COGNITIVE-BEHAVIORAL COUPLE THERAPY FOR SAME-SEX FEMALE COUPLES: A PILOT STUDY

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ABSTRACT

Kimberly Zoe Pentel: Cognitive-Behavioral Couple Therapy for Same-Sex Female Couples: A Pilot Study
(Under the direction of Donald Baucom)

Despite comparable levels of relationship satisfaction and intimacy, same-sex couples break up faster and more often than different-sex couples highlighting a need for quality couple therapy. Research suggests that culturally tailored services are desired by same-sex couples and may be more effective and better received. Although efficacious couple therapies exist to treat relationship distress, they have been overwhelmingly studied with different-sex couples. Sexual minority (SM) affirming couple therapies have not been systematically developed or evaluated. The current study involved developing and pilot testing a tailored couple therapy for distressed same-sex female couples. This treatment integrates the empirically-supported cognitive-behavioral couple therapy framework and SM stress model. Doctoral student therapists delivered the treatment in an open-trial format to a pilot sample of 11 same-sex female couples experiencing relationship distress and SM stress. Treatment was delivered with high adherence to the treatment manual. Participants reported high treatment satisfaction. As hypothesized, participants experienced significant decreases in relationship distress and improvements in couple coping with SM stress from pre- to post-treatment. The small sample size and floor effects precluded clear conclusions regarding anticipated improvements in individual mental health. Participants experienced comparable or stronger improvements in relationship functioning compared to couples in a similar benchmark study. Given this

is a small pilot study, results are interpreted with caution. The ACCESS Program is the first culturally tailored couple therapy for same-sex couples. Implications for culturally tailoring evidence-based couple therapy for marginalized groups are discussed.

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Introduction

Same-sex female couples head over 510,000 households in the U.S. (American Community Survey, 2018). Although same- and different-sex couples experience similar levels of relationship satisfaction and intimacy (Balsam, Beauchaine, Rothblum, & Solomon, 2008), same-sex couples break up faster and more often (Kurdek, 2004). This disparity in relationship outcomes is often attributed to the stressors associated with the stigma and oppression that sexual minority (SM) couples may face (e.g., Khaddouma, Norona, & Whitton, 2015). Same-sex female couples may be at particular risk for relationship dissolution compared to both different-sex couples (1.5 times more likely) and same-sex male couples (twice as likely; Balsam, Rothblum, & Wickham, 2017).

Many SM couples desire culturally sensitive and affirming same-sex couple care (Whitton, 2016; Whitton & Buzzella, 2012). Clinical findings suggest that gains are maximized and service better received when relationship services are well-tailored to the unique needs of SM couples (Whitton, Weitbrecht, Kuryluk, & Hutsell, 2016). Although 70-90% of couple and family therapists have worked with SM clients (Godfrey, Haddock, Fisher, & Lund, 2006), many therapists report a lack of training in culturally-competent care for same-sex couples and feel unsure how to conceptualize the clinical problems that may arise in same-sex couple therapy (Green & Mitchell, 2015; Whitton & Buzzella, 2012). In a survey of 1,716 members of the American Association for Marriage and Family Therapy, nearly half of respondents noted they felt incompetent in treating gay or lesbian clients (Doherty & Simmons, 1996). A more recent survey suggests there

is a broad range in marriage and family therapists' comfort in treating SM clients (Green, Murphy, & Blumer, 2010), and less is known about clinical psychologists' comfort treating SM clients. This lack of therapist competence and comfort around sexual minority-related topics may adversely impact therapeutic rapport and dampen the efficacy of treatment (American Psychological Association, 2003, 2012; Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991; Meyer, 2003).

Terminology

Throughout this paper, the term sexual minority (SM) is used to refer to individuals who may identify as lesbian, gay, bisexual, or another sexual minority identity (e.g., pansexual, queer, no label). We acknowledge that best practices around SM terminology are evolving and may shift regionally and generationally. This paper focuses on sexual minority identity as one possible (although certainly not the only) aspect of an individual's and couple's identity. Recognition and future directions regarding more systematic integration and attention to the needs of diverse gender identities are addressed in the discussion section. In this paper, more specific labels (e.g., same-sex female couple) are used when reflecting research findings that used these terms.

Cognitive-Behavioral Couple Therapy

Cognitive-behavioral therapy (CBT) approaches have been proposed as especially appropriate for SM individuals and are also recommended as a beneficial framework for conducting same-sex couple therapy (Martell, Safren, & Prince, 2004). Applying CBT to the couples realm, Epstein and Baucom (2002) developed cognitive-behavioral couple therapy (CBCT). The CBCT model posits that relationships are a function of (a) the two individuals that make up the relationship, (b) how they interact as a couple, and (c) how

the couple interacts with their broader environment (Baucom, Fischer, Corrie, Worrell, & Boeding, 2020). CBCT offers strategies to intervene on a couple's cognitive, behavioral, and emotional functioning and provides a broad framework to conceptualize and intervene on romantic relationship distress. For example, universal factors may be relevant to all couples' relationship functioning (e.g., the importance of non-hostile, non-critical communication). CBCT has been shown to be efficacious in significantly reducing romantic relationship distress and improving individual mental health including anxiety and depressive symptoms (e.g., Abramowitz et al., 2013; Baucom et al., 2018; Fischer, Baucom, & Cohen, 2016).

CBCT and other evidence-based couple therapies have been primarily developed and evaluated with different-sex couples (Kelly, Bhagwat, Maynigo, & Moses, 2014). However, work extending CBCT to diverse populations has examined how couple-based therapies may be adapted for specific presenting concerns such as infidelity or individual psychopathology (e.g., Baucom, Belus, Adelman, Fischer, & Paprocki, 2014). Adaptations of CBCT for a given population tend to have two main foci: first, CBCT-based skills are used to target broad relationship distress that any couple may experience and to build effective communication. Second, these skills are applied to the unique concerns that the population faces with a specific consideration of the domains and dynamics that the given stressor may create in a couple's relationship. Thus, CBCT has great potential to be adapted for SM couples. This adaptation can be informed by SM-specific literature.

Sexual Minority Stress

Part of the difficulty that clinicians face in conceptualizing same-sex couple functioning is likely due to the added challenges or unique factors that same-sex couples may face in their romantic relationships compared to different-sex couples. These added stressors, related to being a sexual minority in a heteronormative society and experiencing associated discrimination and stigma, are collectively termed *sexual minority (SM) stress* (Brooks, 1981; Meyer, 1995, 2003). The SM stress model draws from the broader social stress theory (Dohrenwend, 2000; Pearlin, 1999) which suggests that individuals must adapt and respond to stressors individually, interpersonally, and in their environment.

Many same-sex couples navigate experiences of minority stress adaptively as a united team, and as a result, their romantic relationship might be strengthened (Green & Mitchell, 2015). However, research suggests increased SM stress is generally associated with decreased romantic relationship functioning in same-sex couples (Balsam & Szymanski, 2005; Frost & Meyer, 2009; Mohr & Daly, 2008; Otis, Rostosky, Riggle, & Hamrin, 2006) as well as increased risk for psychiatric disorders and poorer quality of life in either partner (e.g., Cochran, Sullivan, & Mays, 2003; Mays & Cochran, 2001; Otis et al., 2006; Sandfort, de Graaf, Bijl, & Schnabel, 2001). A study in Norway and Sweden, where same-sex unions have been legally recognized since the 1990s, found that the divorce rate for same-sex couples was significantly higher than for different-sex couples (Andersson, Noack, Seierstad, & Weedon-Fekjær, 2006) with same-sex male couple divorce rates 50% higher than for heterosexual couples, and the same-sex female couple divorce rate nearly double that of same-sex male couples.

In considering how to tailor couple therapy for same-sex female couples, it is important to revisit the SM stress model. SM stress is typically understood as a phenomenon brought on by society's treatment of SM individuals, thus originating at the environmental level. However, the impact of minority stress may be experienced individually, jointly as a couple, or in terms of how the couple interacts with their community (e.g., Hatzenbuehler et al., 2014). These levels map on to the three levels of functioning attended to in the CBCT model (e.g., individual, couple, environmental; Epstein & Baucom, 2002). Major areas of SM stress that are implicated in same-sex couple functioning are highlighted below, grouped by these levels. This is not an exhaustive list nor a systematic review but instead is provided to illustrate aspects of SM stress that the literature suggests may be relevant in romantic relationship functioning.

Environmental-Level Sexual Minority Stress

Discrimination. Perhaps the most pervasive form of SM stress that same-sex couples face is discrimination. Overt or covert experiences of discrimination can occur at home, at work, in a doctor's office, at school, in one's neighborhood, or on a broader societal level (Bigner & Wetchler, 2012) and might be aimed at one partner or the couple as a unit. Institutional discrimination against SM individuals and couples is widespread. For example, it is legal in the majority of U.S. states for SM individuals to be discriminated against in hiring and promotions, to be fired, or to be denied housing, public accommodations, or credit due to sexual orientation (Green & Mitchell, 2015).

In addition to institutional discrimination, a partner or couple may encounter negative or rejecting messages from individuals in their community. Per capita, LGBT people as a whole are at a higher risk of experiencing hate crimes than any other minority

group in the U.S.; in 2014 nearly one-fifth of the single-person hate crimes reported to the FBI were due to the victim's perceived sexual orientation (Park & Mykhyalyshyn, 2016). Same-sex couples may also encounter microaggressions, defined as subtle, commonplace acts or statements that convey a hostile or negative view towards a group. An example of a microaggression towards a same-sex female couple may be asking "Who is the man in the relationship?" or a family member referring to one's significant other as their "roommate." The couple stress and coping literature identifies microaggressions as the type of stressor that is most harmful to a couple's relationship functioning as these stressors are typically chronic in nature and difficult to control (i.e., triggered by factors external to the couple's relationship; Bodenmann, Ledermann, & Bradbury, 2007; Bradbury & Karney, 2004; LaTaillade, 2006).

Family of Origin and Social Support. Same-sex couples face more obstacles than different-sex couples in forming cohesive support systems (Buzzella, Whitton, & Scott, 2015; Filmore, Baretto, & Ysasi, 2016). Decreased social support is associated with decrements in same-sex couple satisfaction, commitment, well-being, and levels of overall stress (Kertzner, Meyer, Frost, & Stirratt, 2009; Porche & Purvin, 2008; Szymanski & Owens, 2009). The level of overt support that families provide SM individuals and couples can vary widely from a warm, welcoming response to "passive acceptance" to acting in an overtly discriminatory and hostile manner (Pachankis & Goldfried, 2004). Compared to different-sex couples, same-sex couples overall report less support from family but more from friends (Kurdek, 2005). Some same-sex couples may seek primary social support from friendships, or "families of choice," defined as a network of close individuals that provide both instrumental and emotional support .

Couple-Level Sexual Minority Stress

Outness and Relationship Disclosure. Same-sex couples must continually and consciously decide to whom they will disclose or show their same-sex relationship (Scott & Rhoades, 2014). Conflict may arise if the partners disagree regarding how or whether to disclose their relationship (or how to refer to their relationship[1]) to others. Individual partners may have different levels of "outness" or desires to be out in different arenas of one's life (e.g., school, work, or family of origin). Concerns of coming out in different areas of one's life also overlap with valid concerns in many states regarding laws that do not ban discrimination based on sexual orientation. Over half of LGBT individuals live in a state that does not provide legal protection against discrimination for employment, housing, or public service (Human Rights Campaign, 2016). Thus, individuals may be concerned that coming out may endanger their employment or lead to denial of housing. Indeed, research suggests that, compared to heterosexual individuals, SM individuals experience higher rates of having been fired (60% versus 40%), denied housing (15% versus 6%), and bullied across their lifetime (41% versus 14%; Meyer, 2019).

Relationship Ambiguity. The majority of SM individuals grow up in households with heterosexual, different-sex parents; thus, heterosexuality is perceived as the norm from their family of origin, media, and society more broadly (Martell et al., 2004). As a result, same-sex couples often have few role models or broader templates of same-sex couplehood (Green & Mitchell, 2015). Two key challenges that SM couples may

[1] Although individuals have their own sexual orientation label, a couple may also develop their own couple-level label. Clinicians must be mindful to distinguish between these two and avoid assumptions that these are identical (e.g., a couple may identify as a lesbian couple, but one partner identifies individually as lesbian and the other bisexual).

navigate as they set up their relationship are: (a) navigating division of household tasks and roles in the absence of traditional gender-roles, and (b) discussing relationship boundaries and possible non-monogamy.

Regarding gender roles, the lack of normative templates may be perceived by couples as freeing, allowing them to develop their own identity and preferences for tasks within their relationship detached from traditional gendered scripts (Kurdek, 2005). As a result, same-sex couples often develop a more egalitarian split of household tasks than different-sex couples (Filmore et al., 2016). Navigating a romantic relationship without clear role models can also be confusing or frustrating given that the couple must negotiate roles more effortfully (Addison & Coolhart, 2015). Clinicians anecdotally report that it takes an average of 10 years for same-sex couples to negotiate and solidify the roles and responsibilities each individual will adopt, suggesting that many couples are left for an extended time in somewhat ambiguous terrain (Green & Mitchell, 2015). Yet, SM individuals are not immune to societal pressures to conform to gender norms. Problems may arise if both partners strongly adhere to societally-imposed gender norms, potentially amplifying gendered patterns and deficits (Connolly, 2004; Green & Mitchell, 2015). For example, if the two partners in a same-sex female couple have similarly been socialized to be highly nurturing and put others' needs above their own, this may lead to over-involvement or enmeshment with one's partner (Krestan & Bepko, 1980).

Another challenging area that can arise due to lack of templates for same-sex couplehood is navigating relationship boundaries and monogamy. Couples seeking an explicit agreement in their relationship regarding monogamy or non-monogamy must also discuss boundaries—namely, which emotional, physical, or other facets of intimacy

will be reserved for the couple relationship versus shared with others (Scott, Whitton, & Buzzella, 2019). A large archival study of gay men, lesbian women, and heterosexual individuals from 1975 to 2000 found that, overall, explicit agreements to be monogamous have increased across all three groups over time (Gotta et al., 2011). Generally, couples function best when they have clarity around each individual's level of commitment and boundaries and place the romantic relationship as a priority over other social relationships (Green & Mitchell, 2015). Evidence-based treatments for infidelity (e.g., Snyder, Baucom, & Gordon, 2008) may be indicated if one or both partners exhibit significant distress following a breach in relationship boundaries.

Parenting as a Same-Sex Couple. Approximately 23% of same-sex female couples have one or more children in the household (American Community Survey, 2018), and same-sex couples are more likely than different-sex couples to be raising foster or adoptive children (Goldberg & Conron, 2018). Research suggests that children of same- and different-sex parent families experience comparable outcomes including psychological well-being, self-esteem, quality of life, and academic outcomes (Goldberg, Gartrell, & Gates, 2014; Patterson & Farr, 2016). Numerous studies suggest same-sex female couples think more about their motives to have children and have a stronger desire to have children than different-sex couples (Bos, Van Balen, & Van den Boom, 2007). In couple therapy, topics specifically related to parenting as a same-sex couple that may arise (as opposed to more universal parenting-related stressors that any couple may experience) include: (a) finding social support and empathy from other parents who have gone through similar experiences (e.g., one parent potentially carrying the child and being the biological mother while the other parent, in some states, has to go through a

stepparent adoption), (b) navigating when and how to talk with their child about what it means to have same-sex parents, and (c) navigating outness as a family or as co-parents in various settings such as parent-teacher conferences, etc.

Individual-level Sexual Minority Stress

Internalized Homonegativity. Over time, SM individuals may internalize messages from society that one's orientation is inherently bad or sinful or that they are a globally bad person due to their sexual orientation (Filmore et al., 2016). Internalized homonegativity may contribute to significant relationship distress if it underlies core beliefs about the value, acceptability, or possibility of one's relationship. For example, if a bisexual individual internalizes the societal stereotype that bisexual individuals are unable to commit to a monogamous relationship, this may make it cognitively and emotionally more difficult for that individual to fully commit to a romantic relationship, perhaps despite a desire to be monogamous (Green & Mitchell, 2015).

Mental and Physical Health Disparities. SM individuals are at higher risk for a broad range of physical and mental health issues compared to heterosexual individuals such as depression, cancer, and HIV/AIDS (Pérez-Stable, 2016). In addition, SM individuals living in communities with high anti-SM discrimination experience an average life expectancy that is 12 years shorter on average than individuals living in low-prejudice communities. In addition, there is an 18-year difference in the age of completion of suicide in high prejudice communities (mean age 37.5 years old) compared to low prejudice communities (55.7 years old; Hatzenbuehler et al., 2014). Emerging research suggests that bisexual and lesbian women experience increased anxiety and depressive symptoms compared to sexual minority males or heterosexual individuals

(Greene, 1997; Kertzner et al., 2009). Given the reciprocal relationship between individual health issues and romantic relationship distress, couple therapists must be attentive to the possibility that health issues are exacerbating romantic relationship distress. Continued research is necessary to understand these disparities fully (Coulter, Kenst, & Bowen, 2014). As a result, in 2016 the National Institutes of Health (NIH) designated "sexual and gender minorities (SGMs) as a health disparity population for NIH research" with the hopes of paving the way for increased funding and prioritization of research addressing health disparities that disproportionately affect LGBTQ communities (Pérez-Stable, 2016).

Despite their aforementioned health disparities and health care needs, same-sex couples are vastly underrepresented in couple treatment outcome research (Clark & Serovich, 1997; Hartwell, Serovich, Grafsky, & Kerr, 2012; Spengler, DeVore, Spengler, & Lee, 2020). However, over the past decade, an emerging body of research has begun to examine the exclusion of SM couples from treatment outcome research and begin efforts to tailor couple care.

Initial Findings from Same-Sex Relationship Programs

A recent systematic review examined the implicit inclusion and exclusion of SM individuals in couple treatment outcome research (Spengler, DeCore, Spengler, & Lee; 2020). This study concluded that most couple treatment outcome studies have excluded same-sex couples. The studies that have included same-sex couples examine a more general couple therapy approach rather than one specifically tailored for same-sex couples; that is, any tailoring of care for SM couples' needs is performed ad-hoc and is not systematically integrated into the treatment (e.g., Gottman method couple therapy to

gay and lesbian couples; Garanzini et al., 2017). These studies allow researchers to draw conclusions regarding what aspects of couple therapy may be broadly beneficial across different- and same-sex couples. In another subset of the extant couples treatment research, same-sex couples comprise a small percentage of the study sample (e.g., Hewison, Casey, & Mwamba, 2016; Monson et al., 2012). The clinical utility of the treatment outcome research including SM couples is dampened by methodological limitations. For example, 100% of the 111 couple treatment studies reviewed assumed participant sexual orientation based upon the gender appearance of their partner (Spengler et al., 2020). Without accurate demographics, accurate conclusions regarding SM couples cannot be drawn.

However, aside from couple therapy, within the past decade, researchers have begun extending *relationship education* programs (i.e., preventative or psychoeducational in nature) to same-sex couples. Of note, relationship education programs target couples with a wide range of relationship adjustment or are aimed at strengthening relationships in the absence of relationship distress. Multiple programs have examined the delivery of relationship education as usual or in tailored form. For example, a sample of 42 same-sex couples who completed the 2-session preventative Marriage Checkup (not tailored; Cordova, 2009) experienced significant increases in relationship functioning at one-month follow-up compared to pre-intervention (Ollen, Gray, & Cordova, 2016). In addition, www.ourrelationship.com (Doss, Benson, Georgia, & Christensen, 2013) has recently been adapted for same-sex couples, and a pilot study is underway (K. Nowlan, personal correspondence, January 2, 2020).

The most extensive efforts in developing tailored relationship education programming for SM couples has come from the Better Together (previously known as Strengthening Same-Sex Relationships, or SSSR) program, aimed at strengthening long-term SM romantic relationships by providing skills to foster healthy relationships and families (Whitton, 2016). This program is delivered in a group format, is designed to eliminate heteronormative bias, and includes content uniquely applicable to same-sex couple functioning (Whitton et al., 2017; Whitton et al., 2016).

The multi-step development of BT/SSSR provides potentially valuable lessons that may carry over into the tailoring of in-person couple therapies. First, Whitton and Buzzella (2012) conducted a survey with therapists who conduct clinical work with same-sex couples. Nearly all clinicians noted that certain core features of all relationship education programs (e.g., content addressing effective communication and conflict resolution) were beneficial with same-sex couples. However, all clinicians reported the need to modify existing evidence-based content to fit better with same-sex couples and eliminate heteronormative bias (e.g., changing language from "marriage" to "relationship", and "husband" or "wife" to "partners", ensuring that promotional materials such as brochures and videos contained images of same-sex couples). Finally, therapists highlighted some unique challenges that same-sex couples face that are not covered in existing curriculum (e.g., negotiating as a couple when to "come out," coping with anti-SM discrimination, and navigating relationship ambiguity in the absence of same-sex couple role-models).

The investigators also conducted focus groups with same-sex couples to assess their needs when seeking relationship services (Scott & Rhoades, 2014). The focus

groups suggested a number of content areas that may be most helpful for same-sex female couples in particular (e.g., communication skills focused on emotional intimacy, how to foster sexual intimacy in a long-term relationship, and parenting or child-rearing related topics) as well as content areas applicable to same-sex couples more broadly (e.g., skills to cope with anti-SM discrimination, navigating relationship disclosure as a couple). As a result, the investigators developed a female and male version of the program (Buzzella & Whitton, 2009; Whitton, Scott, & Buzzella, 2013). Participants who do not identify as male or female can choose the program version which they feel most comfortable to attend. Ultimately, the BT/SSSR program content includes universal, core relationship skills (e.g., communication skills) and areas of interest to SM couples but that are not covered in existing relationship education curriculum.

Findings from a dual-site randomized waitlist-control study examining the BT/SSSR-Female program in thirty-seven same-sex female couples indicated that participants experienced increased positive communication, decreased negative communication, increased relationship satisfaction, and increased relationship confidence from pre- to post-program (Whitton et al., 2017). The gains in increased positive and decreased negative communication were maintained at 3-month follow-up. Program satisfaction ratings were high with participants reporting appreciation that the program was designed for same-sex couples and citing preference for continued specialized programming for SM women and SM men, respectively (Whitton, Scott, & Weitbrecht, 2018). In sum, although there is a paucity of research in tailoring couple therapy for same-sex couples, emerging research from relationship education programs suggests that culturally tailored couple care is feasible, acceptable, and desired by couples.

Clinical Considerations for Developing Same-Sex Couple Therapy

Broad couple research and theory, the SM stress literature, and preliminary clinical findings of preventive education programs for same-sex couples suggest three main conclusions. First, couple-focused programs benefit SM couples. Second, totally new couple interventions likely need not be developed to address relationship distress in SM couples effectively. Third, culturally tailored programs may be feasible, acceptable to couples, and likely beneficial. CBCT provides a conceptual framework for understanding relationships at three levels (the individual, the couple, and the environment) and offers strategies to intervene on a couple's cognitive, behavioral, and emotional functioning. Examining the SM stress literature from this framework highlights facets of SM couple functioning that may be especially relevant to target in therapy for relationship distress.

Taken together, these findings shed light on three key principles that may drive the cultural tailoring of couple therapy for SM couples: (a) there appear to be universal factors relevant to all couples' romantic relationship functioning; (b) there are unique challenges for SM couples, and (c) there are meaningful subgroups of SM couples, including specific content considerations for same-sex female couples. A major next step for the couple field is to examine how evidence-based couple therapies could be made increasingly culturally sensitive, salient, and affirming for same-sex couples and empirically evaluate the effectiveness of these interventions.

Current Study

The aim of the current study was to develop and pilot test a cognitive-behavioral couple therapy tailored for distressed same-sex female couples. The resulting treatment, ACCESS (Affirming Couples Counseling to Engage Same-Sex partners) has dual goals

of treating relationship distress and increasing couple coping as a team with SM stress. We measured treatment feasibility and acceptability and collected data to conduct a preliminary investigation of treatment outcome. ACCESS was delivered in an open-trial format to all eligible couples. In the future, efficacy may be established with larger randomized controlled trials (RCTs). This step-wise approach to treatment development is recommended by leaders in the field of couple treatment outcome research (Christensen, Baucom, Vu, & Stanton, 2005). Thus, the evaluation of this treatment is considered exploratory in nature. Findings will be used to inform a future RCT.

Hypotheses

We hypothesized that treatment would be delivered with high fidelity and adherence to the treatment manual, treatment would be feasible to carry out, and the intervention would be acceptable to participants and therapists. We also hypothesized that treatment would benefit participants in three domains of functioning as evidenced by statistically and clinically significant improvement from pre to post-therapy in: (a) relationship adjustment, (b) individual mental health, and (c) coping as a couple with SM stress. We had no a priori hypothesis regarding overall levels of SM stress changing over the course of therapy given that couples may remain living in the same area and their daily lives (work, socializing) may not change significantly over the 10-week treatment. However, endorsement of SM stress (e.g., experiences of discrimination, internalized homonegativity) was measured across treatment for exploratory evaluation.

Method

Participants

For intervention evaluations where there is no prior information to inform an estimate of an appropriate sample size to demonstrate effectiveness, a pilot sample size of 12 is recommended (Julious, 2005). This sample size maximizes study feasibility while allowing for adequate statistical calculation of mean and variance. This sample size is consistent with other couple therapy pilot studies examining meaningful changes across treatment (e.g., Uniting couples In the Treatment of Eating disorders [UNITE]; Runfola et al., 2018) and was the goal of the current investigation.

Participants were recruited from the greater Triangle area (i.e., Raleigh, Durham, and Chapel Hill, NC) via several methods including email listserv announcements, flyers, and word-of-mouth with local healthcare providers. Treatment was provided at no-cost. Eligibility criteria included both partners in the couple reporting (a) significant relationship distress, (b) self-reported SM stress, (c) being age 21 or older[2], (d) fluency in English, and (e) identifying as cisgender female (i.e., participant's sex assigned at birth [female] aligns with gender identity [woman]).

We describe the rationale for the final criterion here, rooting this study within the broader couples treatment outcome research landscape. This project is grounded in the

[2] Research suggests that collegiate romantic relationships are qualitatively different from committed relationships of adults age 21 and older (e.g., less commitment, may be briefer, developmentally the partners are younger; Shulman & Connolly, 2013).

extant couples literature including a bourgeoning body of basic and applied research on SM couples' needs and desires in relationship services. This research provides pivotal foundational knowledge underpinning how to tailor care. The argument made by culturally tailoring care is that there is important population-specific awareness, knowledge, and skills providers should gather to deliver competent care. Though clinical chapters have begun articulating specific topics that may arise in relationships with one or more trans individual (e.g., implications of transitioning on non-transitioning partner's orientation and identity; Malpas, 2012), further basic research is needed on trans individuals' desires and needs in relationship services to inform more systematic movements in treatment tailoring and therapist training (American Psychological Association, 2003; Spengler et al., 2020). Finally, as a dissertation and pilot study, this project has methodological constraints (e.g., inclusion/exclusion criteria to ensure sample homogeneity, small sample size for feasibility, scope of practice considerations for training therapists in a limited timeframe to provide culturally competent care). Beyond the constraints of a pilot study, moving forward, such limitations may be artificial and unnecessary (see discussion section).

Exclusion criteria included (a) one or both partners being unwilling to participate in couple therapy, (b) concurrent couple therapy, and (c) individual partner psychiatric diagnoses warranting specialty treatment first before a briefer, relationship-distress focused couple therapy was clinically indicated (e.g., untreated schizophrenia, bipolar disorder, posttraumatic stress disorder).

Fifteen couples were deemed initially eligible after phone screen, enrolled in ACCESS, and began assessment and treatment planning. One couple was deemed

ineligible after session 1 due to individual partner psychopathology that the therapist and couple agreed warranted specialty treatment beyond ACCESS; this couple was referred for appropriate clinical care. Three couples withdrew part way into active treatment. Of these, one couple withdrew due to a new work schedule precluding therapy participation, and two reported that our approach to therapy did not fit with their needs and they hoped to pursue therapy with a provider in the community. All couples were offered community referrals if desired. A final sample of 11 same-sex female couples (22 participants) completed the ACCESS Program including all 10 couple therapy sessions and all assessment timepoints. See details in Consort Diagram (Figure 1). See participant demographics described in the descriptive results section.

Procedure

Interested participants contacted the principal investigator (Pentel) via email to schedule an initial phone screening call. Participants who met initial eligibility criteria per the phone screen were scheduled for an in-person pre-treatment (pre) visit. At this visit, a trained research assistant walked the couple through an informed consent form and completion of a videotaped conversation task consisting of two brief couple conversations (see Measures section below for further description). After the pre visit, participants were sent a link to the pre survey to complete at home before the first couple therapy session. Couples were assigned a therapist and this provider reached out to schedule the first couple therapy session.

Couple therapy sessions proceeded once weekly when possible. Following session 5 (mid-treatment; mid), each participant was emailed the mid survey to complete. After the tenth and final session, the couple attended a 20-minute post-treatment (post) visit in

order to complete the videotaped conversation task once more. Participants and therapist were sent a post survey to complete. Four weeks after the final couple therapy session, each partner was emailed the 1-month follow-up survey. Participants were offered modest funds for childcare and for time spent on study surveys and assessments.

Participants received a couple ID number (e.g., 500) as well as a person ID number (e.g. partner 01 or 02) which was used as the primary identifying information on surveys. All in-person study visits were conducted at the University of North Carolina Department of Psychology Community Clinic. Study procedures were approved by the University of North Carolina Institutional Review Board (IRB# 17-2482).

Study Personnel

Five clinical psychology doctoral students were trained as study therapists. The study PI, Pentel, also treated couples. Four study therapists had at least three years of experience delivering CBT under the supervision of a licensed clinical psychologist; one had 1 year experience. All therapists gained in-depth theoretical and clinical training in CBCT via the University of North Carolina's couple therapy practicum (supervisor: Donald Baucom, Ph.D.). Next, therapists gained knowledge regarding key issues and themes that may arise in couple therapy with SM clients by completing empirical and clinical readings, participating in therapy role plays, and listening to training tapes. PI Pentel treated the first two couples and tapes of her sessions were available for therapist observation and discussion. Third, therapists received training in non-specific therapeutic factors that underlie being a SM-affirming couple therapist via completing readings and engaging in discussion regarding how to minimize heteronormative biases in therapy.

Therapists also engaged in self-reflection to consider how their own identity may interact with a couple's and when SM issues may or may not be relevant to a couple's presenting concerns. PI Pentel and faculty advisor Dr. Baucom listened to tapes of sessions and provided weekly clinical supervision to the study therapists. Undergraduate research assistants were trained to assist with pre and post assessment visits. All study staff involved in handling data completed the Health Insurance Portability and Accountability Act (HIPAA) training offered by UNC Healthcare.

Measures

Both members of the couple completed the same measures at each timepoint. All participant surveys given at major timepoints (pre, mid, post, 1-month follow-up) took approximately 30-minutes to complete. See Table 1 for a summary of all assessment time points and measures. The primary outcomes of interest for the current study included relationship functioning, couple coping with SM stress, and individual mental health (depression and anxiety). However, a broader battery of measures was given to assess demographics, individual functioning, relationship functioning, SM stress, and treatment acceptability. All surveys were sent electronically via an email link from UNC's Qualtrics survey platform. Data from the mid-treatment and 1-month follow-up time points were gathered for future analyses and were not analyzed for the current study.

Relationship Functioning. Three domains of relationship functioning were assessed including overall relationship satisfaction (a primary outcome of interest), relationship confidence, and couple communication.

Couple Satisfaction Index (CSI-16; Funk & Rogge, 2007). This 16-item measure assesses overall relationship satisfaction (e.g., In general, how satisfied are you

in your relationship?). Items are rated on a 0 to 5 or 6 Likert-type scale. Lower ratings indicate lower relationship satisfaction. Total scores range from 0 to 81 with scores below 51.5 indicating clinically significant relationship distress. The CSI-16 has excellent reliability and strong construct and convergent validity with other relationship satisfaction measures (Funk & Rogge, 2007).

Confidence Scale (CS; Stanley & Hoyer & Trathen, 1994). This 10-item scale measures one's confidence in their romantic relationship's strength and stability. Participants rate agreement with various statements (e.g., I am very confident when I think of our future together) on a Likert-type scale from 1 *(strongly disagree)* to 7 *(strongly agree)*. Total scores range from 10 to 70. Higher scores indicate increased relationship confidence. Scores falling <50 reflect low-confidence, 51-59 fair confidence, and >60 suggests a happy, committed relationship. The CS demonstrates good reliability and validity (e.g., Kline et al., 2004; Whitton, Rhoades, Stanley, & Markman, 2008).

Communication Patterns Questionnaire – Gender Neutral version (CPQ; Christensen, 1987; Christensen, 1988). The CPQ is a 35-item measure of one partner's perceptions of couple patterns of communication during conflict. Items such as "After a discussion of a relationship problem, both my partner and I withdraw from each other" are rated on Likert-type scale from 1 *(very unlikely)* to 9 *(very likely)*. A recent examination of revised scoring identified three subscales including (1) constructive communication, (2) self-demand partner withdraw, and (3) partner-demand self-withdraw (Crenshaw, Christensen, Baucom, Epstein, & Baucom, 2017). This revised scoring had significantly higher internal reliability than the original, was sensitive to change over time within small samples, and was used in analyses of this measure. The current study

used a gender neutral version of CPQ which contains "I" and "my partner" language rather than "female partner" and "male partner."

Videotaped Couple Interaction. A research assistant guided the couple through two 7-minute couple conversations, first asking them to select an area of concern or difficulty in their relationship related to being a same-sex couple and spend about 7-minutes sharing thoughts and feelings with each other about this issue. Next, the couple was asked to select a moderate-sized problem in their relationship related to being a same-sex couple and attempt to resolve it or make a decision about it. The study staff member remained in the room until a topic was chosen and left for the conversation. These recordings are being retained for future observational coding analyses.

Sexual Minority Stress. Numerous metrics of SM stress were collected to target various factors identified in Meyer's (2003) SM stress model. As a primary measure of interest, we examined couple coping as a team with SM stress. Additional (secondary) measures related to SM stress include measures assessing one's outness, internalized negative messages about being SM, and exposure to anti-SM discrimination.

Dyadic Coping Inventory – English version (DCI; Bodenmann, 2008; Randall, Hilpert, Jimenez-Arista, Walsh, & Bodenmann, 2016). This 37-item questionnaire assesses dyadic coping, defined as techniques to cope with stress that involve both partners in a couple especially through the process of interacting with one's partner for social support, instrumental support, or sharing. Items assess both support *given* to one's partner (e.g., I tell my partner that his/her stress is not that bad and help him/her to see the situation in a different light) and support *received* (e.g., My partner helps me to see stressful situations in a different light). Two items assess overall satisfaction with dyadic

coping. All items are rated on a 1 (*not at all/very rarely*) to 5 (*very often*) Likert-type scale. A DCI total score < 111 suggests dyadic coping is below average, between 111-145 suggests normal range, and >145 suggests dyadic coping is above average. Studies of the original DCI indicate good reliability and validity (Bodenmann, 2008; Ledermann et al., 2010). For the current study, we adapted the original DCI items which assess couple coping with broad stressors to instead focus on the couple's coping as a unit specifically with SM stress. Therefore, the psychometric norms no longer apply and we examine this measure descriptively in analyses.

The Outness Inventory (OI; Mohr & Fassinger, 2000). At pre only, participants completed this 10-item measure assessing the degree to which one has disclosed and openly discussed their orientation with various individuals in their life. Item responses range from 1 (*not out at all)* to 7 (*completely out and openly talked about*). Individual items may be examined to understand outness in various contexts including to family, in everyday life, and in one's religious community. Research suggests initial support for OI having good reliability and validity (Balsam, 2003; Mohr & Fassinger, 2000).

Heterosexist Harassment, Rejection, and Discrimination Scale, LGB Inclusive version (HHRD; Szymanski, 2006). Overall levels of SM stress were assessed via the 14-item HHRD. The HHRD captures the frequency that sexual minority women report having experienced harassment, rejection, and discrimination over the prior year. Individuals rate each event (e.g., Heard anti-lesbian/gay/bisexual remarks from one's family) on a Likert-type scale of 1 (*never happened over the past year) to 7 (that event happened almost all the time, >70% of the time)*. A higher mean score indicates greater

experiences of heterosexist harassment, rejection, and discrimination over the past year. The HHRD has good reliability validity (Szymanski, 2006, 2009).

Lesbian Internalized Homophobia Scale – Short Form, Bisexual Inclusive Version (LIHS; Szymanski & Chung, 2001b). The LIHS is a 39-item measure which assesses internalized homophobia and homonegativity (IH) in SM women. Items assess five dimensions of IH (i.e., connection with the SM community, public identification as SM, personal feelings about being SM, moral and religious attitudes toward being SM, and attitudes toward other SM women) and are rated on a Likert-type scale from 1 (*strongly disagree*) to 7 (*agree*). To score, all items are averaged with higher scores indicating more IH. The LIHS has demonstrated reliability and validity (Szymanski & Chung, 2001a; Szymanski & Chung, 2001b; Szymanski, Chung, & Balsam, 2001).

Individual Functioning and Demographics. Primary outcome of interest included the impact of treatment on depressive and anxiety symptoms. In addition, overall quality of life was assessed. At pre only, participants completed a demographics measure as noted below.

Demographics. Given at pre only, this questionnaire assessed individual (e.g., sexual orientation, age) and relationship characteristics (e.g., relationship length).

Patient Health Questionnaire (PHQ-9; Kroenke & Spitzer, 2002; Kroenke, Spitzer, & Williams, 2001). In this measure of depressive symptoms, nine items are rated on a 0 (*not at all*) to 3 (*nearly every day*) Likert-type scale. A score over 10 is often used as a cutoff for depression and has a sensitivity and specificity of 88% for major depression (Kroenke et al., 2001). Scores of 5, 10, 15, and 20 represent mild, moderate,

moderately severe, and severe depressive symptoms respectively. The PHQ-9 is a valid and reliable measure of depressive symptoms (Kroenke et al., 2001).

Generalized Anxiety Disorder (GAD-7; Spitzer, Kroenke, Williams, & Löwe, 2006). Seven items assess generalized anxiety symptoms rated on a 0 (*not at all*) to 3 (*nearly every day*) Likert-type scale. Scores range from 0 to 21. A score of over 10 suggests clinically significant anxiety. Scores of 5, 10, 15, and 21 indicate mild, moderate, moderately severe, and severe anxiety respectively. The GAD-7 has good validity and reliability (Kroenke, Spitzer, Williams, Monahan, & Löwe, 2007).

Quality of Life Enjoyment and Satisfaction Questionnaire – Short Form (QLESQ-SF; Endicott, Nee, Harrison, & Blumenthal, 1993). This 16-item measure asks a participant to rate their life satisfaction over the past week on a 1 (*poor*) to 5 (*very good*) Likert-type scale across different domains such as work, mood, sexual drive, living situation, and physical health. There is no established cutoff, however, higher total scores indicate better overall quality of life. Evaluations of this measure in clinical populations suggest it has high reliability, validity, sensitivity, and specificity (Stevanovic, 2011).

Treatment Acceptability. Finally, participant and therapist feedback on the acceptability and fit of treatment were gathered via various measures as described below.

Credibility/Expectancy Questionnaire (CEQ; Devilly & Borkovec, 2000). Directly after session two, participants were sent the CEQ to assess whether they have a clear sense of the therapy model, rationale, and treatment plan, and to assess how they perceive the therapy. This was sent after session two because, by this point in treatment, the couple and therapist have fully discussed the therapy model and treatment plan. For this study, CEQ data was gathered for future analyses.

Client Satisfaction Questionnaire-Revised (CSQ-8; Nguyen, Attkisson, & Stegner, 1983). At post, each partner completed this 8-item measure of satisfaction with and effectiveness of the therapy received (e.g., How would you rate the quality of the service you have received?). Item are rated on a 4-point Likert-type scale from 1 (lowest) to 4 (highest satisfaction). The CSQ-8 has high reliability and consistency (Attkisson & Zwick, 1982). We expanded the CSQ-8 to add questions assessing the structure, content, and relevance of topics in ACCESS as well as soliciting open-ended feedback.

Therapist Feedback Survey. At the post timepoint for each couple, the therapist for that couple completed a brief, 8-item feedback survey developed for the current study. This measure assessed the therapist's perspective on the structure, length, and content of treatment as well as ease of delivery (e.g., How satisfied were you with the ACCESS treatment components?) on a 0 to 6 or 0 to 10 Likert-type scale. Therapists were also asked if they had any suggested edits to the ACCESS treatment manual based on the course of treatment they had delivered.

Description of ACCESS Therapy

PI Pentel oversaw development of a 10-session semi-structured treatment manual, drawing upon the CBCT and SM stress frameworks. These ten sessions flowed across three phases of treatment as described below.

Phase I

Phase I (sessions 1 and 2) of ACCESS treatment included assessment, psychoeducation, and treatment planning. Session 1 was the only 2-hour session; all subsequent sessions were 60 minutes. In session 1, the therapist introduced themselves, provided a brief overview of the course of therapy, and collected background information

on the couple's romantic relationship and individual histories. Session 2 focused on feedback and treatment planning. The therapist provided psychoeducation regarding the ACCESS treatment model, summarized the individual-, couple-, and environmental-level resources and stressors in the couples' lives (including SM stressors, as relevant), and collaborated with the couple to generate the key areas to be the main foci of treatment.

Phase II

Phase II of ACCESS (sessions 3 through 5 or 6) involved the introduction and practice of communication skills building including applying these skills to discuss domains relevant to the couple's relationship functioning. This phase lasted approximately 3 to 4 sessions depending on the speed at which the couple grasped and implemented the communication skills. During session 3, the therapist (a) provided psychoeducation regarding common communication patterns of relationally distressed couples, (b) briefly described and differentiated the two main types of conversations that couples have: *sharing thoughts and feelings* (also called emotional expressiveness) and *decision-making* or problem-solving, and (c) discussed considerations for common patterns of communication in same-sex couples (e.g., Krestan & Bepko, 1980).

Phase III

Phase III of ACCESS began during communication skills training (e.g., the couple might practice emotional expressiveness skills while addressing issues related to one partner's *family of origin*). Couples either focused on general relationship distress related topics or were led through various SM-specific modules (2-3 sessions each) as informed by the case conceptualization. The eight available SM-related modules created as part of the ACCESS treatment manual included: *family of origin concerns, community*

or institutional discrimination, relationship disclosure or "outness" as a couple, gender roles and responsibilities, relationship boundaries as a same-sex couple, sex and physical intimacy, parenting as a same-sex couple, and *internalized homonegativity*. These topics were identified to be written into modules based on critical review of the SM stress literature and identification of key issues and themes that most impact SM romantic relationship functioning; see introduction. In addition, these modules offer a range of topics spanning individual (i.e., internalized homonegativity), couple-level (e.g., gender roles and responsibilities), and community-level (e.g., discrimination) impact of SM stress. Couples were invited to describe additional domains of concern regarding being a same-sex couple to be included in treatment as relevant. For example, a few couples brought up the topic of spirituality/religion as a same-sex couple; though we did not have a formal "module" on this we were able to discuss in treatment nonetheless.

Each module included brief psychoeducation for the therapist to provide the couple around the topic as well as suggested questions to assess the couple's prior experience and current concerns around this topic. The module materials included an "intervention appendix" including suggested couple conversation topics or CBCT-informed interventions that may be beneficial when helping a couple address this topic. Additional interventions were proposed within each module as clinically indicated, such as role-playing an anticipated upcoming conversation, and setting boundaries with, or addressing inappropriate anti-SM comments with one's family-of-origin member (in the *family of origin* module). Many modules also included a "therapist information sheet" summarizing findings from clinical research in this area that may inform the therapist's

practice. The final session (session 10) focused on bringing treatment to a close by helping the couple reflect on treatment gains and prepare for the future.

In line with the semi-structured nature of this treatment, other therapeutic interventions could also be utilized within each module for the therapist to incorporate as clinically indicated, drawing from the broader cognitive-behavioral couple therapy treatment model (Epstein & Baucom, 2002). For example, the module on *internalized homonegativity* could be used for couples who identify that one or both partners have come to believe negative messages about SM individuals. The therapist would help the couple identify negative or stigmatizing beliefs that they hold about SM individuals, consider where these messages originated, and make sense of conflicting messages they hear (e.g., SM-affirming messages from friends and stigmatizing messages from the media or family). To do this, the therapist could use skills such as downward arrow questioning and Socratic questioning to challenge these beliefs.

Therapists decided which modules were appropriate for a given couple in order to be consistent with the aim of ACCESS, that is, to address relationship distress with an emphasis on any facets that are complicated by being a same-sex couple. The degree of focus on SM or more general relationship distress-related issues was driven by couple and therapist agreement on the key issues most impacting their relationship functioning. Thus, as clinically indicated, sessions could be spent on broad relationship distress related issues that were unrelated to or marginally impacted by being a same-sex couple.

Results

We first present data on whether the study was feasible and acceptable to participants and therapists, treatment module usage, and to what degree therapists adhered to the treatment manual. Next, we present descriptive statistics. Third, we examine initial pre to post outcome data at the group- and individual-level, discussed in further detail in that section. In discussion of treatment outcome results, we also integrate within-group pre- to post-treatment effect sizes. For the relationship functioning domain only, a comparison of the current study's effect sizes to a similar benchmark study are provided. Given the lack of control condition in this small pilot study, all results are considered preliminary and are interpreted with caution.

Treatment Feasibility

Feasibility was examined by whether we could complete the study as proposed and achieve the initially proposed goal of twelve completer couples. A final sample of 11 couples completed ACCESS. There was significant interest in the ACCESS program as evidenced by 42 couples reaching out to inquire about participation. Thirty-four couples ultimately completed the phone screen, 15 of whom were deemed eligible and enrolled to participate in ACCESS. One couple was withdrawn by study investigators after session 1 (assessment session) and referred to more appropriate services. Three couples withdrew

part-way through treatment, two citing a desire to pursue different services and one citing scheduling conflicts. See Figure 1 for Consort Diagram.

Treatment Acceptability

At post, all participants who had completed ACCESS provided feedback on their experience in and satisfaction with treatment. The feedback measure combined the 8-item Client Satisfaction Questionnaire (CSQ-8; items rated on a 1=*lowest satisfaction* to 4=*highest satisfaction* Likert-type scale) with additional open-ended questions added by the authors. As hypothesized, treatment was acceptable to couples as reflected by high satisfaction. See Tables 2 and 3 for summaries of the quantitative and qualitative feedback, respectively. Average participant ratings on the CSQ-8 ranged from 3.68 to 3.86 with no individual's score below a 3 on any item. All participants rated the quality of treatment as either excellent (n=19) or good (n=3). Participants noted that either all of their needs (n=15) or most of their needs (n=7) had been met by treatment. All participants noted they would recommend the ACCESS Program to a friend.

On the free-text items, participants provided strong positive feedback regarding ACCESS therapists' sensitivity and knowledge about same-sex couple issues (item 3) and whether treatment helped them cope better as a team (item 5; see Table 3; n=21 positive responses and n=1 blank respectively). In addition, participants provided valuable suggestions to improve ACCESS in the future. The most frequently provided suggestions included (a) extending the length of treatment to more than 10 sessions, (b) integrating more intersectional content (e.g., around the intersection of sexual orientation and race/ethnicity), (c) offering evening and weekend availability, and (d) offering ACCESS in group format to facilitate social support and community-building.

Each therapist completed a brief measure at post regarding their perception of acceptability and fit of treatment for the couple they had just treated as well as ease of treatment delivery. See Table 4. Most items were rated on a 0 (very dissatisfied) to 6 (very satisfied) Likert-type scale. Therapists reported high satisfaction with ACCESS session structure (M=5.54, SD=.52) and overall treatment structure (M=5.18, SD=.87). Therapists reported lower satisfaction with the treatment length (M=4.45, SD=1.37), consistent with approximately half of the participants (n=11) desiring longer treatment.

Treatment Adherence

Two undergraduate research assistants coded approximately one-third of the recorded treatment tapes from completer couples (i.e., three full courses of couple therapy). As a result, coders coded an equal number of tapes for each session number. The three cases for adherence coding were selected via a random number generator (http://www.random.org) with the condition that three different ACCESS therapists be represented. Coders underwent four months of training by the PI. Throughout training, inter-rater agreement was monitored and assessed informally.

Coders rated eight adherence-related items per session from a coding manual developed by Pentel, Baucom, and Carrino (2019). These items assess whether the therapist covered required content and administered appropriate interventions only (i.e., those interventions consistent with ACCESS and the underlying treatment of CBCT). Most items' available answer choices were *yes*, *no*, or *not applicable* (e.g., homework check-in was always not applicable for the first couple therapy session since homework was not assigned at a prior session). An item rating the degree to which required parts of a session were delivered (e.g., at session 1, five agenda items are to be covered including

therapist introducing themselves and the ACCESS model) was rated as *none*, *<50%, >50%*, or *all*. Interrater reliability was excellent; coders demonstrated simple agreement on 235 out of 240 adherence items (98%). Group consensus meetings were held to reach agreement when two coders' initial ratings diverged. Overall, final ratings suggest ACCESS therapists were highly adherent in delivering the treatment as designed (99%, 3 out of 240 items rated as non-adherent). The non-adherent ratings reflect instances where a therapist did not assign homework or did not check in on a homework assignment.

Taken together, these findings suggest that the ACCESS pilot study was overall feasible to carry out, was acceptable to participants and therapists, and was delivered as intended with high adherence. Thus, we proceed with examining whether we observed anticipated improvements in participant well-being from pre to post.

Descriptive statistics

Demographics

Of the eleven completer couples, the average age was 37.60 years (*SD*=10.18) and average relationship length 5.40 years (*SD*=3.71). Participant race included white (n=13), Black/African American (n=6), Biracial White/Asian (n=2), and one marked Hispanic ethnicity with no race selected. Ten participants endorsed having at least one child, n=13 endorsed having at least one mental health disorder diagnosed by a mental health professional. Participants endorsed numerous labels for sexual orientation from a "check all that apply" item (i.e., n=12 lesbian, n=7 bisexual, n=6 queer, n=3 pansexual, n=2 gay, n=1 no label, n=0 questioning, n=0 asexual). Six participants endorsed more than one orientation label. All participants identified as women and reported being assigned female

at birth. Two participants reported gender identity as woman and also genderqueer, gender non-binary, or gender non-conforming. No participants identified as transgender.

Outness Inventory

One measure, the Outness Inventory, was given at pre-treatment only. This measure indicates areas of one's life in which one is most "out" or has disclosed their sexual minority identity versus those areas of life with most concealment or least knowledge of SM identity. We had no a priori predictions regarding the relation between one's outness in various domains of life and treatment outcomes; thus, these findings are presented purely descriptively. Participants rated how open they are about their sexual orientation to various categories of people including family members, friends, and community members on a Likert-type scale of 1 (*person definitely does not know about your sexual orientation status*) to 7 (*person definitely knows about your sexual orientation status and it is openly talked about)*.

Among the 22 completer participants, participants reported being most open about their sexual orientation to their mother (*M*=5.91, *SD*=1.51) followed by new straight friends (*M*=5.50, *SD*=2.38), siblings (*M*=5.50, *SD*=2.44), extended family (*M*=5.36, *SD*=1.78), old straight friends (*M*=5.09, *SD*=1.77), work peers (*M*=5.00, *SD*=2.53), work supervisors (*M*=4.23, *SD*=2.79), father (*M*=4.18, *SD*=2.86), strangers/new acquaintances (*M*=3.77, *SD*=1.87), members of religious community (*M*=2.73, *SD*=2.99), and leaders of religious community (*M*=2.23, *SD*=2.86). Though preliminary, these findings should raise therapist awareness regarding the potential range of outness one person may have in different domains of life and its impact on couple well-being.

Module Usage

All eight prepared ACCESS modules were utilized at some point across the eleven completer couples' courses of treatment. Specifically, nine sessions pulled upon the *relationship boundaries* module, six sessions used the *gender roles and responsibilities* module, five sessions used the *discrimination module*, *family of origin* module, and *parenting as a same-sex couple* module respectively, three sessions used the *outness and disclosure* and *sex and intimacy* modules respectively, and the *internalized homonegativity* module was used once. Any given couple was exposed to an average of 2.35 SM modules' worth of content (range 1 to 4 modules). The trained coders watching three full courses of treatment session video tapes rated one purely descriptive item to gather information on the amount of the session (sheer time out of the full hour) that was focused on SM stress related topics versus general relationship-distress related topics. Available rating responses included: (a) the session mostly focused on SM stress related topics, (b) the session was somewhat evenly split in its focus on sexual minority stress versus general relationship distress topics, or (c) the session mostly focused on general relationship distress. Coders rated 96% of the sessions as *mostly* focused on general relationship distress. Of note, this does not mean that 96% of all time in therapy session was spent on general relationship-distress related topics; a rating of "(c) the session focused on general relationship distress" may have been given if 40% of the session focused on SM-related topics. Moreover, many SM and general relationship distress-related topics overlapped; e.g., parents discussing finding community may mention explicitly finding community as a same-sex couple at one point in the session, but discuss

finding community more broadly throughout the rest. However, their experience finding community is shaped overall by their experience as a same-sex couple.

Analytic Method: Treatment Outcomes

Treatment outcome results are presented further below grouped by the three domains of interest: relationship functioning, SM experience, and individual functioning. Multiple statistical methods were used to clarify whether we observed meaningful shifts within and across these domains. Given the similarity in analyses conducted across all pre to post measures, we first describe the analytical methods in further detail before presenting results grouped by domain. Within each domain, results for the primary measures of interest (i.e., CSI-16, DCI, PHQ-9, GAD-7) are prioritized although results from secondary measures are presented for additional context.

Statistically Significant Change

Multilevel modeling (MLM) was used to assess for group-level statistically significant changes from pre to post. See Table 5 for full MLM results. The MLM procedure is similar to a within-groups t-test but accounts for the nesting of individual partners within a couple (Kenny, Kashy, & Cook, 2006). Within each MLM, level 1 consists of the within-time observation per person (e.g., partner 1's pre and post score on a given measure); level 2 consists of the partners within a couple (e.g., partner 1 and 2), and level 3 consist of the couple identifier (e.g., Couple A). A given partner's response is a function of a fixed effect of time, the between-couple effect, the between-partner effect, and a within-person effect. Analyses determine whether the coefficient for the time variable indicates statistically significant change from pre to post.

Reliable and Clinically Significant Change

Using methods described by Jacobson and Truax (1992), we examined whether the magnitude of change on a given variable from pre to post was larger than chance or measurement error (i.e., *reliable change*) and whether this represented a shift from the clinical to the non-clinical range (i.e., *clinically significant change*). Whenever reliable change or clinical cutoff points were established in the literature for a given measure, we calculated what was possible from this extant data. This analytic method can examine both group-level change (e.g., the magnitude of pre to post treatment group mean shift) as well as individual participant change over treatment. If needed, the Reliable Change Index (RC) was calculated by subtracting a participant's post score from their pre and dividing by the standard error of the difference between the two scores. This determined whether a participant's score had shifted enough to surpass fluctuations that might be expected via measurement error. An RC of 1.96 or above was considered to reflect reliable change beyond measurement error. Based on these results, we report on how many individuals showed reliable and clinically significant improvement, no meaningful change, or reliable and clinically significant deterioration from pre to post.

Effect Size

Within-group pre to post effect sizes examined group-level improvement for each measure. The effect sizes for all relationship functioning measures were compared to those in a benchmark study per procedures outlined by Minami and colleagues (2008). The closest benchmark group is the Better Together/Strengthening Same-Sex Relationships - Female program (BT/SSSR-F; Whitton et al., 2017). This comparison allows us to determine whether the ACCESS Program had a comparable, lesser, or

stronger effect on relationship functioning compared to this benchmark study. See Table 6 for all ACCESS Program within-group effect sizes and Table 7 for a statistical comparison of the ACCESS and BT/SSSR-F effect sizes.

Treatment Outcome Results

Couple Functioning

We first examined change in relationship satisfaction as measured by the CSI-16. MLM results suggested that, as a whole, participants experienced clinically and statistically significantly improvement in relationship satisfaction from pre (M_{pre}= 47.36, *SE*=3.49) to post (M_{post} = 59.82, *SE* = 3.49, *t*=4.15, *p*=.0005). CSI-16 scores under 51.5 indicate clinically significant relationship distress. Thus, the group mean crossed from the clinically distressed range at pre to non-distressed at post. Three participants showed a clinically significant improvement from pre to post that was also reliable. However, given there is not a reliable change index established for CSI, the calculation for RCI with the wide range of scores at pre (range 8 to 64) generates an RCI that may be requiring an artificially large improvement to be categorized as reliable. Consistent with these observed improvements in relationship satisfaction from pre to post, there was a notable within-group effect size in the hypothesized direction from pre to post (effect size=.91). This effect size was statistically significantly higher (*t*=-2.76, *p* =.0077) than the within-group pre to post effect size calculated from the BT/SSSR-F data (effect size=.17, see Table 7) suggesting that the ACCESS program evidenced a statistically larger improvement in relationship satisfaction for participants.

As outcomes of secondary interest, we examined relationship confidence and communication patterns. Per MLM analyses, participants exhibited statistically

significant increase in relationship confidence from pre to post as a group (t=4.15, p=.0005) along with promising shifts in the number of participants in the *low-confidence* range (n=7 at pre, n=5 at post), *fair* range (n=10 at pre, n=2 at post) and *happy, committed relationship* range (n=5 at pre, n=15 at post). Our observed within-groups effect size of .57 on relationship confidence pre to post was not statistically different from BT/SSSR-F, suggesting ACCESS participants experienced comparable improvements in relationship confidence. Participants exhibited statistically significant improvement on all three subscales of the Communication Patterns Questionnaire including an increase in constructive communication (t =4.21, p =.0004) and a decrease in both negative communication patterns including the self-demand partner-withdraw (t =-4.49, p =.0002) and partner demand self-withdraw pattern (t=-4.08, p =.0005). Effect size comparison between ACCESS and BT/SSSR-F indicated that our effect sizes were statistically comparable, suggesting participants experienced similar benefits across these areas of communication (See Table 7).

Sexual Minority Experience

On average, participants reported a statistically significant improvement in couple coping with SM stress from pre (M_{pre} = 128, SD = 15.74) to post (M_{post} = 142, SD = 18.45, p=.0001). This measure was adapted by the current authors and there are no benchmarks for clinically significant change. However, higher scores indicate more adaptive couple coping. Using the broad categories established by the authors, participants exhibited an upward shift in their dyadic coping as evidenced by the number of participants in the *below average* (n=4 pre; n=2 post), *average* (n=16 pre; n=9 post), and *above average* dyadic coping range (n=1 pre; n=11 post) across treatment. These findings suggest that

couples improved across treatment in their ability to cope as a team with SM stress. Similarly, a notable within-groups pre to post effect size of 0.89 was observed. Since no RCI index exists in the current literature, per RCI calculation extrapolating from the current data, only two individuals reliably increased on the DCI. As previously noted, this method of calculating RCI may be flawed given our small sample size.

Two additional metrics of SM stress were examined at pre and post: internalized homonegativity (IH) and experiences of anti-SM discrimination. We had no a priori hypotheses regarding shifts in either of these variables so they were examined in an exploratory manner. Although group means decreased pre to post suggesting less IH and experiences of discrimination at post, MLM results indicated that the magnitude of this change was not statistically significant for either metric (see Table 5).

Individual Functioning

MLM results suggested that the sample as a whole experienced a significant decrease in depressive symptoms from pre to post (M_{pre}=6.73, M_{post}=4.41, t=-2.87, p=.0091) consistent with the within-group effect size of -0.48; see Table 5.. However, it was not possible to assess reliably whether these changes were clinically significant since only 5 individuals started treatment with clinically significant depression. Of these, only 1 demonstrated both reliable and clinically significant improvement. Anxiety symptoms did not statistically significantly decrease from pre to post, in-line with the lesser effect size of -.32 albeit in the hypothesized direction (decreased anxiety symptoms pre to post). Only 3 individuals started treatment with clinically significant anxiety. Of these, none had both reliable and clinically significant improvement. In summary, a floor effect was observed such that few individual began in the clinical range for depressive or anxiety

symptoms. Thus, small sample size precludes clear conclusions regarding the impact of treatment on anxiety and depressive symptoms.

Despite the lack of clarity regarding changes in individual mental health symptoms, participants experienced an increase in overall quality of life from pre to post (effect size = .75, t=3.27, p=.0036). The QLESQ-SF does not have a clinical cutoff point or reliable change index established in the literature. Thus, we calculated the RCI per the available data. Four individuals exhibited reliable improvement pre to post although this metric may not accurately capture true reliable change given the large change needed.

Examining Patterns in Treatment Outcome Effects

Given this study had multiple key outcome measures and no one "gold standard" measure of treatment success, we examined patterns of improvement broadly across our four key pre to post measures in a way that can be replicated by future studies. Using the Standardized Replication Rate method (De Los Reyes, Kundey, & Wang, 2011), we set a priori criteria which determines whether the sample as a whole "improved" or "did not improve" on each measure. We set a goal of achieving a within-group pre to post effect size of 0.5 on three out of four main measures of outcome (relationship distress, couple coping, anxiety, depression). We achieved two out of four effect sizes we hoped for, including notable effect size for relationship satisfaction (.91) and couple coping with SM stress (.89). The effect size fell short of this goal for depression (.48) and anxiety (-.32). However, this pattern must be interpreted within the context of the small number of individuals who started treatment with significant anxiety or depressive symptoms. The largest effect sizes are in-line with our primary treatment aims of improving relationship distress and couple coping with SM stress.

Discussion

Despite comparable levels of relationship satisfaction and intimacy, same-sex couples break up faster and more often than different-sex couples, highlighting a need for quality couple therapy. Research suggests that culturally tailored services are desired by same-sex couples and may also be more effective and better received (Whitton, 2016; Whitton & Buzzella, 2012). Although efficacious couple therapies exist to treat relationship distress, they have been overwhelmingly studied with different-sex couples (Kelly et al., 2014; Scott et al., 2019). To-date, sexual minority-affirming couple therapies have not yet been systematically developed or evaluated (Spengler et al., 2020).

Accordingly, the current study is the first to develop and pilot test a couple therapy that is culturally tailored for same-sex female couples. This investigation involved the development of a 10-session semi-structured treatment manual called the ACCESS Program (Affirming Couples Counseling to Engage Same Sex partners), training doctoral student therapists, delivery of treatment to a small sample of couples, and participant completion of assessments at pre-, mid-, post-therapy, and 1-month follow-up. Only those data collected at pre and post were analyzed in the current document; mid- and follow-up data were gathered for future analyses. We hypothesized that therapists would deliver treatment with high adherence to the treatment manual and that treatment would be feasible to carry out and acceptable to participants and therapists. We anticipated that changes over the course of treatment would be suggestive of benefit

to couples as evidenced by pre to post improvements in relationship functioning, couple coping with SM stress, and individual well-being.

Adherence coding of thirty session tapes indicated that the therapists delivered treatment with strong adherence to the treatment manual, as hypothesized. In other words, therapists delivered all required aspects of the intervention and did not deliver any inappropriate interventions that were inconsistent with the ACCESS program and its CBCT approach. This high adherence along with informal feedback from therapists in group supervision suggested that the treatment manual was clear and easy to follow, offering adequate structure to guide therapists in delivering a consistent intervention while allowing flexibility in integrating SM-specific content as clinically indicated.

Feedback from participants shed light on the acceptability of the ACCESS Program. Overall, participants were highly satisfied with the treatment received (see Tables 2 and 3). Of the fifteen couples initially enrolled in access, 11 couples proceeded to complete the treatment. Although one couple was withdrawn after session 1 and the other three couples who dropped out reported to their therapist the reason for discontinuation (see Figure 1, Consort Diagram), we did not deliver a drop-out survey; this will be a helpful addition in future iterations of ACCESS in order to gather data on ways in which the program may not meet the needs of couples who drop out.

Given treatment was feasible, acceptable, and delivered adherently, we conducted an initial examination of treatment outcomes. Since there was not a comparison control condition, the findings cannot be attributed to the effects of treatment per se but can provide valuable initial results that can be explored further in future randomized controlled trials. We hypothesized that participants would demonstrate clinically and

statistically significant improvements pre to post in relationship functioning, couple coping with SM stress, and individual well-being. Of note, couples were assessed on the phone screen call for significant relationship distress as well as sexual minority stress, both inclusion criteria. Couples were not screened nor recruited based on level of individual partner anxiety or depressive symptoms. In line with this focus of the therapy, treatment was primarily designed to intervene on relationship distress and couple coping with SM stress. Notably, two of the most impressive treatment effects observed were in these two domains. These treatment effects are encouraging given the small sample size.

On average, the couples in ACCESS began at pre in the relationally distressed range and by post moved into the non-distressed range. This finding is consistent with the statistically significant improvements observed in relationship confidence as well as increased constructive communication and less demand-withdraw patterns of communication from pre to post. Moreover, the observed effects were comparable (e.g., in increasing positive and decreasing negative communication, increasing relationship confidence) or statistically larger (decreasing relationship distress) than a similar benchmark study, the Better Together/Strengthening Same Sex Relationships program. Of note, BT/SSSR-F does not explicitly recruit couples who have clinically significant relationship distress so ACCESS couples may have more room to improve as a cohort. Considering these multiple relationship functioning findings taken together, couples in the ACCESS program experienced significant improvements across the board in relationship well-being including both decreases in harmful relationship factors (e.g., relationship distress, unhealthy communication) and increases in healthy relationship factors (e.g., relationship confidence, healthy communication). This is encouraging for

the future of culturally tailored couple therapy, suggesting brief couple therapies significantly benefits couples and couples appreciate culturally tailored care.

In addition, couples in ACCESS experienced significant improvement in their coping as a team with SM stress. Increased dyadic coping buffers the negative impact of external stressors (e.g., SM stress) on individual and relationship well-being (Merz, Meuwly, Randall, & Bodenmann, 2014). Individuals reporting higher dyadic coping also tend to report higher relationship satisfaction and this in turn predicts higher partner relationship satisfaction (Merz et al., 2014). Thus, interventions that improve dyadic coping may lead to a positive ripple effect on couple and individual well-being, especially important in the face of potentially chronic stressors such as SM stress (Rostosky, Riggle, Gray, & Hatton, 2007). As noted in the introduction, frequent exposure to microaggressions can be highly deleterious to couple well-being over time. This may be particularly true in the absence of strong dyadic coping. Although it is not yet well established as such, improving dyadic coping may be an important mechanism of change in couple therapy for couples facing some form of minority stress. More broadly, this finding points to the importance of understanding a couple's environment and its interaction with individual and couple well-being. As the couples field begins to expand services to historically underserved groups, we must design treatments that do not only contain couple-level interventions but also contain environmental-level interventions, equipping the couple to effectively navigate pressures from the outside world.

Given the strong reciprocal relation between relationship functioning and individual well-being, we hypothesized that participation ACCESS may also improve individual partner's mental health (i.e., anxiety and depressive symptoms). Contrary to

hypotheses, a floor effect was observed such that very few individuals began treatment with clinically significant depression (n=5) or anxiety (n=3). Pre to post effect sizes, although in the anticipated direction suggesting a decrease over time, were weak (see Table 6). Thus, the small sample size precludes conclusions regarding the impact of ACCESS on individual mental health. As noted, participants were not screened for participation in ACCESS based on anxiety and depressive symptoms. However, the pre to post effect size of .75 on the quality of life measure suggests that participants did experience significant improvement in overall quality of life from pre to post.

Although we had relatively low depressive and anxiety symptoms in our sample, this may not be reflective of the broader population of distressed couples. A large body of literature documents the relation between relationship distress and depressive symptoms (see Baucom et al., 2020). Although data in same-sex couples is lacking, the extant couples-based research suggests that individuals in distressed relationships are at higher risk for depressive symptoms, and depressive symptoms are similarly associated with relationship distress (Barry, Barden, & Dubac, 2019; Baucom et al., 2007; Whitton & Whisman, 2010). Future research with a larger sample size may allow for more breadth of individual symptom severity and a nuanced examination of the potential impact of ACCESS on individual mental health.

In summary, these initial treatment outcomes are interpreted with caution due to the small sample size and lack of a control condition; yet, the findings provide initial support for the potential efficacy of the ACCESS Program. As hypothesized, ACCESS participants experienced significant reduction in relationship distress and significant improvement in couple coping with SM stress from pre to post. Because anxiety and

depressive symptoms were minimal throughout treatment, it is not possible to draw even tentative conclusions regarding the impact of treatment on these individual difficulties.

Though there was no direct control or comparison condition, this study sheds light on potential benefits of same-sex tailored couple therapy in comparison to couple therapy "as usual" delivered to same-sex couples. First, same-sex tailored treatment may help couples feel more comfortable initiating care. Anecdotally, many couples who reached out to ACCESS shared that they had been looking for couple therapy for months to years but had not found a therapist or clinic where they felt confident they would receive sensitive and affirming care as a same-sex couple. Numerous participants noted that seeing our rainbow study logo and reading about the treatment being specifically designed for same-sex couples helped them feel seen and prioritized, and participants expressed appreciation for this on the phone screen call.

Second, a tailored treatment such as ACCESS integrates clinical research and provides updated same-sex couple knowledge to therapists; this may help therapists feel better prepared to proactively attend to key issues and themes that may arise in treatment. As a result, tailored care may lessen the burden participants may feel to educate their therapist about SM issues. This idea is in-line with the open-ended feedback participants provided at post. All participants rated their therapist as highly knowledgeable regarding same-sex couple issues.

ACCESS aimed to strike a balance in addressing same-sex couple stressors and general couple difficulties. Participants were asked about the degree to which the intervention succeeded in achieving an appropriate balance of focusing on same-sex versus general couple issues and whether one domain should have been emphasized more

than it was. Feedback was quite positive (based on categorizing responses as solely positive, negative, neutral/mixed, or blank, 21 were positive responses, 1 left blank); thus, participant's quantitative (e.g., CSI and DCI sores) and qualitative data (e.g., open-ended feedback) converged on suggesting ACCESS was successful in its dual-focus of treating relationship distress and helping the couple cope with SM stress. Many participants expressed appreciation for being treated as any other couple might in couple therapy but also recognizing therapist preparedness to integrate discussion of SM-topics as relevant, for example:

> "I wanted a therapist who would see us as - first and foremost - a couple. I felt that we received that with [our therapist]. Importantly, though, I think it's only possible to achieve that sense of comfort and trust with a therapist who acknowledges that we are LGBT and expresses an awareness and acceptance of that fact at the outset. Again, this was the case with [our therapist]."

One notable finding as treatment progressed was that many ACCESS couples sought an affirming space for couple therapy but the content of what they sought to focus on was more general couple therapy content. In the open-ended feedback portion of the post-therapy survey, couples remarked on the broad benefit of these elements of general couple therapy helping equip them to navigate any life stressor better as a team, including SM stress. Many couples also provided feedback at post regarding the utility of the therapist flexibly adjusting to what degree the session focused on more general couple therapy content (e.g., effective communication skills, helping a couple with financial or work stress) versus more SM-focused content (e.g., navigating coming out as a couple). In the field of multicultural counseling, this concept is termed dynamic sizing (e.g., Kelly et al., 2014). That is, in same-sex couple therapy, we should not presume SM identity is one or both partner's most central or salient identity nor that it underlies why a couple is

seeking therapy. Affirming care adjusts the degree to which identity-related topics are centered in treatment based on its relevance and helpfulness.

Given the utility many couples saw in the "general couple therapy" aspect of ACCESS, this raises a question regarding whether existing couple therapies are sufficient as-is, untailored, and delivered to same-sex couples. Alternatively, should existing couple therapies be discarded and the approach to therapy completely re-designed to meet same-sex couples' needs? If we do use existing treatments, what if any aspects of couple therapy could be revised or critically examined (e.g., to remove heteronormative bias, more proactively attend to same-sex couples' needs)?

In an attempt to answer these questions, we developed a clinical framework to guide our adaptation of evidence-based couple therapy for same-sex couples. Although we focused on adapting CBCT, this framework could be used trans-theoretically. Specifically, clinicians seeking to tailor couple therapy for same-sex couples are encouraged to think through the (a) *universal factors* and principles that guide adaptive functioning across romantic relationships, (b) *sexual-minority specific factors* that may impact same-sex couple well-being, including a distinction between the environmental-level origin of minority stress (e.g., living in heteronormative society) and multi-level impact (e.g., individual-, couple- and environmental-level), (c) meaningful *within-group diversity* which may inform further tailoring needs especially for couples where partners hold multiple marginalized identities, and finally (d) *non-specific therapeutic factors* (also sometimes called "common factors") which underlie affirming and sensitive care delivery. Non-specific factors that underlie being an SM-affirming therapist include examining one's own biases and assumptions, mindfully generating rapport and

demonstrating sensitivity within the therapy session, demonstrating inclusion and representation in the advertisement and promotional materials for one's clinical services, and having an LGBTQ welcoming and accessible office space.

This clinical framework could also be extended to consider how to deliver optimally tailored couple care to historically underserved groups more broadly. While the focus in this pilot study involved tailoring couple therapy around SM identity, our focus was not meant to diminish each partner's multiple intersecting identities (e.g., gender identity and expression, racial/ethnic identity, physical ability/disability, socio-economic status, religion/spirituality, or nationality/immigration status). The *sexual-minority specific* portion of the aforementioned model may be most relevant to consider when SM issues are significantly impacting the couple's relationship functioning. It may be artificial or impossible to consider just one identity in the absence of the others. For example, consider same-sex female couples possibly facing the combined powers of heteronormativity and sexism, couples in which one or both partners face transphobia in addition to SM stress, or couples in which one or both partners experience discrimination based on race or ethnicity in tandem with SM stress.

The current study had numerous strengths. This is the first investigation to develop and evaluate a couple therapy specifically tailored for same-sex female couples, integrating an existing evidence-based treatment (CBCT) with the sexual minority stress model and literature. In addition, the observed treatment effects are encouraging given the modest length of treatment and small sample size. A ten-session couple therapy is brief compared to typical courses of CBCT for various populations, for example, depression (18-session CBCT for depression; Baucom et al., 2016), obsessive-

compulsive disorder (16-session CBCT for OCD; Abramowitz et al., 2013), eating disorders (22-session couple-based treatment for anorexia nervosa; Bulik, Baucom, Kirby, & Pisetsky, 2011), or studies of other evidence-based couple therapies (e.g., an average of 21 to 23 in initial IBCT efficacy studies; Christensen et al., 2004; Jacobson, Christensen, Prince, Cordova, & Eldridge, 2000).

In addition, the current study sample was fairly diverse across a range of demographics including SES (individual income ranged from $5,000 to $250,000+ with fairly even spread) and race and ethnicity (59% white, 27% black/African American, 9% biracial Asian and white, and 5% marked Hispanic ethnicity). Contrary to the prevailing practice to assume and not assess sexual orientation in couples treatment outcome research (Spengler et al., 2020), participants in the ACCESS Program self-identified their orientation at pre-treatment. We could have presumed that since our sample was 100% same-sex female couples all participants identified as lesbian. However, self-report demographic data highlighted the diversity of sexual orientation identities embraced among our sample including bisexual, queer, pansexual, lesbian, gay, using no label, or using multiple labels.

At the same time, the current study's findings should be understood in the context of its limitations. As an open-trial study, this investigation had no control or comparison condition. The population studied was relatively homogenous on some variables (e.g., all cisgender per study inclusion criteria, relatively highly educated). In addition, conducting this treatment in the Southern U.S. may not be representative of the experience of delivering this treatment in other regions of the US. For example, North Carolina has a history of anti-LGBTQ legislation and current roadblocks (e.g., a non-birthing same-sex

parent must do a time-intensive and expensive step-parent adoption process to adopt their own child). Thus, there may be regional differences including possible areas of increased, decreased, or differential SM-stressors relevant to couple well-being.

These findings, in combination with participant and therapist feedback, suggest numerous promising future directions for the ACCESS Program. First, additional modules could be created to address additional areas of SM stress relevant in couple functioning, such as creating a module addressing navigating religion/spirituality or a module focused on building community/finding social supports as a same-sex couple. This treatment could also be expanded to serve a broader sexual and gender minority (SGM) audience. This would require mindful integration of up-to-date clinical and research findings and the expansion of therapist materials around key issues and themes that may arise for couples in which one or both partners are non-cisgender (e.g., transgender, nonbinary, genderqueer, or agender), as well as considerations regarding gender minority identity intersecting with another marginalized identity.

Another possible future direction is to adapt the ACCESS materials into a trans-theoretical toolkit that could be used by couple therapists trained in a range of theoretical orientations and couple therapies, not just CBCT. Such a toolkit could bring couple therapists up-to-speed on key issues, themes, current events, pieces of legislation, and relationship functioning/couple therapy considerations related to various sexual and gender-minority-identity topics. Therapists could consult various topics within this toolkit as-relevant to increase their own cultural competence and spur their critical thinking regarding how to tailor a course of couple therapy for a given couple.

A future randomized controlled trial could examine differences in outcome between ACCESS in comparison to a couple therapy that is not explicitly tailored for same-sex couples (to consider the impact of treatment tailoring), or comparing ACCESS couple therapy to a more preventative relationship education program such as BT/SSSR (to compare tailored couple therapy versus tailored relationship education). The ACCESS Program could also be adapted into a group-format to facilitate delivery of care to multiple couples at once with fewer therapist hours required. This treatment format could also facilitate social support and connection amongst group participants.

Both the sexual-minority health and couples fields are ripe for an examination of how evidence-based, efficacious couple therapies could be made increasingly culturally sensitive, salient, and affirming for same-sex couples. The current study involved the development, implementation, and initial evaluation of a 10-session, semi-structured couple therapy tailored for same-sex female couples. Findings are promising, suggesting that participants might have benefitted from and did greatly appreciate this couple therapy. Participant feedback suggested that both the universal aspects of CBCT and the tailored, SM-specific material were helpful to participants, though on the whole participants found the general couple therapy intervention to be the most beneficial aspect of ACCESS. Participant and therapist feedback will inform the refinement and expansion of ACCESS in the future. Although continued research is needed, this pilot study contributes to the scientific knowledge base on tailoring romantic relationship services for sexual minority couples, advancing the field of SM-affirming mental health care.

Table 1
Assessment Schedule

	Pre-treatment	Between session 2 and 3	Mid-treatment	Post-treatment	1 month follow-up
Demographics	X				
PHQ-9	X		X	X	X
GAD-7	X		X	X	X
QLESQ-SF	X		X	X	X
CSI-16	X		X	X	X
Confidence Scale	X		X	X	X
CPQ	X		X	X	X
Videotaped couple interaction	X			X	
HHRD	X		X	X	X
LIHS	X		X	X	X
DCI	X		X	X	X
OI	X				
CEQ		X			
CSQ-8				X	
1 Month F/U Questions					X
Therapist feedback form				X	

Note. PHQ-9= Patient Health Questionnaire (Kroenke & Spitzer, 2002; Kroenke et al., 2001); GAD-7= Generalized Anxiety Disorder (Spitzer et al., 2006); QLESQ-SF= Quality of Life Enjoyment and Satisfaction Questionnaire, Short-Form (Endicott et al., 1993); CSI-16=Couple Satisfaction Index (Funk & Rogge, 2007); CPQ= Communication Patterns Questionnaire (Christensen, 1987, 1988); HHRD= Heterosexist Harassment, Rejection, and Discrimination Scale (Szymanski, 2006); LIHS= Lesbian Internalized Homophobia Scale (Szymanski & Chung, 2001b); DCI= Dyadic Coping Inventory, English version (Randall et al., 2016); OI= Outness Inventory (Mohr & Fassinger, 2000); CEQ= Credibility/Expectancy Questionnaire (Devilly & Borkovec, 2000); CSQ8=Client Satisfaction Questionnaire-Revised (Nguyen et al., 1983).

Table 2
Participant feedback at Post – Quantitative (CSQ-8 Measure)

Item	Answer choices	*M (SD)*
1. How would you rate the quality of service you have received?	1=poor 2=fair 3=good 4= excellent	3.86 (.35)
2. Did you get the kind of service you wanted?	1= no, definitely not 2= no, not really 3= yes, generally 4= yes, definitely	3.73 (.46)
3. To what extent has our program met your needs?	1= none of my needs have been met 2= only a few of my needs have been met 3= most of my needs have been met 4= almost all of my needs have been met	3.68 (.58)
4. If a friend were in need of similar help, would you recommend our program to him or her?	1= no, definitely not 2= no, I don't think so 3= yes, I think so 4= yes, definitely	3.82 (.40)
5. How satisfied are you with the amount of help you have received?	1= quite dissatisfied 2= indifferent or mildly satisfied 3= mostly satisfied 4= very satisfied	3.73 (.46)
6. Have the services you received helped you to deal more effectively with your problems?	1= no, they seemed to make things worse 2= no, they really didn't help 3= yes, they helped 4= yes, they helped a great deal	3.77 (.46)
7. In an overall, general sense how satisfied are you with the services you received?	1= quite dissatisfied 2= indifferent or mildly dissatisfied 3= mostly satisfied 4= very satisfied	3.86 (.35)
8. If you were to seek help again, would you come back to our program?	1= no, definitely not 2= no, I don't think so 3= yes, I think so 4= yes, definitely	3.77 (.43)

Table 3
Participant feedback at Post – Qualitative (Text Box Responses)

Item	Responses (out of N=22 completer participants)
1. Do you have suggestions of topics that we did not cover that should be added in the future?	n=5 left blank n=15 no new topic ideas n= 2 suggesting an additional topic focused on intersectionality, e.g., race/ethnicity and queerness
2. Did the length of the treatment feel appropriate (too short, too long)?	n=10 appropriate length n=3 appropriate length but noted they could have benefitted from longer n=8 too short
3. How sensitive or knowledgeable was your therapist in addressing same-sex couple issues?	n=21 positive responses (e.g., "very sensitive and understanding") n=1 blank
4. The program attempts to provide some balance in addressing same-sex couple stressors versus general couple difficulties. How do you feel about this balance- should one domain have been emphasized more than it was?	n=12 balance was good/appropriate n=4 mixed feedback (some aspects of treatment felt well-balanced, others did not) n=2 neutral or no feedback on this aspect n=4 blank
5. To what degree do you think treatment helped you cope better as a team?	n=21 positive responses indicating coping better as a team (e.g., "We are better communicators now and stronger as a unit") n=1 blank
6. Any other feedback?	n=6 solely expressed appreciation n=5 provided a suggestion for future versions of ACCESS n=3 provided a suggestion and expressed appreciation n=3 no additional feedback n=5 blank

From item 6 responses, suggestions for future versions of ACCESS included:

- appointment times outside of business hours (e.g., evenings, weekends)
- multiple clinic locations
- editing all survey language be gender neutral and more inclusive
- requests for the pre assessor to also be the couple's therapist

Table 4
Therapist feedback at Post

Item	Answer choices	*M (SD)*
1. Overall, how well did you think ACCESS worked in treating the couple's **relationship distress**?	0 to 10 Likert-type scale where 0= extremely poorly 5=okay 10=exceptionally well	7.72 (.94)
2. Overall, how well did you think ACCESS worked in helping the couple cope as a unit with **LGBQ related stressors**?	0 to 10 Likert-type scale where 0= extremely poorly 5=okay 10=exceptionally well	6.64 (1.29)
3. How satisfied were you with ACCESS treatment components (i.e., session content)?	0 to 6 Likert-type scale where 0= very dissatisfied 3=neutral 6= very satisfied	5.54 (1.28)
4. How satisfied were you with ACCESS overall structure?	0 to 6 Likert-type scale where 0= very dissatisfied 3=neutral 6= very satisfied	5.18 (.87)
5. How satisfied were you with ACCESS within-session structure?	0 to 6 Likert-type scale where 0= very dissatisfied 3=neutral 6= very satisfied	5.54 (.52)
6. How satisfied were you with ACCESS number of sessions (10 sessions)?	0 to 6 Likert-type scale where 0= very dissatisfied 3=neutral 6= very satisfied	4.45 (1.37)
7. How satisfied were you with ACCESS session frequency (weekly)?	0 to 6 Likert-type scale where 0= very dissatisfied 3=neutral 6= very satisfied	5.54, (.52)
8. Based on your experience with this couple, any recommended edits to the ACCESS treatment?	No (n=3), Yes (n=8). Suggestions included: dynamic sizing of SM stress to fit couple's desire to talk about it, increase number of sessions, consider SM issues across lifespan, consider distance barriers and telehealth possibility	

Table 5
Multilevel modeling results: Statistically significant change from Pre to Post

	Pre Mean (SE)	Post Mean (SE)	Post vs. pre difference (SE)	*t*-value	*p*-value
CSI-16: Relationship adjustment	47.36 (3.49)	59.82 (3.49)	12.45 (3.00)	4.15	*p* =.0005**
CS: Confidence Scale	53.45 (2.43)	58.45 (2.43)	5.00 (1.55)	3.23	*p* =.0040*
CPQ-CC: Constructive communication	52.41 (2.76)	63.68 (2.76)	11.27 (2.68)	4.21	*p* =.0004**
CPQ-SD: Self demand partner withdraw	26.45 (1.97)	18.45 (1.97)	-8.00 (1.78)	-4.49	*p* =.0002**
CPQ-PD: Partner demand self-withdraw	25.73 (2.16)	18.50 (2.16)	-7.23 (1.77)	-4.08	*p* =.0005**
DCI: Dyadic coping with SM stress	122.77 (4.34)	141.86 (4.34)	14.09 (3.03)	4.65	*p* =.0001**
HHRD: Discrimination experiences	1.69 (0.13)	1.58 (0.13)	-0.11 (0.07)	-1.55	*p* =.14
LIHS: Internalized homonegativity	2.99 (0.26)	2.74 (0.26)	-0.26 (0.10)	-2.55	*p* =.02*
PHQ9: Depressive symptoms	6.73 (1.15)	4.41 (1.15)	-2.32 (0.81)	-2.87	*p* =.0091*
GAD7: Anxiety symptoms	5.05 (0.96)	3.77 (0.96)	-1.27 (0.67)	-1.89	*p* =.07
QLESQ-SF: Quality of life	52.50 (2.16)	59.28 (2.16)	6.78 (2.07)	3.27	*p* =.0036*

Note. *p <.05., ** p < .001. A negative value for the estimate (t-statistic) indicates decrease from pre to post. All estimate values except from GAD-7, HHRD, and LIHS are significant and in the anticipated direction, indicating improvement (less distress or symptomatology) from pre to post.

Table 6
Within-group effect size for all ACCESS measures Pre to Post

	Effect Size
CSI-16: Relationship adjustment	0.92
CS: Confidence Scale	0.57
CPQ-CC: Constructive communication	1.11
CPQ-SD: Self demand partner withdraw	-0.88
CPQ-PD: Partner demand self-withdraw	-0.72
DCI: Dyadic coping with SM stress	0.89
HHRD: Discrimination experiences	-0.24
LIHS: Internalized homonegativity	-0.25
PHQ9: Depressive symptoms	-0.48
GAD7: Anxiety symptoms	-0.32
QLESQ-SF: Quality of life	0.75

Note. While there have been proposed cutoff points for small, medium, and large effect sizes (e.g., Cohen, 1988), these guidelines are often used for between-groups research. There are no clear guidelines for within-group small, medium, or large effect sizes. We refrain from using such labels. Negative effect sizes indicate a decrease in that score from pre to post. All effect sizes are in the anticipated direction, indicating improvement (less distress or symptomatology) from pre to post

Table 7

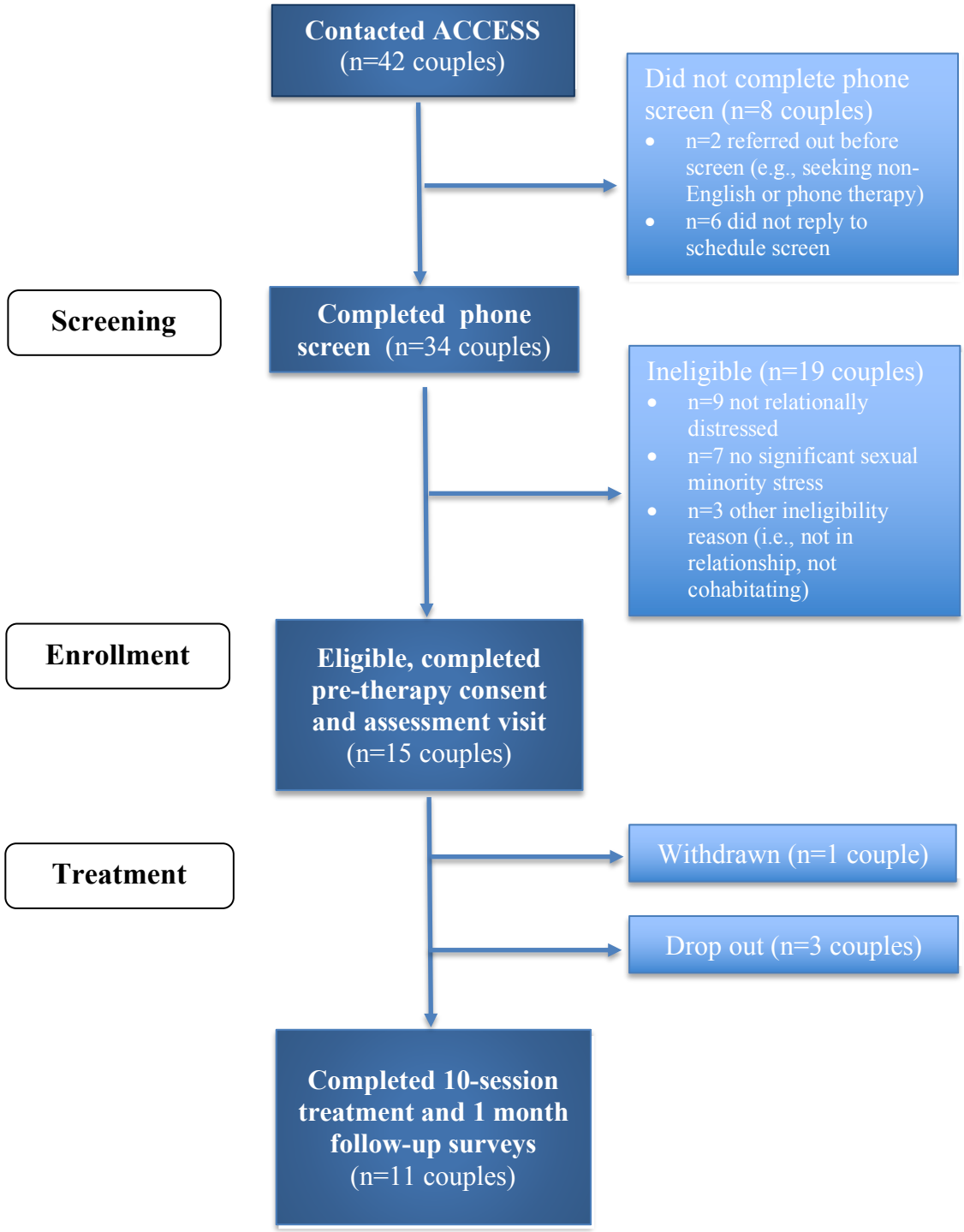
Within-group Pre to Post effect size comparison: ACCESS and Better Together/Strengthening Same Sex Relationships – Female (BT/SSSR-F)

	ACCESS Effect Size	BT/SSSR-F Effect Size	Effect size comparison *t*-value	Effect size comparison *p*-value
Relationship adjustment	0.92	0.17	-2.76	*p*=.0077*
Confidence Scale	0.57	0.20	-1.88	*p* =.0649
Constructive communication (positive communication)	1.11	0.52	-1.90	*p* =.0627
Self-demand partner-withdraw (negative communication)	-0.88	-0.38	1.89	*p* =.0641
Partner-demand self-withdraw (negative communication)	-0.72	-0.38	1.44	*p* =.1549

Note. *p <.05., ** p < .001. ACCESS N=22, BT/SSSR-F N=37. A two-tailed t-test was conducted to detect either study having a significantly different (i.e., higher *or* lower) effect size than the other. Accordingly, a non-significant p-value (p≥.05) indicates that the effect size observed in ACCESS for this construct did not statistically significantly differ from that observed for BT/SSSR-F.

Note. Though ACCESS and BT/SSSR-F examined similar constructs, the measures differed. Relationship adjustment in ACCESS was measured via CSI-16; in BT/SSSR-F participants completed a 12-item measure of relationship satisfaction (McNulty & Karney, 2001) adapted to assess the past week (Whitton, Stanley, Markman, & Baucom, 2008) . The same Confidence Scale was delivered in both studies. While ACCESS examined the self-demand partner-withdraw and partner-demand, self-withdraw subscales of the CPQ, BT/SSSR-F examined self-report negative communication via the Communication Skills Test (CST; Jenkins & Saiz, 1995). Similarly, ACCESS examined self-report positive communication via the constructive communication subscale of the CPQ; BT/SSSR-F examined a positive communication subscale of the CST.

Figure 1
Consort Diagram



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