric Stress Inventory (PPSI). *Health Psychology*, *33*(2), 130-138. doi:10.1037/ a0032306

Dionne-Odom, J. N., Lyons, K. D., Akyar, I., & Bakitas, M. A. (2016). Coaching family caregivers to become better problem solvers when caring for persons with advanced cancer. *Journal of Social Work in End-of-Life & Palliative Care, 12*(1/2), 63-81. 19 doi:10.1080/15524256.2016.1156607

Dionysiou, D. D., & Tsoukas, H. (2013). Understanding the (re) creation of routines from within: A symbolic interactionist perspective. *Academy of Management Review*, *38*(2), 181-205. doi:10.5465/amr.2011.0215

Dworkin, S. (2012). Sample size policy for qualitative studies using in-depth interviews. *Archives of Sexual Behavior, 41*(6), 1319-1320. doi:10.1007/s10508-012-0016-6

Ellisaon, M. J., Dibble, S. L., & Robertson, P. A. (2011). Lesbian, gay, bisexual, and transgender (LGBT) physicians' experiences in the workplace. *Journal of Homosexuality, 58*, 1355-1371. doi:10.1080/00918369.2011.614902

Erickson, F. (2012). Qualitative research methods for science education. In B.J. Fraser et al (eds.), *Second International Handbook of Science Education* (pp. 1451-1469). New York: Springer International Handbooks of Education.

Erickson, T. (2015). Legalization of gay marriage – United States Supreme Court declares it unconstitutional for states to deny same sex couples the right to marry: Immediate impact of gay marriage in North Dakota. *North Dakota Law Review*, *91*(1), 219-232. Retrieved from http://law.und.edu/law-review/index.cfm

Fagundes, C. P., Berg, C. A., & Wiebe, D. J. (2012). Intrusion, avoidance, and daily negative affects among couples coping with prostate cancer: A dyadic investigation. *Journal of Family Psychology*, *26*(2), 246-253. doi:10.1037/a0027332

Fife, B. L., Weaver, M. T., Cook, W. L., & Stump, T. T. (2013). Partner interdependence and coping with life-threatening illness: The impact on dyadic adjustment. *Journal of Family Psychology*, *27*(5), 702-711. doi:10.1037/a0033871

Francis, L.E., Kypriotakis, G., O'Toole, E.E., Bowman, K.F. & Rose, J. (2015). Grief and risk of depression in context: The emotional outcomes of bereaved cancer caregivers. *Omega: Journal of Death & Dying*, 70(4), 351-379. doi:10.1177/0030222815573720.

Fusch, P.I., & Nessm, L.R. (2015). Are we there yet? Data saturation in qualitative research. *The Qualitative Report, 20*(9), 1408-1416. Retrieved from http://tqr.nova.edu/

Gelo, O., Braakmann, D., & Benetka, G. (2009). Quantitative and qualitative research: Beyond the debate. *Integrative Psychological & Behavioral Science, 43*(4), 406-407. doi:10.1007/s12124-009-9107-x

Gill, M. J. (2014). The possibilities of phenomenology for organizational research. *Organizational Research Methods*, *17*(2), 118-137. doi:10.1171/10944281 13518348.

Gottlieb, B.H., Maitland, S.B., & Brown, J. (2014). Social support and adjustment among wives of men with prostate cancer. *Journal of Psychosocial Oncology, 32*(1), 6-36. 21. doi:10.1080/07347332.2013.855962.

Harper, G. W., Brodsky, A., & Bruce, D. (2012). What's good about being gay? Perspectives from youth. *Journal of LGBT Youth*, *9*(1), 22-41. doi:10.1080/19361653.2012.628230

Henslin, J.M. (2015). *Essentials of Sociology: A down-to-earth approach*. (11th ed.). New York, NY: Pearson.

Hetzel, C. J. (2011). Exploring the relationship between public opinion and personal attitudes and behavior toward Lesbians and Gay men: Social conformity revisited. *Journal of Homosexuality, 58*(10), 1421-1441. doi:10.1080/00918369.2011. 614910

Honda, A., Data, Y., Abe, Y., Aoyagi, A., & Honda, S., (2013). Work-related stress, caregiver role, and depressive symptoms among Japanese worker. *Safety and Health at Work*, *5*(1), 7-12. doi:10.1016/j.shaw.201311.002

Houghton, C., Casey, D., Shaw, D., & Murphy, K. (2013). Rigour in qualitative case-study research. *Nurse Researcher, 20*(4), 12-17. Retrieved from journals.lww. com/nursingresearchonline/pages/default.aspx

Hoyt, M. A., Stantion, A. L., Irwin, M. R., & Thomas, K. S. (2013). Cancer-related masculine threat, emotional approach coping, and physical functioning following treatment for prostate cancer. *Health Psychology*, *32*(1), 66-74. doi:10.1037/a0 03002

Iantaffi, A., & Bockting, W. O. (2011). Views from both sides of the bridge? Gender, sexual legitimacy and transgender people's experiences of relationships. *Culture, Health & Sexuality*, *13*(03), 355-370. doi:10.1080/13691058.2010.537770

Jabson, J.M., & Kamen, C.S. (2016). Sexual minority cancer survivors' satisfaction with care. *Journal of Psychosocial Oncology, 34*(1/2), 28-38. doi:10.1080/07347332. 2015.1118717

John, L. K., Loewenstein, G., & Prelec, D. (2012). Measuring the prevalence of questionable research practices with incentives for truth telling. *Psychological science, 23*(5). doi:10.1777/10956797611430953.

Kamen, C., Mustian, K., Johnson, M. O., & Boehmer, U. (2015). Same-sex couples matter in cancer care. *Journal of Oncology Practice*, *11*(2), e212-e215. doi:10.1200/JOP.2014.000877

Kaplan, L. M., Kaal, K. J., Bradley, L., & Alderfer, M. A. (2013). Cancer-related traumatic stress reactions in siblings of children with cancer. *Families Systems, & Health, 31*(2), 205-217. doi:10.1037/a0032550

Kim, Y., Carver, C. S., Rocha-Lima, C., & Shaffer, K. M. (2013). Depressive symptoms among caregivers of colorectal cancer patients during the first since diagnosis: A longitudinal investigation. *Psycho-Oncology*, *22*, 362-367. doi:10.1002/pon.2100

Kim, Y., Shaffer, K. M., Carver, C. S., & Cannady, R. S. (2014). Prevalence and predictors of depressive symptoms among cancer caregivers 5 years after the relative's cancer diagnosis. *Journal of Consulting and Clinical Psychology*, *82*(1), 1-8. doi:10.1037/a0035116

Klassen, A.F., Gulatia, S., Granek, L., Rosenberg-Yunger, Z.R.S., Watt, L., Sung, L., Klaassen, R., Dix, D., & Shaw, N.T. (2012). Understanding the health impact of caregiving: A qualitative study of immigrant parents and single parents of children with cancer. *Quality Life Research, 21*, 1595-1605. doi:10.1007/s11136-011-0072-8

Kramer, B. J., Kavanaugh, M., Trenthan-Dietz, A., Walsh, M., & Yonker, J. A. (2011). Complicated grief symptoms in caregivers of persons with lung cancer: The role of family conflict, intrapsychi strains, and hospice utilization. *Omega*, *62*(2), 201-220. doi:10.2190/OM.62.3.a

Li, A., Shaffer, J., & Bagger, J. (2015). The psychological well-being of disability caregivers: Examining the roles of family strain, family-to-work conflict, and perceived supervisor support. *Journal of Occupational Health Psychology*, *20*(1), 40. doi:10.1037/a0037878

Liang, H. (2015). Are you tired? Spillover and crossover effects of emotional exhaustion on the family domain Asian. *Journal of Social Psychology, 18*(1), 22-32. doi:10.1111/ajsp.12075

Lim, F. A., Brown Jr, D. V., & Kim, S. M. J. (2014). CE: Addressing health care disparities in the lesbian, gay, bisexual, and transgender population: A review of best practices. *AJN The American Journal of Nursing*, *114*(6), 24-34. doi:10.1097/01.NAJ.00450423.89759.36

Lynch, K. (2007). Modeling role enactment: Linking role theory and social cognition. *Journal for the Theory of Social Behavior, 37*(4), 379-399. doi:10.1111/j.1468-5914.2007.00349.x

Macionis, J. J. (2011). *Sociology* (13th ed.). Pearson: Prentice Hall Publishing.

Manen, M. (2014). *Phenomenology of Practice: Meaning-giving methods in phenomenological research and writing (Developing qualitative injury).* (1st ed.). New York: Routledge.

Margolies, L. (2014). The psychosocial needs of lesbian, gay, bisexual, or transgender patients with cancer. *Clinical Journal of Oncology Nursing*, *18*(4), 462-464. doi:10.1188/14.cjon.462-464

Mazanec, P., Daly, B. J., Ferrell, B. R., & Prince-Paul, M. (2011). Lack of communication and control: Experience of distance caregivers of parents with advance cancer. *Oncology Nursing Forum, 38*(3), 307-313. doi:10.1188/11. ONF.307-313

McCutcheon, J. & Morrison, M.A. (2015). The effect of parental gender roles on student’s attitude toward Lesbian, Gay, and Heterosexual Adoptive Couples. *Adoption Quarterly*. *18*(2), 138-167. doi:10.1080/10926755.2014.945702

McQueen, A., Kreuter, M. W., Kalesan, B., & Alcaraz, K. I. (2011). Understanding narrative effects: The impact of breast cancer survivor's stories on massage processing, attitudes, and beliefs among African American women. *Health Psychology*, *30*(6), 674-682. doi:10.1037/a0025395

Mehta, A., Chan, L.S., & Cohen, S. R. (2014). Flying blind: Sources of distress for family caregivers of palliative cancer patients managing pain at home. *Journal of Psychosocial Oncology, 32*(1), 94-111. doi:10.1080/07347332.2013.856057.

Merton, R.K. (1996). *On social structures and science. In P. Sztozpka* (ed.). Chicago, IL: University of Chicago Press.

Mooney, L. A., Knox, D., & Schacht, C. (2013). *Understanding Social Problems* (9th ed.). Stamford, CT: Cengage Learning.

Myles, R. (2015, November). Qualitative data analysis. In *2015 APHA Annual Meeting & Expo (Oct. 31-Nov. 4, 2015)*. APHA.

Onwauegbuzie, A.J., Leech, N.L., & Collins, K.T. (2012). Qualitative analysis techniques for the review of the literature, *Qualitative Report*, 17. Retrieved from www.nova.edu/ssss/QR/calls.html

Papadoppoulos, A., Vrettos, I., Kamposioras, K., Anagnostopulos, F., Giannopulps, G., Pectasides, D., & Econompoulos, T. (2011). Impact of cancer patients' disease awareness on their family members' health-related quality of life: A cross-sectional survey. *Psycho-Oncology*, *20*, 294-301. doi:10.1002/pon.1731

Peredaryenko, M. S., & Krauss, S. (2013). Calibrating the human instrument: Understanding the interviewing experience of novice qualitative researchers. *Qualitative Report, 18*(43), 1- 17. Retrieved from www.nova.edu/ssss/QR/ calls.html

Petrova, E., Dewing, J., & Camilleri, M. (2016). Confidentiality in participatory research: Challenges from one study. *Nursing Ethics, 23(4),* 442-454. doi:10.1177/096973 3014564909

Punch, K.F., (2014*). Introduction to social research: Quantitative and qualitative approaches* (3rd ed.). Thousand Oaks, CA: Sage Publication.

Quinn, G. P., Schabath, M. B., Sanchez, J. A., Sutton, S. K., & Green, B. L. (2015). The importance of disclosure: Lesbian, Gay, Bisexual, Transgender/Transsexual, Queer/Questioning, and Intersex individuals and the cancer continuum. *Cancer, 121*(8), 1160-1163. doi:10.1002/cncr.29203

Railka, A., Oliveira, S., Cordeiro Rodrigues, R., Emille Carvalho De Sousa, V., Gabrielle De Sousa Costa, A., Venícios De Oliveira Lopes, M., & Leite De Araujo, T. (2013). Clinical indicators of ‘caregiver role strain’ in caregivers of stroke patients. *Contemporary Nurse*, *44*(2), 215-224. doi:10.5127/conu.2013.44.2.215

Ralph, N., Birks, M., & Cahpman, Y. (2015). The methodological dynamism of grounded theory. *International Journal of Qualitative Methods*, 1-6. doi:10.1177/160940 6915611576

Reblin, M., Donaldson, G., Ellington, L., Mooney, K., Caserta, M. & Lund, D. (2016). Spouse cancer caregivers’ burden and distress at entry to home hospice. *Journal of Social & Personal Relationships, 33*(5), 666-686. doi:10.1177/0265407515 588220.

Rhoads, S. E., & Rhoads, C. H. (2012). Gender roles and infant/toddler care: Male and female professors on the tenure track. *Journal of Social, Evolutionary, and Cultural Psychology*, *6*(1), 13. doi:10.1037/h0099227

Richardson, A.E., Morton, R., & Broadbent, E. (2015). Caregivers' illness perceptions contribute to quality of life in head and neck cancer patients at diagnosis. *Journal of Psychosocial Oncology, 33*(4), 414-432. doi:10.1080/07347332.2015.1046011.

Robinson, O.C. (2014). Sampling in interview-based qualitative research: A theoretical and practical guide. *Qualitative Research in Psychology, 11*(1) 25-41. doi:10.1080/14780887.2013.80154

Rosario, M., Corliss, H.L., Everett, B.G., Reisner, S.L., Austin, S. B., Buchting, F. O., & Birkett, M. (2014). Sexual orientation disparities in cancer-related risk behaviors of tobacco, alcohol, sexual behaviors, and diet and physical activity: Pooled youth risk behavior survey. *American Journal of Public Health, 104*(2), 245-254. doi:10.2105/AJPH.2013.301506.

Sanjari, M., Bahramnezhad, F., Khoshnava Fomani, F., Shoghi, M., & Ali Cheraghi, M. (2014). Ethical challenges of researchers in qualitative studies: The necessity to

69 develop a specific guideline. *Journal of Medical Ethics & History of Medicine*, *7*(14), 1-6. Retrieved from http://jmehm.tums.ac.ir/index.php/jmehm

Sautter, J.M., Tulsky, J.A., Johnson, K.S., Olsen, M.K., Burton-Chase, A.M., Hoff Lindquist, J., Zimmerman, S., & Steinhauser, K.E. (2014) Caregiver experience during advanced chronic illness and last year of life. *Journal of the American Geriatrics Society*. *62*(6), 1082-1090. doi:10.1111/jgs.12841.

Solomon, M. R., Surprenant, C., Czepiel, J. A., & Gutman, E. G. (1985). A role theory perspective on dyadic interactions: the service encounter. *Journal of Marketing*, *45*. 99-111. doi:10.2307/1251180

Sluss, D. M., van Dick, R., & Thompson, B. S. (2011). Role theory in organizations: A relational perspective. *American Psychological Association, 1*, 505-534. doi:10.1037/12169-016

Stenberg, U., Cvancarova, M., Ekstedt, M., Olsson, M., & Ruland, C. (2014). Family caregivers of cancer patients: Perceived burden and symptoms during the early phases of cancer treatment. *Social Work in Health Care, 53*(3), 289-309. doi:10.1080/00981389.2013.873518.

Sutphin, S. (2013). The division of child care tasks in same-sex couples. *Journal of GLBT Family Studies*, *9*, 474-491. doi:10.1080/1550428X.2013.826043

Suri, H. (2011). Purposeful sampling in qualitative research synthesis. *Qualitative Research Journal*, *11*(2), 63-75. Retrieved from http://tqr.nova.edu/

Testa, M. F. (2013). Systems of kinship care: Enduring challenges and emerging opportunities *Journal of Family Social Work, 16*(5), 349-363. doi:10.1080/10522158.2013.834169

Tessier, S. (2012). From field notes, to transcripts, to tape recordings: Evolution or combination? International. *Journal of Qualitative Methods, 11*(4), 446-460. Retrieved from https://ejournals.library.ualberta.ca/index.php/IJQM/

Thomas, C., Wootten, A., & Robinson, P. (2013). The experiences of gay and bisexual men diagnosed with prostate cancer: Results from an online focus group. *European Journal of Cancer Care*, *22*(4), 522-529. doi:10.1111/eec.12058

Toubia, B. (2014). Gender role conflict, role division, and the gay relational experience. *Journal of Systemic Therapies*, *33*(4), 15-23. doi:10.1521/jsyt.2014.33.4.15

Treloar, A., Stone, T.E., McMillan, M. & Flakus, K. (2015). A narrative in search of a methodology. *Perspect Psychiatr Care 52(3),* 202-210. doi:10.1111/ppc.12081.

U.S. Census Bureau (2015). *Same sex couples main*. Retrieved from http://www.census .gov/ hhes/samesex/

Vagle, M.D. (2014). *Crafting phenomenological research*. (1st ed.). New York: Left Coast Press.

Valdes-Stauber, J., Vietz, E. & Kilian, R. (2013). The impact of clinical conditions and social factors on the psychological distress of cancer patients: an explorative study a consultation and liaison services in a rural general hospital. *BMC Psychiatry, 13*. 226-246. doi:10.1186/1471-244X-13-226

Vines, A.I., & Demissie, Z. (2013). Racial differences in social support and coping among family caregivers of patients with prostate cancer. *Journal of Psychosocial Oncology, 31*(3), 305-318. doi:10.1080/07347332.2013.77893

Weisshaar, K. (2014). Earnings equality and relationship stability for same-sex and heterosexual couples. *Social Forces*, *93*(1), 93-123. doi:10.1093/sf/sou065

Wellisch, D.K., Sumner, L.A., Kim, Y., & Spillers, R.L. (2015). Psychosocial characteristics of adult daughters of breast cancer patients: Comparison of clinic and community caregiver's samples. *Journal of Psychosocial Oncology, 33*(5), 561-575. doi:10.1080/07347332.2015.106728

White, J. L., & Boehmer, U. (2012). Long-term breast cancer survivors' perception of support from female partners: An exploratory study. *Oncology Nursing Forum, 39*(2), 210-217. doi.org/10.1188/12ONF210-217

White D., Oelke, N.D., & Friesen, S. (2012). Management of a large qualitative data set: Establishing trustworthiness of the data. *International Journal of Qualitative Methods, 11*(3), 244-258. Retrieved from www.iiqm.ualbert.ca/en/International JournalofQualitati.aspx

Wight, R. G., LeBlanc, A. J., Vries, B. d., & Detels, R. (2012). Stress and mental health among midlife and older gay-identified men. *American Journal of Public Health*, *102*(3), 503. doi:10.2105/AJPH.2011.300384

Williams, E., & Morrow, S.L. (2009). Achieving trustworthiness in qualitative research: A pan-paradigmatic perspective. *Psychotherapy Research, 19*(4/5). 576-582. doi:10.1080/1050330082702113.

Wong, J. C., Payne, A. Y., Mah, K., Lebel, S., Lee, R. N., Irish, J., Devins, G. M. (2013). Negative cancer stereotypes and disease-specific self-concept in head and neck cancer. *Psycho-Oncology*, *22*, 1055-1063. doi:10.1002/pon.3109

Wood, A.W., Gonzalez, J., & Barden, S.M. (2015). Mindful caring: Using mindfulness-based cognitive therapy with caregivers of cancer survivors. *Journal of Psychosocial Oncology*, *33*(1), 66-84. doi:10.1080/07347332.2014.977418.

Yin, R. (2013). *Case study research: Design and methods.* (5th ed.). Thousand Oaks, CA: Sage Publications Inc.

Appendix A: Recruitment Flyer

Research Study
Participants Needed

What the Study is About?

The effect that the diagnosis of cancer has on the roles of partners in LGBTQ relationships. I am looking for LGBTQ couples with a partner diagnosed with cancer to volunteer. Your participation will contribute to healthcare practitioners gaining a better understanding of the experience of LGBTQ couples, by providing them with validated research.

Who can Participate?

LGBTQ couples with a partner diagnosed with Stage II or III cancer.

Individuals must speak English.

How do I volunteer to participate?

Please call Lisa Thomason at (423)268-3273, if you are interested in participating in a 45 - minute face-to-face interview.

All information obtained is confidential. All information obtained from participants' will be confidential, and your privacy will be maintained throughout the research project and will not be used for any other purpose. This study will be conducted by Lisa Thomason a student at Walden University for my dissertation.

Appendix B: Interview Protocol

Interview Protocol

Topic: A Case Study of LGBTQ Couples whose partner has cancer experiencing role strain

Time: ________________

Date: __________________________

Lisa Thomason: interviewer

Fictional name: ______________________ Participants names: ____________________

Greet the participant at the door of the interview room by shaking hands. During the hand shaking, I will say I am Lisa Thomason. Please come in and make yourself comfortable. I greatly appropriate you coming today. Without you this research would not be possible, thank you.

An explanation of the research: The desired goal of this section is to seek your knowledge, from your perspectives, your experiences of role strain while dealing with a partner diagnosed with cancer. All responses are confidential. During the interview, if there is question you do not desire to give a response to, please say so. The interview will be stop any you it to be stop.

1. Describe your roles before learning about the diagnosed of cancer?
2. Describe your experiences as you prepared for the treatment of cancer?
3. What has changed for you?

4. How do you feel about having to adjust your roles within your relationship?
5. Describe what your roles are like since the diagnoses of cancer or during treatment?
6. Describe what your interaction is like since the diagnoses of cancer.
7. How were your roles within your relationship chosen or determined when you first began a couple?
8. Describe what roles you performed within your relationship prior to the diagnoses of cancer.
9. What roles are your performing since the diagnosed of cancer?
10. How has your relationship changed since the diagnoses of cancer?
11. How do you feel about the changes in your roles within your relationship?
12. What do you believe has been the hardest obstacle (s) you have faced in your relationship since the diagnoses of cancer?
13. How do you think society views your roles with relationship?
14. Is there anything else you would like to add that will help me understand your experiences with roles/role strain?

Thank you again for your participating in this study. All your information is confidential.

Appendix C: Certification of Completion

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Lisa Thomason** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 06/13/2016.

Certification Number: 2094539.