2022

Exploring the Relational Impact of Breast Cancer on Younger Women Partnered with Women

Kaitlin V. Ross
University of Denver

Recommended Citation

Ross, Kaitlin V., "Exploring the Relational Impact of Breast Cancer on Younger Women Partnered with Women" (2022). *Electronic Theses and Dissertations*. 2154.
https://digitalcommons.du.edu/etd/2154

Exploring the Relational Impact of Breast Cancer on Younger Women Partnered with Women

---

A Dissertation

Presented to

the Faculty of the Morgridge College of Education

University of Denver

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Philosophy

---

by

Kaitlin V. Ross

August 2022

Advisor: Trisha L. Raque, Ph.D.

Author: Kaitlin V. Ross
Title: Exploring the Relational Impact of Breast Cancer on Younger Women Partnered with Women
Advisor: Trisha L. Raque, Ph.D.
Degree Date: August 2022

Abstract

Approximately 268,600 new cases of breast cancer in women are diagnosed each year in the United States. Due to improvements in cancer detection and treatment, survivorship is higher than in the past. More than ten percent of new diagnoses are in women 45 years or younger. There are approximately one million sexual minority individuals living with cancer in the US, yet this population is understudied in cancer care. For sexual minority women with breast cancer, sociocultural factors such as lack of affirmative care influences their disease experience. Further, sexual minority women and women partnered with women may be subject to minority stress experiences, such as discrimination and stigma, during daily life and while coping with cancer. This dissertation study sought to qualitatively explore the relational impact of breast cancer on younger women partnered with women. Ten individuals, members of five monogamous women couples, were interviewed for the study. The focus of the study is on women who are 50 years of age or younger, and wherein one partner was diagnosed with breast cancer at age 45 or younger. Participants completed a questionnaire measuring mutuality in their relationship and a demographic questionnaire. Interviews explored the following in the context of breast cancer, 1) impact of breast cancer on younger survivors and their women partners with regard to the Relational Cultural Theory constructs of authenticity, mutuality, relationship awareness, connection, and disconnection, 2) barriers and supports to couples' sense of connection with each other, 3) how minority stress may affect the couple's relationship dynamic and ability to feel connected and 4) lasting relational changes within the couple after cancer. The qualitative interview data was rigorously analyzed by a research team using the Consensual Qualitative Research method. The domain level findings include the relational processes that contributed to more or less connection, as well as how external influences such as healthcare providers and systems, interpersonal relationships, and organizational support impacted their connection. The findings contribute to the psycho-oncology research literature by presenting an in-depth description of the lived experiences of women partnered with women, who are also younger in age, a population that has not been adequately represented in the literature. Further, it highlights how a variety of influences, both within and outside of women couples, such as sociocultural forces, contributed to their sense of connection and well-being.

Table of Contents

Chapter One: Introduction

This dissertation begins by presenting information about the prevalence and medical aspects of breast cancer, as well as research findings about how sexual minority women experience this illness. Next, Relational Cultural Theory (Jordan, 2018) is the main theoretical basis for this study, so this theory is described in detail and connected with cancer research. Then information about the influence of sociocultural factors on the disease experience for sexual minority women is discussed, including intersectionality and minority stress theories, and research findings related to how these forces impact sexual minority women and women partnered with women. Next, to establish rationale for the age of the participants and highlight issues relevant to younger survivors, information about age and cancer is provided, including research about younger breast cancer survivors and younger couples and relevant developmental models to contextual the period of life of the participants. Then, important topics within the research on couples and cancer is outlined. Much of the prior research covered is based on heterosexual women or couples, and whenever possible, research on sexual minority women and women partnered with women is presented.

This dissertation seeks to address the underrepresentation of women partnered with women in the cancer literature (Boehmer & Elk, 2015). Gaps in the cancer literature also indicate the need to focus on younger cancer survivors—particularly younger couples (Acquati & Kayser, 2019)—and to integrate relational research with sociocultural issues impacting those facing breast cancer (Adams et al., 2011; American Cancer Society, 2020; Raque et al., 2015; Raque et al., 2020). Researchers have noted the lack of studies about cancer and relationship functioning that include partners' perceptions and experiences (Drabe et al., 2016; Nalbart et al., 2021; Sjovall et al., 2009; Stephens et al., 2016), and thus this study enriches our understanding of cancer survivorship through the incorporation of the partners of cancer survivors.

Breast Cancer

Prevalence. Cancer is a disease that impacts people across the globe and is the second leading cause of death in the United States (Boehmer & Elk, 2015). Other than skin cancer, breast cancer is the most common cancer (American Cancer Society, 2020). Breast cancer is the second leading cause of cancer death among women in the United States, second to lung cancer (American Cancer Society, 2020). Regarding annual new diagnoses of female breast cancer, more than ten percent of cases are diagnosed in those 45 years or younger (National Cancer Institute, 2020). In the United States in 2019, approximately 268,600 new cases of female breast cancer were diagnosed, representing approximately 15% of all new cancer cases. Approximately 127.5 per 100,000 women are diagnosed with breast cancer per year (National Cancer Institute, 2020). The lifetime risk of developing female breast cancer at some point during life is 12.8%, and the risk is highest for White and Black women. Women have a 2.6% chance of dying from breast cancer (American Cancer Society, 2020). Yet, due to improvements in cancer detection and treatment, the rates of cancer survivorship are higher than in the past (National

Cancer Institute, 2020). In 2016, an estimated 3,477,866 women were living in the United States with breast cancer and 20.3 million cancer survivors overall are expected by 2026 (National Cancer Institute, 2020).

Within LGBT+ Community. Within the global community of cancer survivors, there are smaller populations that may face unique challenges as well as unique strengths. Approximately 15 million lesbian, gay, bisexual, and transgender individuals live in America (Meyer, 2019) and although approximately 1 million of these individuals are living with cancer (Margolies & Kamen, 2015), this population continues to be understudied within cancer care (Lisy et al., 2018). Research evidence shows that compared to heterosexual women, the incidence of breast cancer and risk of dying of breast cancer may be slightly higher for lesbian and bisexual women (Boehmer & Elk, 2015). Other research has not found differences in breast cancer risk related to sexual orientation, indicating that, the overall results on this topic are mixed (Boehmer & Elk, 2015). Because sexual orientation has not been historically included in cancer registries, the availability of information about cancer incidence and outcomes for the LGBT population is limited (Boehmer & Elk, 2015).

Survival. New female breast cancer cases have been rising 0.3% each year over the last ten years, but the death rate has been decreasing by 1.8% each year over the same period (National Cancer Institute, 2020). The decrease in mortality rates for female breast cancer can be attributed to earlier and more effective detection and treatment (Bleicher et al., 2016; National Cancer Institute, 2020). Timely treatment is important, as overall survival decreases when treatment is delayed after diagnosis (Bleicher et al., 2016). Prior to 1990, death rates for women with breast cancer ranged from 12-35 women per 100,000 diagnosed, but death rates have decreased for all racial and ethnic groups since the 1990s (National Cancer Institute, 2020). Based on data from the Surveillance, Epidemiology, and End Results (SEER) Program from 2009-2015, 89.9% of women with breast cancer survived five or more years after diagnosis (National Cancer Institute, 2020). Approximately 41,760 female breast cancer deaths were estimated in 2019 (National Cancer Institute, 2020). Approximately eighteen percent of these deaths were women 54 years or younger (National Cancer Institute, 2020).

What is Breast Cancer? Breast cancer is a disease in which malignant (cancer) cells develop in breast tissue (National Breast Cancer Association, 2022). The internal part of the breast is made up of fatty tissue, lymph nodes and vessels, blood vessels, lobes, lobules, and ducts. Externally are the areola and nipple. Signs of breast cancer include a lump or other physical changes in the breast, such as thickening near the breast or underarm (American Breast Cancer Foundation, 2022). Other problematic breast changes include a change in size or shape, dimpling of skin, inwardly turned nipple, and non-milk fluid discharge. Ductal carcinoma begins in the cells of the ducts and is the most common type of breast cancer. Lobular carcinoma begins in the lobes or lobules and is more often found in both breasts. An uncommon type of breast cancer is inflammatory breast cancer when the breast is swollen, red, and warm (American Cancer Society, 2020).

Risk factors for breast cancer include family history of breast cancer in a first-degree relative, inherited gene mutations in the BRCA1 or BRCA2 genes, dense breast tissue, benign noncancerous breast disease, more than average natural estrogen made by the body, alcohol use, obesity, and hormones replacement during menopause (American Cancer Society, 2020). Prior cancer as well as advanced age increases cancer risk. Research has identified risk factors for cancer that are higher in the LGBT+ community, including low levels of cancer screening, alcohol use, cigarette smoking, and being overweight and obese, which is only relevant to women and girls (Boehmer & Elk, 2015; Meads & Moore, 2013). Some medicines and other factors, such as a healthy lifestyle, can decrease the risk of breast cancer (American Cancer Society, 2020).

Diagnosis. Breasts can be examined to detect cancer (American Breast Cancer Foundation, 2022). Non-invasive options include an overall physical exam, self or physician breast exam, mammogram (x-ray), ultrasound exam that creates a sonogram picture, magnetic resonance imaging (MRI), and study of blood chemistry (American Cancer Society, 2020). Biopsy is when tissue and cells are removed and examined for cancer, which is frequently done if a lump is detected (National Breast Cancer Foundation, 2022). There are a variety of biopsy types including excisional, incisional, core, and fine-needle aspiration (American Cancer Society, 2020). There is some evidence that SMW receive earlier diagnoses of breast cancer than their heterosexual counterparts, but conflicting research shows low levels of cancer screening in the LGBT+ community (Dibble & Roberts, 2002; Boehmer & Elk, 2015).

Female breast cancer is diagnosed with a stage, referring to the size and location of the primary tumor and the extent of cancer in the body elsewhere (National Cancer Institute, 2020). In breast cancer, stage determines treatment options and has a large impact on the length of survival (National Cancer Institute, 2020). Stage 1 refers to localized cancer, meaning it is only found in the part of the body where it started (breast) (American Breast Cancer Foundation, 2022). The 5-year survival for localized female breast cancer is 98.8% (National Cancer Institute, 2020). Regional stages are when it has spread to regional lymph nodes and has an 85.5% 5-year survival rate (National Cancer Institute, 2020). Distant cancer means it has metastasized, or spread, into other parts of the body and has a 27.4% 5-year survival rate (National Cancer Institute, 2020). If cancer is found, more hormone and genetic tests are done to determine severity including the likeliness and nature of possible cancer growth and spreading, how well treatments will work, and likeliness of recurrence (National Breast Cancer Foundation, 2022). After these tests, breast cancer is described as one of three types: hormone receptor positive (HR+) or negative (HR-), HER2/neu positive or negative, or triple negative. If cancer cells have estrogen and/or progesterone receptors on them, then the cancer is called hormone receptor positive (HR+), or hormone receptor negative (HR-) if these receptors are not present. HER2/neu positive means that breast tumors have more HER2 protein. Triple-negative breast cancer indicates that the cells are hormone receptor negative and do not create a significant amount of HER2 protein. There are fewer effective treatment options for triple-negative breast cancer, as this type of breast cancer is typically diagnosed at a later stage, tends to spread and grow more quickly than the other types and is more common in younger women (American Cancer Society, 2020; Kumar & Aggarwal, 2016). Generally, the type, stage, and overall characteristics of the cancer determines treatment options, recommendations, and prognosis (National Breast Cancer Foundation, 2022).

Treatments. There are six types of standard treatment for breast cancer: surgery, radiation therapy, chemotherapy, hormone therapy, targeted therapy, and immunotherapy (American Cancer Society, 2020). Surgery to remove the breast cancer is extremely common among patients. Surgery may be aimed at removing the tumor and some surrounding normal tissue, the complete breast may be removed (mastectomy), and at times surrounding lymph nodes are also removed (Susan G. Komen Breast Cancer Foundation, 2022). Radiation therapy uses a high-energy radiation machine outside the body, or radioactive substance inside the body, to destroy or slow down cancer cells. Chemotherapy has the same goal. Chemotherapy drugs may be taken by mouth or injected into a vein or muscle for absorption by the body. Hormone therapy blocks or removes hormones from the body that are contributing to cancer cell growth. Targeted therapy aims to destroy cancer cells but not normal cells with drugs and other substances (Susan G. Komen Breast Cancer Foundation, 2022). Immunotherapy seeks to restore, use, or improve the body's natural ability to ward off cancer with the immune system (American Cancer Society, 2020).

Treatments for breast cancer have a variety of side effects, including immediate, ongoing, and long-term (American Breast Cancer Foundation, 2022; Boehmer & Elk, 2015; Susan G. Komen Breast Cancer Foundation, 2022). The severity and prevalence of symptoms due to side effects are quite varied among survivors (American Breast Cancer Foundation, 2022; Boehmer & Elk, 2015; Susan G. Komen Breast Cancer Foundation, 2022). Side effects include hair loss, lymphedema, chest pain, appetite loss, fatigue, memory or concentration problems, myocardial infarction, general pain and discomfort, sleep difficulty and insomnia, cardiovascular disease, ovarian failure, fertility issues, sexual health issues, and decreased arm mobility (American Breast Cancer Foundation, 2022; Boehmer & Elk, 2015; Susan G. Komen Breast Cancer Foundation, 2022).

Sexual Minority Women. Studies examining differences based on static groups, such as sexual orientation, may overlook the complex processes at play, including societal processes such as heterosexism within the healthcare system (DeHart, 2008; Morrison & Dinkel, 2012). Further, few studies have focused exclusively on the experience of women partnered with women in relation to breast cancer within the framework of intersectionality (Kayser et al., 1999). This dissertation seeks to uncover more information about the relational strengths and challenges that this population experiences from a systems and process perspective. Although limited in what conclusions can be drawn, summaries of prior research (Arena et al., 2007; Boehmer, Glickman, Winter, Clark, 2013a, 2013b, 2014a; Dibble & Roberts, 2007) comparing lesbian and heterosexual cancer survivors may provide information on how sexual minority women cancer survivors have been perceived and treated within cancer care.

Regarding the treatment process, decision-making processes have not been well-explored, and it is not clear whether SMW of reproductive age are provided with fertility options and information (Boehmer & Elk, 2015). Boehmer and colleagues (2007) found that when faced with whether to pursue breast reconstruction, SMW prioritize a sense of well-being associated with functioning, strength, and survival rather than appearance associated with heteronormative beauty standards. The researchers suggest that providers learn about and consider the unique considerations of sexual minority women related to their treatment decision-making (Boehmer et al., 2007).

Regarding internal response to a diagnosis and coping strategies during breast cancer, prior research has compared sexual minority women to heterosexual women and found differences (Boehmer & Elk, 2015). While one qualitative study found that lesbian women were more stressed than heterosexual women at the time of diagnosis (Matthews et al., 2002), other studies found significant coping strengths among SMW (Fobair et al., 2001; Arena et al., 2007). Researchers found that strengths among SMW partnered with women include more active coping, sharing of feelings, and positive reframing than their heterosexual counterparts, who reported more cognitive avoidance and controlling or withholding those emotions related to adjustment to breast cancer (Arena et al., 2007; Fobair et al., 2001). One of these studies also found that lesbian breast cancer patients "were significantly less satisfied with their physicians' care and the inclusion of their partner in medical treatment discussions" (Fobair et al., 2001, p. 47). The article does not include demographic details that may shed light on overall intersectionality considerations.

A study by Boehmer and colleagues (2014a) compared coping and benefit finding among 257 heterosexual women and 69 lesbian women, who had a range of breast cancer diagnoses up to stage III. Researchers hypothesized that sexual minority women would report more adaptive coping, in part due to resilience from coping with social prejudice throughout life, and this was supported based on the results of the Mini-Mental

Adjustment to Cancer Scale (Boehmer et al., 2014a). Similar to other studies, SMW reported less cognitive avoidance coping, less anxious preoccupation, and less hopelessness than heterosexual women (Boehmer et al., 2014a). SMW and heterosexual women reported similar levels of benefit findings, or posttraumatic growth, as a result of their breast cancer experience (Boehmer et al., 2014a). The findings of these quantitative studies suggest that due to coping with minority stress experiences sexual minority women may develop resilience in the face of life stressors. Qualitative exploration of these issues with sexual minority women may more clearly describe the mechanisms at work, and better account for the relevant systems-level factors.

Studies comparing heterosexual women and SMW's quality life and longer-term psychological adjustment to cancer find comparable results (Boehmer & Elk, 2015). These findings are another indication that despite evidence that SMW are underserved and may confront more challenges in treatment based on their sexual minority status, their resilience and strengths may support functioning at the same or better level of heterosexual women who do not have similar barriers (Boehmer & Elk, 2015; Boehmer et al., 2013a).

Sexual minority and heterosexual women with breast cancer appear to seek mental health support at different rates. Interestingly, based on a study of 257 heterosexual women and 181 SMW with breast cancer, SMW sought psychosocial support, including support groups and counseling, at a higher rate than heterosexual women, suggesting that this population may actively seek ways to improve their well-being (Boehmer et al., 2013a). Forty two percent of SMW compared with 25% of heterosexual women (HSW) ever attended a cancer support group, and 35% of SMW compared with 17% of HSW sought counseling related to cancer (Boehmer et al., 2013a). This is consistent with other literature indicating that people who identify as LGBTQ+ access counseling services more than their heterosexual counterparts (Alessi, Dillon, & Kim, 2016; Bieschke, Perez, & DeBord, 2007) at a rate of up to five times more (Alderson, 2013). A more detailed description of the contextual forces that may impact sexual minority women with breast cancer is necessary, and several theories exist that detail these sociocultural factors.

Relational Cultural Theory

History and Tenets. The feminist Relational Cultural Theory (RCT) is a useful theoretical framework through which to explore the cancer experiences of women partnered with women. This theory explores relationships in the context of culture, including how relationships characterized by connection and growth versus disconnection and marginalization impact development, well-being, and relational resilience (Jordan, 2018). In our society, women partnered with women are in the minority, and these couples encounter many societal forces during a vulnerable period of illness. As this study seeks to understand how the relationships of WPW are impacted by their cancer experience, the tenets of Relational Cultural Theory provide a lens of understanding both into important dynamics that influence the quality of their relationship and how cultural forces influence their relational well-being.

Jean Baker Miller's book, *Toward a New Psychology of Women* (1976), presented a new way to understand human development and initiated a collaboration with three other psychologists, Judith Jordan, Irene Stiver, and Jannet Surrey (Jordan & Hartling, 2008). They worked together to create Relational Cultural Theory, a theory of development and clinical practice rooted in counseling psychology that promotes growth through relationships (Jordan & Hartling, 2008). Goals of other significant theories of the time were representative of the cultural values of the majority in the west, including autonomy, individuation, and separation; however, Baker Miller argued that these indicators of well-being and growth neglect important aspects of positive functioning for those with marginalized identities, including women and people of color (Jordan, 2000; Comstock et al., 2008). For the founders of RCT, psychological resilience, well-being, and growth are born out of positive growth-fostering relationships in which mutuality exists, meaning mutual empathy and empowerment, rather than separation (Jordan, 2000).

Growth-fostering relationships have five important outcomes according to Jean Baker Miller, including a sense of zest; clarity - better understanding or self, other, and the relationship; a sense of worth; an enhanced capacity to take action or be productive; and an increased desire for more connection (Miller & Stiver, 1997). Authenticity and mutual empathy are also core tenets of RCT and characteristics of relationships that foster growth and connection (Jordan, 2018). Authenticity is defined as the ability to be fully oneself in a relationship without fear and mutuality captures the ability to be open to the influence of others while sustaining a strong sense of self (Jordan, 2018). With these components, individuals in a relationship are able to be fully seen and to give and receive authentic and empathic responses to their true self and experience (Jordan, 2018).

Baker Miller describes the attitude of mutuality that is closely related to mutual empathy and mutual empowerment, practices that engender growth and change based on a Relational Cultural Therapy model (Jordan, 2018). Further, mutual empathy occurs when two individuals know that they are impacting and caring for one another and are acting genuinely in response to the other (Jordan, 2018). As two people continue to practice mutual empathy and empowerment, feelings of isolation are replaced with a desire and ability to pursue growth-fostering connections (Jordan, 2018). Importantly, the relational goal of RCT is not for relationships to be continually harmonious or pleasant, but rather authentic and honest (Jordan, 2018). Jean Baker Miller believed that "good conflict" is necessary for profound relational change (Jordan, 2018). For example, when two people encounter differences or conflict, they should seek to approach the issue with openness, honesty regarding one's contribution to a problem, and a willingness to learn how to change to avoid similar issues in the future (Jordan, 2018). These series of behaviors in therapy or within a couple foster relational connection, whereas avoidance, violence, dominance, or aggression do not (Jordan, 2018).

Research has investigated the attitude of mutuality and associated behaviors in heterosexual couples. One of the first studies to investigate women's adaptation to chronic and/or life-threatening illnesses from a feminist theory included 49 women who had young children and cancer (Kayser et al., 1999). Drawing from Relational Cultural Theory, the article points to the development of women's sense of self as being in relation to others, with the ability to identify the feelings of others and their own (Kayser et al., 1999). Participants aged 23 to 48 years were diagnosed within the prior three years, and had a child under 12, and approximately 50% had breast cancer (Kayser et al., 1999). The predictor variables were mutuality of close relationships, coping with cancer, and relationship-focused coping strategies and the outcome variables were quality of life, depression, and self-care agency (Kayser et al., 1999). Those with higher mutuality within their partner relationship had significantly higher quality of life and self-care agency, and significantly lower levels of depression (Kayser et al., 1999). Further, women's attempts at protective buffering, or not sharing difficult information or feelings with their partners, resulted in more depression and less empowerment around caring for self and health needs (Kayser et al., 1999). This study is important because it goes beyond looking at the support that a cancer patient receives from their partner and instead also assesses what she experiences as giving to her partner (Kayser et al., 1999). A woman in a relationship with low mutuality is unlikely to receive adequate support related to her coping, whereas an understanding and empathetic partner will create more positive outcomes (Kayser et al., 1999). Understanding bidirectional mutuality is pertinent to understanding the well-being of women in relationships who have chronic health conditions. Authors noted that a methodological limitation was the lack of diversity with their participant sample and called for studies of lesbian women to deepen our understanding of the roles of partner mutuality and support in the coping process (Kayser et al., 1999). Given the many ways that relationships can take form, additional research is needed on mutuality and support in the context of health conditions such as cancer for a wider range of relationship types.

Relational Cultural Theory attends closely to experiences of disconnection in relational and cultural contexts and attributes psychological distress to these disconnections (Miller & Stiver, 1997). Interpersonal experiences of disconnection can create isolation, confusion, disempowerment, shame, and withdrawal from others (Jordan, 2018). Research has identified challenges that cancer survivors may face in their relationships with others and within themselves, causing disconnection at various relational levels (Raque, 2019). Loneliness may stem from societal pressure to appear strong and brave in the face of cancer, and to protect loved ones from the pain of the cancer experience (Rosedale, 2009). Further, survivors describe loneliness due to inauthenticity in their relationships as a result of cancer, as others do not grasp the impact of cancer, understand it, or actively avoid addressing it, which isolates survivors in their experience (Raque, 2018). Coping mechanisms such as avoidance of emotions related to cancer and other cancer patients, as well as minimizing the impact of the experience on the self, inhibits survivors' ability to connect with others and gain support (Kayser et al., 2007; Trusson & Pilnick, 2017).

Baker Miller used the term condemned isolation to describe the impact of many incidents of disconnection over time that contributes to hopelessness that barriers to connection can ever be overcome (Jordan, 2018). This relational hopelessness and expectation of disconnection diminishes attempts at connection, creating a cycle that contributes to further isolation. Condemned isolation is difficult to transform because one has determined that the risk of seeking connection with others is too high, and the vulnerability required for relationship is out of reach (Jordan, 2018). Baker Miller's concept of the central relationship paradox describes the process wherein we strongly desire and require connections yet are too fearful of rejection that may come with vulnerability, so large aspects of oneself remain hidden and therefore out of connection (Jordan, 2018). For cancer survivors, this may occur when others are not able to be with them emotionally in their cancer experience, and rather, deny the reality and implications of cancer because it is too painful or scary (Raque, 2019). Cancer survivors may begin to hide their feelings and experiences among others to avoid being misunderstood, closed out, or judged, ultimately increasing the sense of aloneness they feel while coping with cancer. Within relationships, fear of more disconnection can inhibit authenticity and decrease mutuality over time leading to sustained disconnection (Jordan, 2018). Research using Relational Cultural Theory has extended these concepts into models of couple functioning, which will be discussed later in the chapter. As noted, Relational Cultural Theory (Jordan, 2018) attends to sociocultural factors that contribute to isolation and disconnection in relationships such as discrimination and marginalization. Intersectionality Theory and Minority Stress Theory will be described in the context of sexual minorities and cancer in order to more completely describe the impact of sociocultural factors on well-being and relational processes.

Intersectionality Theory

Broadly, intersectionality is concerned with how people and their unique identities relate to systems of power and societal structures. The concept of intersectionality addresses the impact of holding multiple marginalized identities, such as race and gender, and was initially connected with antidiscrimination activism, highlighting how those with several marginalized identities are often misunderstood and mistreated in society (Crenshaw, 1989). Researchers (Shields, 2008) have called for more attention to intersectionality and the exploration of how each identity is "defined in terms of relative sociocultural power and privilege" which shapes our experiences in the world (Parent et al., 2013, p. 639). For example, the combination of many privileged identities (Man, White, Heterosexual, High SES) often results in holding more power and opportunity in society and the opposite is also true, that holding many less privileged or marginalized identities (Woman, Black, Lesbian, Low SES) may result in less power and fewer opportunities in society. Intersectionality work exists in many disciplines, including psychology (Cole, 2009; Purdie-Vaughns & Eibach, 2008), and literature calls for it to be incorporated into more research, as intersectionality is not a stand-alone theory (Cho et al., 2013).

This dissertation uses the lens of intersectionality to understand the experience of coupled women going through breast cancer and attends to how the intersection of their identities impacts their experience of sexism, racism, and heterosexism as they interact with the healthcare system. A manuscript applying intersectionality to LGBT cancer patients states that "when marginalized individuals interact with large social systems, such as educational, political, legal, and health care systems, they can experience discrimination and further marginalization on multiple levels (Damaskos et al., 2018, p. 31). Further, in a study about lesbian/gay identity formation and psychosocial well-being it was found that, compared to gay men, lesbians reported more experience with individual discrimination, which was attributed to research findings on the intersectionality of identities (Kranz & Pierrard, 2018). Specifically, this study suggested that lesbians experience double victimization and discrimination based on their gender and minority sexual orientation (Kuyper & Fokkema, 2011).

Survivors' identities before cancer are important to consider when evaluating the impact of sociocultural factors on their cancer experience (Raque, 2019). One qualitative study interviewed 24 women, including two lesbians, between six months and 29 years post breast cancer diagnosis regarding their perceptions of social interactions during and after treatment (Trusson & Pilnick, 2017). For example, one lesbian participant articulated her experience of navigating two marginalized identities, both in terms of sexuality and cancer status, and that deciding whether to share these identities was an issue she confronted on a daily basis (Trusson & Pilnick, 2017). Another lesbian participant stated that due to fear of homophobia and prior experiences with homophobia due to sexuality, she was inhibited from seeking support within cancer support groups because of holding two identities subject to cultural anxieties (Trusson & Pilnick, 2017). In short, intersecting sociocultural factors impact couples, as well as individuals, as they navigate cancer.

Minority Stress Theory

After a breast cancer diagnosis, women and their partners become embedded among health care providers and the overall health care system as they pursue treatment. Sociocultural factors impact their interactions and experiences navigating the world as women partnered with women (Boehmer & Elk, 2015)**.** The framework of minority stress was developed originally to explain the higher rate of mental health disorders found in the lesbian, gay, bisexual population (LGB) when compared to heterosexuals, moving from a focus on individual level factors to a focus on policy and other systems-level factors (Meyer, 2003). Meyer (2003) proposed that everyone experiences stressors throughout each day; however, more stress is endured by LGB individuals due to their minority status. Meyer (2003) describes distal stressors and proximal stressors. Distal stressors are external or objective stressors including experiences of prejudice events, such as violence and discrimination, whether overt or more subtle (Meyer, 2003). Proximal stressors are more internal, including expectations of rejection and internalized self-stigma (Meyer, 2003). Victimization based on sexual orientation has been linked to mental health concerns among LGB adults including anxiety, depression, posttraumatic stress disorder, and suicidal ideation and attempts (Cogan, 1996; Plöderl et al., 2014). The negative implications of minority stress may occur due to extreme circumstances of victimization as well as microaggressions related to sexual orientation for the LGB population (Sue, 2010). Microaggressions refer to intentional or unintentional brief and daily actions that communicate negative or hostile insults to another person (Sue et al., 2007).

Sexual Minority Population and Minority Stress. Recent research supports the relevance of minority stress theory for the sexual minority population. A meta-analysis presented findings based on 386 studies about victimization experiences of lesbian, gay, and bisexual individuals (Katz-Wise & Hyde, 2012). The meta-analysis concluded that victimization experiences within this population was substantial, as 55% reported experiencing verbal harassment and 41% reported experiencing discrimination (Katz-Wise & Hyde, 2012). The meta-analysis identified over 20 categories of victimization including threats of violence, physical attack/abuse, police victimization, sexual assault, threats of being outed, and knowledge of others who have been victimized on the basis of sexual orientation (Katz-Wise & Hyde, 2012). Likely the most relevant types of victimization to this dissertation are general discrimination – including healthcare-based discrimination, relational victimization – being deliberately excluded from social groups, and general victimization – including general harassment; the meta-analysis found that 41-44% of sexual minorities experienced all three of these types of victimization (Katz-Wise & Hyde, 2012). The meta-analysis also compared their results to a quantitative literature review on the same topic that was completed in 1992 (Berrill), over fifteen years prior, and found that despite cultural changes during that 15-year period, the rates of victimization for the sexual minority population had stayed the same or increased in that time (Katz-Wise & Hyde, 2012). Lastly, the meta-analysis did not report significant differences in global victimization experiences between sexual minority individuals of different genders (Katz-Wise & Hyde, 2012).

Social Stigma and Functioning for Sexual Minority Couples. A meta-analytic review of 35-cross sectional studies on social stigma and sexual minorities' romantic relationship functioning found a significant, albeit small, negative association between relationship functioning (trust, commitment, satisfaction) and perceived stigma (Doyle & Molix, 2015). Todosijevic and colleagues (2005) found a negative association between discrimination and relationship functioning within a lesbian population, including 199 couples. Stress experienced by lesbian couples was more highly related to their families' reactions to their sexuality and relationship than harassment by strangers, compared to gay male couples, pointing to the importance of acceptance, harmony, and social support in intimate relationships for women (Todosijevic et al., 2005)**.** On the other hand, a study of same-sex romantic couples found that internalized homonegativity, which is thought to be a consequence of sexuality-related minority stress, negatively impacted mental health and relationship quality for 99 coupled men, but not for 86 coupled women (Thies, 2016).

Generally, findings from studies about discrimination and relationship functioning among sexual minorities have been mixed; it seems that discrimination is associated with relationship resiliency and satisfaction for some and have a negative impact for others (Sullivan et al., 2017). These inconsistent and interesting gender-specific findings indicate the need for more research into the intimate relationships between women and how they are impacted by discriminatory experiences.

Same-Sex Relationship Strengths Despite Sociocultural Stressors. Although much research has focused on negative associations between minority stress and relationship outcomes for same-sex couples, a growing body of literature reports on the strengths of same-sex relationships. Recently, Rostosky and Riggle (2017) reviewed and synthesized 66 empirical research studies published between 2000-2016 regarding same-sex couple relationship strengths. The systematic review findings were organized into three relationship processes and four positive relationship characteristics; findings about women partnered with women are highlighted (Rostosky & Riggle, 2017). The three positive relationship processes were respecting and appreciating individual differences, generating positive emotions and interactions, and effectively communicating and negotiating (Rostosky & Riggle, 2017). Regarding respecting and appreciating individual differences, two interview studies with women couples reported that this strength supported their communication with one another and their empathic attunement (Rostosky & Riggle, 2017). In five studies, women couples reported more ability than other types of couples to engage in positive problem solving (Rostosky & Riggle, 2017). Women couples were also found to have more harmonious interactions during conflict and that expressions of affection were associated with relationship satisfaction (Rostosky & Riggle, 2017). Two studies included 26 interviews with long-term women couples who reported that their relationship success was due in part to their ability to negotiate during conflict (Rostosky & Riggle, 2017). Women couples were more likely than men to report that members of the couple were equally responsible for beginning discussions about an area of conflict for them (Rostosky & Riggle, 2017).

The four positive relationship characteristics were perceived intimacy, commitment, egalitarian ideals, and outness (Rostosky & Riggle, 2017). Many studies looking at perceived intimacy compared different sex relationships with women-in-relationships and men-in-relationships. Overall, these studies found that women-in-relationships had the highest scores in relationship satisfaction, psychological intimacy, trust, collaboration on emotional work, and maintaining intimacy (Rostosky & Riggle, 2017; Szymanski et al., 2016). On commitment, same sex couples reported similar understanding and moral obligation to their partners as within different sex relationships (Rostosky & Riggle, 2017). Studies found that egalitarian relationships appear to be particularly important to women as they are more likely than other couple types to report equality with regard to power, contributions, and commitment to the relationship (Rostosky & Riggle, 2017; Solomon et al., 2004; 2005). Lastly, studies found that being out as a couple was an important strength of same-sex relationships, in that it relieved minority stress of attempting to conceal their relationship (Rostosky & Riggle, 2017). In particular, same-sex partnered women reported higher satisfaction and social support in their relationship when they were more out (Rostosky & Riggle, 2017). Research has established that women in relationships with other women have more shared friendships, attend more social engagements together, and enjoy the same leisure activities more so than other relationship types (Solomon et al., 2004).

Minority Stress Experiences in the Context of Cancer. Research on the topic of sociocultural factors and lesbian women, bisexual women, and same-sex women couples navigating cancer together paints a complex relationship between these patients and their support system, including their providers and the health care system as a whole (Boehmer & Elk, 2015). In the context of their cancer care, SMW patients have reported healthcare discrimination, including refusal to address their sexuality and questioning of their romantic relationships (Moore, 2002; Willging et al., 2006). More than half of participants in a national survey of LGBTQ+ participants with a chronic health condition reported experiencing some form of discrimination in the healthcare system, and these experiences were associated with unequal cancer outcomes and delayed treatment seeking (Lambda Legal, 2020).

Some sexual minority survivors have described how heteronormative microaggressions permeated their cancer experience at every stage of the care process, including in forms and informational material and when communicating with their providers about visitation and treatment decision-making policies (Dean et al., 2016). Meta-ethnography findings also revealed providers' widespread heteronormative assumptions about their patients' romantic relationships, body image, and sexual functioning after cancer (Raque et al., 2020). As one example of how heteronormativity pervades cancer care, a systematic review found that lacking LGB-specific information and support groups engendered feelings of invisibility, isolation, worry, and irritation for these survivors and their partners (Lisy et al., 2018). In another study, survivors reported the mixed impact of participating in a non-LGBT support group, with some benefitting and others feeling alienated due to the heterocentric focus of the group; whereas most of those who were able to find a LGBT-specific support group, mostly online, found benefit (Brown & McElroy, 2018).

Lesbian and queer women have reported challenges accessing affirmative providers and support services (Fish et al., 2019). Although most SMW disclose their sexual orientation to providers, those who do not have fewer support resources and are more fearful of rejection or discrimination during cancer treatment (Boehmer & Case, 2004). Bisexual and lesbian women have described more concerns about their personal safety and less trust in providers during cancer care than heterosexual women (Boehmer et al., 2013a). In a survey study including 67 participants, 76% identified as lesbian, gay, or same-sex loving, and all participants were within five years of a breast cancer diagnosis (Brown & McElroy, 2018). Many participants who disclosed their sexual minority status reported relief and gratitude that their healthcare providers were respectful and inclusive of their partners during appointments, which enhanced their connection to their provider (Brown & McElroy, 2018). In another study, lesbian breast cancer patients reported worrying about how their partner would be received in the healthcare setting but found that their partners were met with respect (Katz, 2009). Further, SMW report less satisfaction with care and more negative experiences with providers than heterosexual women; although they may not experience direct forms of discrimination like being denied standard care, they have reported experiencing microaggressions related to identity and partner relationships (Matthews et al., 2002; Fobair et al., 2001; Sinding et al., 2004).

More broadly, research has shown how cancer is a stigmatized disease by highlighting the experiences of cancer survivors, even among people they are closest to (Trusson & Pilnick, 2017). An empirical study asked 100 breast cancer patients and 100 disease-free individuals about their perceptions and behaviors related to people with cancer and found that 61% of healthy individuals admitted to avoiding people with cancer to avoid their own unpleasant internal experiences, and 52% of breast cancer survivors felt that their friends and family were avoiding them (Peters-Golden, 1982). Lally and colleagues (2013) found that women within 15 weeks of a breast cancer diagnosis reported many unsupportive social interactions in which people distanced themselves, minimized their experience, overreacted, and were intrusive, which increased survivors' sense of social isolation (Lally et al., 2013). For women with breast cancer, managing stigma, everyday relational disruptions, and negative interactions may add another layer of difficulty to their cancer experience. This dissertation study sought to address a gap in the research by considering the impact of intersecting identities upon relational well-being after cancer, as participants will hold, at minimum, identities as a partner or a cancer survivor, women, and a sexual minority (Raque, 2019).

RCT, Minority Stress, and Well-Being of Sexual Minorities. Several recent theoretical (Raque, 2019) and empirical studies (Mereish & Poteat, 2015a, 2015b) have utilized the Relational Cultural Theory framework to investigate the impact of minority stress on several facets of experience for sexual minorities, including well-being and relationships. Mereish and Poteat (2015a) conducted a complex study seeking to understand how stressors experienced by sexual minorities lead to psychological and physical distress. This study utilizes a relational cultural theory framework to build on the minority stress model and seeks to understand the relationship between distal stressors such as victimization, discrimination, and rejection and proximal stressors such as concealment of sexual orientation and internalized homophobia (Mereish & Poteat, 2015a). Associations between the distal and proximal stressors were mediated by relationships within the LGBT community and with peers, shame, and loneliness (Mereish & Poteat, 2015a). These findings suggest that relational and interpersonal mechanisms regulate the impact of sexual minority stressors on the well-being of LGBT individuals (Mereish & Poteat, 2015a). This study calls for future research to address the importance of societal marginalization and oppression on the relationships of LGBT individuals, including with partners (Mereish & Poteat, 2015a).

RCT and Growth-Fostering Relationships of Sexual Minorities. Also through a Relational Cultural Therapy lens, Mereish and Poteat (2015b) researched conditions under which growth-fostering relationships contribute to functioning for sexual minorities. The study examined growth-fostering relationships with a close friend, the close friend's sexual orientation, and internalized homophobia. Researchers found that less psychological distress was associated with having a growth-fostering friendship with a LGBT or heterosexual friend when internalized homophobia was low; however, if internalized homophobia is high, then psychological distress was only less if their friend was also LGBT (Mereish & Poteat, 2015b). Findings illuminate the potential for growth-fostering resilience and decreased distress when support is received from certain sources (Mereish & Poteat, 2015b). Mereish and Poteat (2015b) indicate that much research on social support has focused on the quantity of support and their study shows that the quality and source of support are also important factors contributing to whether the support will provide positive benefit. These findings contribute to our understanding of what factors are important when developing affirmative and culturally sensitive healthcare for sexual minorities (Mereish & Poteat, 2015b). For example, these findings support the likely benefit for LGBT individuals when they can access health providers who identity as a sexual minority, and health-related support groups specifically for sexual minority populations. However, to better understand the support needs of SMW cancer survivors, it may be helpful to consider their developmental stage at the time of diagnosis and treatment.

Age and Cancer

Another aspect of identity explored in this dissertation relates to survivors' developmental stage, with a specific focus on young breast cancer survivors. Organizations and research sources vary in their precise age determination of a younger breast cancer survivor, with the higher end of the younger cohort being between 40 and 50 years old. One source noted that breast cancer survivorship research on younger women has usually enrolled women ages 50 and below, assuming diagnosis at approximately 45 years (Champion et al., 2014). A prominent organization for younger breast cancer survivors also uses 45 years or younger at diagnosis, pointing to breast cancer research that identifies younger women as in their reproductive years, with 51 years as the mean age of menopause (Hulvat & Jeruss, 2009; National Institute of Aging, 2015). For adults under the age of 45, a quarter of all cancers diagnosed are breast cancers, yet younger women and cancer-related issues relevant to their age are under-researched (Adams et al., 2011). The American Cancer Society (2020) reported that less than 1% of breast cancer studies examine women diagnosed under the age of 45. Since 2007, breast cancer deaths have been steady in women younger than 50 but continue to decrease in older women (American Cancer Society, 2020).

This dissertation sought to include participants ages 30-50 years of age. This criterion reflects the research and advocacy in this area, including the age criteria for young breast cancer survivors and the paucity of research on survivors in this age group. Further, women in this age group are in a shared developmental stage (Mehta et al., 2020). Women couples in this age group have likely had life experiences and relationships impacted by similar cultural attitudes and policies. The rationale for this age range will be further supported by research in the remainder of this section.

Established Adulthood and Developmental Considerations. A recent article described a new theoretical conceptualization for a developmental stage or phase of adult life, age 30 to 45 years, and terms this period established adulthood (Mehta et al., 2020). Havighurst (1953), an early developmental theorist, also recognized an adult life phase focused on family and career. Mehta and colleagues (2020, p. 431) argue that this period is “the most intense, demanding, and rewarding years of adult life” as so many important aspects of life are happening simultaneously, including forming or maintaining an intimate partnership, caring for children, and working on a career. This period from 30 to 45 years has been included in young adulthood (18-45) or middle adulthood (40-65), but authors argued that by looking at such large bands of life the uniqueness of a time high in work and family obligations was lost (Adams et al., 2011; Mehta et al., 2020).

Mehta and colleagues (2020) describe notable features of established adulthood including physical health and well-being and cognitive development. Regarding physical health and well-being, authors notes that established adulthood is typically the healthiest throughout the lifespan, so cancer survivors have a very divergent experience from their peers regarding physical health and related activities (Mehta et al., 2020). As well, they point to this period as one of great creativity, productivity, and expertise, with many reaching their highest intellectual accomplishments during this time (Mehta et al., 2020). The negative impact of cancer treatment on cognitive functioning and work/career has been documented (American Cancer Society, 2020; Raque et al., 2015), so again, cancer survivors may experience significant disruptions to important life tasks due to their illness. Mehta and colleagues (2020) discuss the “crunch” of schooling, career progression, intimate relationship progression, family rearing, and career advancement that is more and more frequently happening in the 30s and early 40s. Cancer has the potential to seriously disrupt plans and hopes in many of these areas. As the established adulthood conceptualization is new, it has not been applied to many areas of investigation, including related to women partnered with women or cancer. The established adulthood theory discusses the role of gender; however, only in relation to heterosexual women and the increased demands they experience during this period compared to men in the same age group. This dissertation seeks to explore how this period of established adulthood is experienced by women couples who experience cancer.

Organizations Focused on Younger Survivors. In recognition of the potentially unique challenges faced by young breast cancer survivors, several organizations have been established to meet this population’s survivorship needs. For instance, the Tigerlily Foundation is a national breast cancer foundation that provides hands-on support to young women aged 15 to 45, as well as awareness, education, and advocacy, before, during and after breast cancer (Tigerlily Foundation, 2020). Additionally, the Young Survival Coalition (YSC) (Young Survival Coalition, 2020) is a national non-profit organization focused on breast cancer in young women (Young Survival Coalition, 2020). They report that more than 13,000 young women are diagnosed each year, and over 250,000 young survivors live in the United States (Young Survival Coalition, 2020). These organizations appear to be primarily focused on serving heterosexual women, and do not include information on their websites about the cancer experience of sexual minority women, except for a link to an outside partner organization on one site.

Challenges for Younger Survivors. The age at which one is diagnosed with cancer impacts their experience and recovery, including levels of distress. YSC states that younger adults with breast cancer face unique challenges due to their life phase, as described by Mehta and colleagues (2020), and that breast cancer may impede quality of life and length of life (Young Survival Coalition, 2020). Young breast cancer survivors reported a variety of physical challenges including fatigue and pain, mental health concerns including anxiety, depression, or emotional exhaustion, and cognitive problems related to memory, concentration, and communication (Raque, 2013). Sexual dysfunction, body image, and intimacy issues are also relevant to some breast cancer survivors in this cohort (Young Survival Coalition, 2020). Work-related challenges are also relevant to this population of breast cancer survivors who weigh the decision of whether to continue working, potential consequences of disclosure, symptoms and side effects impacting work, and managing workload and work schedule during cancer treatment (Raque et al., 2015).

Younger Couples. This dissertation study is focused on women couples who are younger and facing breast cancer, so research about age differences among couples facing breast cancer is important. A study compared younger and middle-aged couples coping with breast cancer to address what the authors identified as a significant gap in the literature, as little is known about how the life stage of couples influences their coping processes in the face of chronic illness, such as breast cancer (Acquati & Kayser, 2019).

This quantitative study measured relational mutuality (Mutual Psychological Development Questionnaire - MPDQ), dyadic coping (Dyadic Coping Scale), and quality of life (Functional Assessment of Cancer Therapy-Breast - FACT-B) (Acquati & Kayser, 2019). Relational-Cultural Theory (RCT) was the theoretical framework for this study, and authors state that from an RCT perspective the pattern of dyadic coping that couples develop is determined by relationship awareness, authenticity, and mutuality (Acquati & Kayser, 2019). The results of the two groups were compared, including 35 younger couples (mean age 38-40 years), and 51 middle-aged couples (mean age 55-57 years); and the Actor-Partner Interdependence Model (APIM) identified both partners' effects of relational mutuality on coping (Acquati & Kayser, 2019). This study found that younger couples had significantly worse quality of life and dyadic coping than the middle-aged couples, highlighting the more negative impact of breast cancer on younger patients and partners (Acquati & Kayser, 2019). Findings supported earlier research that younger breast cancer patients have more negative emotional and physical well-being and cancer symptoms (Acquati & Kayser, 2019). The same was found for younger partners, who had higher levels of intrusiveness and hostile coping and lower emotional well-being than their middle-aged counterparts (Acquati & Kayser, 2019). Further, each partner's relational mutuality was a stronger predictor of adaptive and maladaptive coping in the younger couples, indicating that younger couples may be less effectively utilizing mutual empathic responsiveness with one another (Acquati & Kayser, 2019).

Acquati and Kayser (2019) summarized the research literature on developmental differences in younger versus older couples to explain why younger couples are at higher risk for negative adjustment to cancer. They stated that younger couples have less effective emotional regulation and collaborative coping skills, have higher expectations and lower satisfaction with their relationships, and are impacted more by contextual factors like economic hardship and work-related stress (Acquati & Kayser, 2019). It is important to note that much of the research on dyadic coping has been focused on older heterosexual couples, so there is much to learn about what is unique to younger couples, and non-heterosexual couples, from a relational perspective (Acquati & Kayser, 2019).

Family Challenges. Beyond the couple relationship, research findings also highlight challenges with family planning including pregnancy concerns and the need to seek infertility treatment (Raque et al., 2015). For many young women that already have young children, treatment side effects and the impact of the disease will likely have a significant impact on the family (Young Survival Coalition, 2020). In fact, younger survivors expressed greatest distress about their families and children, and family distress may be higher for young survivors due to the daily demands of raising a young family (Northouse, 1994). Over 200 women diagnosed with breast cancer ages 25-50 completed a one-time survey as well as open-ended qualitative questions about the impact of cancer on their relationship with their romantic partner and children (Walsh et al., 2005). Results revealed that for women in this age group, their relationship with their partner was impacted in four varying primary ways: increased closeness and intimacy, communication avoidance, separation or termination of the relationship, and problems related to sexuality (Walsh et al., 2005). Themes regarding relationships with children included role shifts, emotional distress, and increased closeness (Walsh et al., 2015).

Quantitatively, a quarter to one half of participants reported that talking about death, fears, feelings, finances, and the future were reported as problematic after the breast cancer diagnosis (Walsh et al., 2005). Findings by Braun and colleagues (2005) suggest that having cancer can cause a perspective change wherein the family domain becomes more important than work or social domains. Three quarters of survivors in a qualitative study reported that their family, partner, and children were of primary importance after cancer (Raque et al., 2018).

Impact of Cultural Factors on Generational Cohorts. Just as one's age when they are diagnosed with cancer contributes to the nature of survivors' personal, relationship, and life concerns, broader cultural attitudes and events are also relevant to the experience and perspective of generational cohorts who experience a chronic illness (Dentato et al., 2014). After a period of protest and civil unrest in summer 1969 in New York City, at the Stonewall Inn, significant social, cultural, and legal changes began to occur related to LGBT rights (Dentato et al., 2014). Especially before that time, LGBT individuals were pathologized by the medical and psychological communities, experienced criminalization and subjections to anti-gay legislation and social consequences such as loss of jobs, social standing, family separation, and lack of personal safety due to their sexual orientation (Dentato et al., 2014).

Since that time, over 50 years ago, the LGBT community has been in a period of increased visibility and activism that has significantly impacted the identities of older LGBT individuals who lived through this change in cultural attitude (Dentato et al., 2014). Dentato and colleagues (2014) argue that an understanding of age cohort similarities and differences is necessary to inform best practices in research with the LGBT population. While intergenerational groups within the LGBT community may share similarities, they may differ in their lived experiences of prejudice and discrimination, coming out, relationships with family, and openness regarding intimate relationships (Vaccaro, 2009). For example, policy changes such as the removal of “homosexuality” as a pathology and disorder from the American Psychiatric Association’s DSM III, overturning of “Don’t Ask, Don’t Tell” in the military, passage of marriage equality for same-sex couples, and legal ramifications related to housing and employment discrimination have increased acceptance in society and positively impacted the lived experiences for LGBT people in the United States in recent decades (Dentato et al., 2014).

Couples’ Coping with Cancer

This section of the literature review presents couples’ coping with cancer, including a brief review of several cancer and coping studies and a model of coping based on the theoretical framework for this dissertation, Relational Cultural Theory. This section also covers research about the impact of couples’ coping with cancer on intimacy, communication, negotiation of roles, sexuality, and social support. A couple’s adjustment to cancer is dependent on their individual and collective responses from an emotional, cognitive, and behavioral perspective (Ben-Zur et al., 2001). If a chronic illness is framed as the sick person’s problem, the rest of the relationship interactions will be impacted by this premise and illness as a conjoint problem empowers couples to cope conjointly (Rolland, 1994). Research has sought to understand how coping and adjustment differs for patients and partners and how their pattern of coping interacts with one another (Ben-Zur et al., 2001). Ben-Zur and colleagues (2001) measured distress and coping using the established Brief Symptom Inventory (e.g., somatization, obsessive-compulsive, depression, anxiety) and the COPE Scale (seeking emotional social support, restraint coping, denial), respectively, and measured psychosocial adjustment (work, family, social relations, house care, and self-care) using a scale developed for this study. They found that in a study of heterosexual couples coping with breast cancer, the husband group reported similar psychosocial adjustment to their wives (patients), yet the breast cancer patients experienced higher distress, and this result has been echoed in other breast cancer literature (Hoskins, 1995). However, not all studies found patients to experience more distress than their spouse (Gilbar et al., 1995).

Heterosexual couples (*n* = 191) early in treatment for metastatic breast cancer were measured for cancer-related distress and dyadic coping (Badr et al., 2010). They found that the more common negative dyadic coping strategies were used, the greater distress for the couple, and more so for the patient (Badr et al., 2010). Negative dyadic coping involves mutual avoidance and withdrawal (Badr et al., 2010). On the other hand, common positive dyadic coping, such as joint problem solving, relaxing together, sharing, and coordinating daily demands was mutually beneficial for patients and partners (Badr et al., 2010). These studies point to the impact of cancer on both members of a couple and how processes within the relationship influence the well-being of survivors and partners and relationship functioning.

Relational Cultural Coping Model (RCCM). One model of couple's coping with cancer that is particularly relevant to this dissertation is the Relational Cultural Coping Model (RCCM), which is based on Relational Cultural Theory (RCT) (Kayser et al., 2007). Kayser and colleagues (2007) interviewed nine heterosexual couples and one lesbian couple about their experiences with breast cancer from a relational perspective and found two patterns of couple coping, mutual responsiveness, and disengaged avoidance (Kayser et al., 2007). Those in mutually responsive relationships characterized cancer as a "we-disease" and cancer-related distress as "we-stress" (Kayser et al., 2007). Authors stated that these couples exhibited more of the relational qualities of authenticity, mutuality, and relationship awareness. Relationship awareness refers to thinking about the relationship in the context of the illness, the impact of the disease on the partner, and considering how to sustain the relationship despite illness (Kayser et al., 2007). Authenticity is defined as disclosing genuine feelings and not hiding feelings between partners (Kayser et al., 2007). Lastly, mutuality is empathic responding and a way of relating in which both partners are participating fully in a shared experience (Kayser et al., 2007). Although one lesbian couple was included in the study, the study did not address intersectionality in the cancer experiences of couples and much remains unknown about how sexual minority couples' approach "we" problems (Kayser et al., 2007). A systemic review of marital adjustment to breast cancer also found that when both members of a couple take a "we" approach to coping with the cancer experience their relationship is more adjusted (Brandao et al., 2017).

Intimacy. Chronic conditions can be understood as an uninvited guest into a relationship that must be incorporated into life (Rolland, 1994). Cancer introduces the threat of loss, and even cancer in remission can intrude in a myriad of ways on couples' lives, particularly intimacy (Rolland, 1994). Intimacy looks different among couples, but may include sharing feelings, interests, mutual protection, financial security, and taking care of responsibilities. In a study of sexual minority women breast cancer survivors, 58% were in relationships and the most frequently cited effect of cancer was on their relationship, including a lack of sexual activity, intimacy and pleasure, and poorer coping skills due to cancer-related trauma (Brown & McElroy, 2018). Relationship awareness, a concept embedded into Relational-Cultural Theory, describes the extent to which couples incorporate cancer into their relationship, and can be understood as a set of cognitions by the couple that help maintain the quality, normalcy, and intimacy of the relationship (Acitelli, 1988). A study of couples coping with early-stage breast cancer found that couples who had more relationship awareness specific to cancer reported more relationship talk and higher levels of perceived and actual disclosure and responsiveness between partners (Manne et al., 2014).

Communication. In the face of a chronic illness, Rolland (1994) states that strong and intense emotions and high reactivity are to be expected, so normalizing these are important for functioning as a couple. A study of couples coping with early-stage breast cancer investigated communication processes including constructive communication, mutual avoidance, and demand-withdraw strategies and the impact on relationship satisfaction and distress (Manne et al., 2006). Authors called for couple-focused communication skills training for cancer patients and their partners to enhance well-being (Manne et al., 2006). A quantitative study including 20 heterosexual couples measured whether talking about their marital relationship more during cancer, but not specifically about cancer, would benefit them (Badr et al., 2008). They found that distress of both spouses decreased as satisfaction with relationship talk increased, suggesting that this type of communication is a connecting and normalizing force for couples going through cancer together (Badr et al., 2008). Experiences of connection and disconnection during communication is one aspect of relationship functioning that this dissertation explored.

A grounded theory study with 41 couples in which the woman partner had breast cancer were interviewed at five time points over the course of the first year since diagnosis (Hilton, 1994). A couple communication scale and a state trait anxiety measure were also used in conjunction (Hilton, 1994). Couples fell into three categories regarding frequency of communication which were “talkers”, “medium talkers”, and “nontalkers”, and talkers were the most satisfied with their communication as a couple and nontalkers the least satisfied (Hilton, 1994). Couples who had majorly discrepant views about how much to communicate about concerns were much more and consistently dissatisfied than other couples (Hilton, 1994). Coping and adjustment to cancer was described as significantly easier for the talkers who were in sync with one another (Hilton, 1994). Nontalkers had consistently higher anxiety levels (Hilton, 1994).

A systematic review of marital adjustment in the context of female breast cancer reviewed fourteen articles (Brandao et al., 2017). Higher levels of marital adjustment was associated with three psychosocial variables including constructive communication, more social support, and common positive dyadic coping (Brandao et al., 2017). Constructive communication about cancer was defined as open expression of thoughts, emotions, fears, and opinions that enhances the emotional closeness of the couple (Brandao et al., 2017). Common positive dyadic coping was described as when couples take a “we” approach to develop and utilize resources to cope with cancer together (Brandao et al., 2017). Note that across studies, the importance of communication suggests the need to examine it with SMW cancer survivors and their partners.

A grounded theory study explored relationship vulnerabilities in close interpersonal relationship among heterosexual couples coping with breast cancer and specifically explored relational dynamics, referred to as interactional perspectives (Fergus & Gray, 2009). Nineteen women at various stages of breast cancer illness and eleven men spouses were interviewed about their breast cancer specific experiences (Fergus & Gray, 2009). Three types of interviews were conducted including an initial focus group, couples together, and then individual interviews (Fergus & Gray, 2009). The global theme describing day-to-day couple adjustment to breast cancer was Relationship Vulnerabilities, which included how certain Relationship Dynamics and certain Personal Characteristics contributed to challenging experiences within couples related to illness with breast cancer. Personal Characteristics as a relationship vulnerability was broken down into Patient, including these traits: self-absorption, counter-dependency, exaggerated dependency, and over-controlling (Fergus & Gray, 2009). Spouse characteristics included: solution-driven, unchecked anger, not prioritizing patient, and not reaching out (Fergus & Gray, 2009). Within Relationship Dynamics, Pitfalls included communication barriers, withholding-withdrawal, under-burdening, and conflictual intentions, and Challenges included negotiating support, accommodating changes in other, coping with sexual disruption, and incorporating death and separation (Fergus & Gray, 2009). The findings of this study highlight the significant relational impact of cancer on the heterosexual couples studied, including how emotions and behaviors of the partner group and survivor group differed, contributing to problems between them. This dissertation sought to extend this work with a different demographic group and understand relationship dynamics of women partnered with women.

Research has shown that heterosexual women are less distressed emotionally and adapt better to breast cancer when they perceive emotional support and involvement by their partners (Fergus & Gray, 2009; Manne et al., 2006; Sormanti & Kayser, 2000). However, research findings note that men supporting women with cancer may feel they are lacking the skills or resources to meet the various needs of their partners, in particular their emotional and psychological distress and so responsiveness to those needs may decrease (Fergus & Gray, 2009). The authors noted that a primary limitation of this study was lack of varied backgrounds of participants and called for research to determine whether lesbian couples share similar relational patterns (Fergus & Gray, 2009). Indeed, a similar qualitative study with lesbian couples coping with breast cancer did not reveal similar complaints of partner withdrawal or avoidance behaviors regarding cancer topics (White & Boehmer, 2012).

Negotiation of Roles. Couples' desire for balanced and egalitarian relationships, or maintaining of their preferred roles, may not be possible with an acute illness or chronic condition like cancer, in which the patient-caregiver relationship must occur (Rolland, 1994). Understanding the roles of the patient, and caregiver, or other outside help is important (Baider et al., 2003; Kayser & Acquati, 2019; Rolland, 1994). Negotiating what is possible or desired by both partners is important to avoiding ongoing asymmetries that may lead to resentment, guilt, and other painful emotions that negatively impact intimacy and relationship functioning (Rolland, 1994). Younger couples may experience more resentment about their restricted life due to a partner's illness, and due to socialization, women may be more likely to subvert their own needs in favor of caregiving (Rolland, 1994). Eight heterosexual couples were interviewed about their experiences early in breast cancer survivorship and many women reported difficulties continuing the roles and responsibilities they had before cancer (Keesing et al., 2016). After experiencing cancer, women reported more need to prioritize themselves over their relationship or household duties, which created tension in their relationship (Keesing et al., 2016).

Sexuality. Chronic conditions can have direct and secondary effects on a sexual life (Rolland, 1994). Changes in one's body due to cancer may impact feelings of self-worth, sexual desire, and increased stress associated with sexual activity for both partners and couples may struggle to express intimacy through sexuality (Sheppard & Ely, 2008). Redefining and broadening intimacy can help couples cope with changes in their sexual routine and find satisfaction through alternative sexual practices than the couple previously engaged in (Rolland, 1994; Gilbert et al., 2010). Thinking about this domain from a Relational Cultural Theory perspective, sexual intimacy may be one way that partners authentically connect with one another.

One qualitative study shed light on how heterosexual couples navigated sexual intimacy after breast cancer treatment and found that cancer was perceived as a threat, the body was the primary concern after diagnosis and treatment, and the importance of communication in navigating sex after cancer (Loaring et al., 2015). Members of four long-term heterosexual couples were interviewed in a semi structured fashion about their experiences around diagnosis, decision-making, and experiences of sexual intimacy and body image, and interpretative phenomenological analysis (IPA) was used to analyze the personal meaning of these events for participants (Loaring et al., 2015). Women reported discomfort about how their bodies were treated and discussed when considering reconstruction with their surgeons, as well as disappointment and a sense of violation when surgeries were not conducted as planned or did not produce expected results (Loaring et al., 2015). In this study, women who were the cancer survivors reported not talking about their feelings related to their bodies and men felt they were treading on eggshells related to topics of body image and intimacy (Loaring et al., 2015). Readjusting to sexual intimacy after cancer was both a personal and relationship task, and the importance of building communication was reported across couples as a way to come back together after treatment (Loaring et al., 2015).

A study of 191 heterosexual dyads in which the woman had metastatic breast cancer investigated the relationship between reported sexual problems, communication patterns, and depressive symptoms. For men partners only, sexual problems and depressive symptoms were positively associated. For women partners (cancer patients), depressive symptoms were only associated with high levels of demand-withdraw communication and low constructive communication reported within the couple (Milbury & Badr, 2013).

Several studies compared the breast cancer experiences of heterosexual women and sexual minority women. Compared to heterosexual women (*n* = 257) at various stages (DCIS - stage III) of breast cancer and years post-diagnosis (1.8 - 6.0 years), sexual minority women (*n* = 181) had similar levels of body image, sexual function, and sexual enjoyment (Boehmer et al., 2013a). SMW breast cancer survivors after active treatment (*n* = 85) were compared to SMW without breast cancer (*n* = 85), who were matched by age and partner status (Boehmer et al., 2014b). Based on responses to the Female Sexual Function Index, no differences were found in risk of sexual dysfunction or level of overall sexual dysfunction (Boehmer et al., 2014b). However, survivors reported having sexual interaction less frequently, lower desire, more difficulty reaching orgasm, more pain with sex, and earlier onset of menopause (Boehmer et al., 2014b). Forty six percent of SMW partnered survivors met criteria for risk of sexual dysfunction, compared to 53% of SMW unpartnered partnered survivors (Boehmer et al., 2014b).

Social Support. The disease experience for patients and survivors of breast cancer may include the involvement of their partners, friends, and family members. These people provide a variety of support to a cancer survivor such as emotional or spiritual support, transportation, household support, and treatment decision-making (Boehmer & Elk, 2015). For SMW with breast cancer, utilization of effective social support may be beneficial and associated with higher quality of life and fewer negative mental health symptoms, regardless of whether that support comes from a partner or a broader network of support (Jabson et al., 2011).

One study focused on the primary support people of SMW during breast cancer (Boehmer et al., 2005). This research found that all primary support providers were women (Boehmer et al., 2005). Further, a partner filled that role 79% of the time, 13% were friends, 9% relatives, and 10% reported they did not have a support person (Boehmer et al., 2005). Partnered survivors were more likely to have a support person, indicating that single SMW are at risk of lacking support during cancer (Boehmer et al., 2005). One finding that was repeated in a quantitative study and qualitative study is that, for sexual minority women, their women partners are their most valuable source of support (Fobair et al., 2001; White & Boehmer, 2012). One study measured social support using a structured interview format called the Support Network and Support Assessment (SNSA) and compared results for breast cancer survivors who identified as lesbian and heterosexual (Fobair et al., 2001). They found that lesbians were significantly more likely to report that their partners were willing to listen, help with daily tasks, and provide love and care (Fobair et al., 2001). Boehmer and Elk (2015) reported that an important gap in the literature is the lack of research exploring the experiences of partners of breast cancer patients, who also confront significant challenges throughout the health crisis of their loved one. For the well-being of breast cancer patients and their partners, the meaningful incorporation of their relational supports is an important aspect of affirmative cancer care (Raque et al., 2020).

In addition to quality and amount of support from partners, the gender identity of the SMW's partner also impacts well-being. A study of long-term breast cancer survivors that collected one-time data for a correlational study found that the gender of a sexual minority woman's partner was correlated with their self-reported anxiety and depression (Boehmer et al., 2013b). Self-identified lesbian (*n* = 161) and self-identified bisexual women (*n* = 19) partnered with a woman partner had significantly better mental health than those who were unpartnered, and those with a male partner fared the worst in mental health; however, the sample of bisexual women partnered with a man was only three participants (Boehmer et al., 2013b).

A qualitative study including 15 partnered sexual minority women described perceptions of support from their female partners as they lived with breast cancer over a significant period (White & Boehmer, 2012). Participants had a mean age of 52 years and were an average of six years past diagnosis. Six primary themes emerged from the interviews with breast cancer survivors (White & Boehmer, 2012). These women reported that their partners were their most valuable source of high-quality support regarding communication and decision-making related to cancer, and regarding managing the home and caretaking (White & Boehmer, 2012). Survivors reported a perception that their partners do experience distress related to their cancer and health status, and shoulder increased burden and responsibility due to the survivors' health status (White & Boehmer, 2012). Importantly, the survivors emphasized that they share a meaningful, pleasurable, and future focused life with their partners, which helps them both cope with cancer and enjoy daily life (White & Boehmer, 2012). White and Boehmer (2012) suggest that future qualitative studies involve women partners directly to learn about their experiences during and after the breast cancer diagnosis.

Many of the studies summarized in this section only included heterosexual couples, some included a small number of same sex couples, some compared heterosexual and sexual minority couples, and some were focused solely on sexual minority women or couples. It is important that future studies, including this dissertation, focus more exclusively on sexual minority couples and attend to the impact of cancer on specific types of couples within the LGBTQ+ community, in order to understand their unique experiences.

Purpose of the Present Study

In summary, sexual minority women appear to actively seek support from mental health providers, support groups, friends, and their partners during cancer; however, relational needs, supports, and experiences for partners of survivors are less known, and represent a gap that this dissertation seeks to fill. More specifically, this dissertation seeks to explore the relational dynamics of women partnered with women and incorporate sociocultural issues relevant to this population, such as minority stress and the intersectionality of identities. Qualitative methods were used to gain a deep and rich understanding of these topics. The following research questions were addressed:

Research Question 1: What is the impact of breast cancer on younger survivors and their women partners with regard to authenticity, mutuality, relationship awareness, connection, and disconnection?

Research Question 2: What are the barriers and supports to the sense of connections between women partnered with women in the context of breast cancer?

Research Question 3: How does minority stress affect the couple's relationship dynamic and ability to feel connected after cancer?

Research Question 4: What lasting relational changes do the couples report due to cancer?

Chapter Two: Method

Design

This dissertation study utilized a qualitative design. Individual semi-structured interviews were conducted to investigate the relational impact of breast cancer on women partnered with women. The study aimed to include approximately 10 couples for a total of 20 participants; however, due to recruitment challenges, a total of five couples and 10 individuals participated in the study. The qualitative data was analyzed using Consensual Qualitative Research (CQR; Hill et al., 1997; 2005). CQR employs a rigorous method of data analysis that values context, culture, and trustworthiness (Hill, 2012). Researchers read and analyze participant interviews and then discuss the emerging themes to reach consensus in understanding of the data (Hill, 2012). The University of Denver's Institutional Review Board approved this study before it was conducted.

Consensual Qualitative Research

This section provides general information about the utility and benefits of qualitative research. Next, CQR is described both in terms of the philosophical underpinnings and practical steps for conducting research with this method.

Qualitative Research. Qualitative research has distinct qualities that distinguish it from quantitative research and make it uniquely suited for investigating particular research questions (Polkinghorne, 2005). Qualitative research is a framework suited to describing and clarifying the depth and complexity of the lived human experience, and creates an environment in which each participant, in this case breast cancer survivors and their partners, has the platform to articulate their perspective on their personal experiences (Polkinghorne, 2005).

Positionality Statement of Researcher. The primary investigator (PI) is a 38-year-old, White, heterosexual cisgender woman, who is in a Counseling Psychology doctoral program. The PI acknowledges that this research topic and method are of personal interest and relevance due to her worldview and personal experiences. More specifically, the PI has close friendships with women couples and is an ally to the queer community, participating in advocacy and celebratory events. Further, she has gained clinical and research experiences in the oncology area throughout graduate school, included working with Rocky Mountain Cancer Centers and practicing individual therapy with clients who have cancer, experiences that contributed to her interest in this dissertation topic. The researcher values: 1) equitable treatment of all in society, 2) critical investigation of and resistance against systems that maintain status quo and disadvantage members of particular groups, 3) the beauty, hardship and complexity of interpersonal relationships, 4) understanding human experience as being interconnected with aspects of the mind, body, and spirit, 5) the importance of sharing one's story, 6) daily acts that engender empathy, mutual understanding, authenticity, and empowerment among people, 7) making room for growth, resilience, and optimism alongside negativity and pessimism during serious life challenges, and 8) research as an avenue to explore, deepen, and challenge these perspectives and ways of seeing the world.

The PI sought to exhibit reflexivity throughout this research, to bracket expectations and potential biases related to the data, and to honor the spoken words of participants by staying close to the original data throughout the coding process. The PI shared thoughts about the findings of this dissertation that were informed by research and her own perspectives and agreed to be transparent about possible biases and researcher positionality during the coding process with her team (Levitt et al., 2018). It was expected that many of the couples would exhibit authenticity, mutuality, relationship awareness, and a sense of connection despite the difficulty of cancer, and that experiences of disconnection would be recognized and addressed in many instances by the couples. It was expected that relational strengths within the WPW couples would support their resilience during cancer, and that social support from other sources (friends, family) would be beneficial. Barriers to connection within the couples would be due to stressors related to cancer care, including experiences of minority stress within the healthcare system or from family. Lasting relational changes within the couples were expected, including growth-oriented change and increased closeness, as well as the potential for some couples to experience commitment uncertainty and increased distance due to the cancer experience. The investigator was open to all data that was collected, including surprising or unexpected results.

Essential Components of CQR. Consensual Qualitative Research (CQR) is a method of qualitative research that was created by researchers who wanted a qualitative research method that was easy to learn, rigorous, and integrated the best features from other qualitative methods (Hill et al., 1997). CQR includes elements of phenomenological, grounded theory, and comprehensive process analysis (Hill et al., 2005). The creators of CQR (Hill et al., 2005) state that the essential components are (a) open-ended questions in semi-structured interviews so that consistent data is collected and more in-depth examination of individual experiences can be explored, (b) several judges are included throughout data analysis to foster multiple perspectives, (c) consensus to arrive at judgments about the meaning of the data, (d) at least one auditor checks the work of the team of judges to minimize the impact of groupthink, and (e) domains, core ideas, and cross-analyses in the data analysis.

This is a structured coding approach, that maintains close connection with the original interview data throughout. The method provides an opportunity to see how participants are alike and different from one another. Reaching consensus from differing perspectives is a critical part of the process that requires judges to discuss feelings and disagreements about the data (Hill et al., 2005). Hill et al. (2005) suggests that judges like and respect each other and have strong interpersonal skills. The purpose of the present study was to understand the impact of breast cancer on the relational processes of women partnered with women, and consensual qualitative research was utilized to gather and analyze data.

Philosophical Assumptions of CQR. Philosophically, CQR is mainly constructivist with some postpositivist elements (Hill et al., 2005). Ponterotto (2005) wrote about the research paradigms and philosophy of qualitative research in counseling psychology, including the five constructs of ontology, epistemology, axiology, rhetorical structure, and methods. In terms of ontology, which is the view of the nature of reality, CQR is constructivist. Hill et al. (2005) wrote that CQR researchers are constructivists, who believe in multiple realities that are socially constructed, and often use qualitative methods. Epistemology refers to the influence between the researcher and participant and axiology refers to the role of the investigators' values in the research process. On these paradigms, CQR is between constructivist and postpositivist. Positivists researchers believe in a universal and objective truth and take a more detached and objective role in the research process. CQR is constructivist in that it recognizes the mutual influence of the researcher and participant on one another, as well as the existence of researcher biases, which are actively addressed through bracketing. However, unlike some other methods, CQR takes a postpositivist approach to data analysis by attempting to minimize the impact of research bias in the process (Hill et al., 2005). This approach assumes that bias can potentially be minimized in some way. In CQR, this is accomplished by reporting participants' experiences as they shared them, rather than with a researcher's interpretation of what they reported. The rhetorical structure refers to the language used in presentation of procedures and results. CQR leans more toward the postpositivist approach by presenting results in third-person perspective (Hill et al., 2005). CQR researchers attempt to objectively summarize findings and represent general themes across participants that, to some extent, generalize to the population (Hill et al., 2005).

Four Key Steps in CQR. The primary steps in CQR completed in this study were interviewing, determining domains, developing core ideas, and conducting cross-analysis. CQR studies often collect data by conducting semi-structured interviews, which was done in this study. Secondly, domains are topics used to group data, and these were determined consensually by the judges. The research team, also known as judges, reviewed interview transcripts and collaboratively listed prominent domains, which were modified as needed. The development of core ideas, the third step, was also done consensually. During this part of the process, judges summarized participant statements, and excluded non-relevant information, reduced redundancy, and provided clarity to the data. Lastly, the judges conducted cross-analysis. This is when data for all participants across each domain was combined. Judges consensually generated the categories (sub-themes) under each domain and then each core idea was put into a category. Based on the frequency of participant interviews (cases) that were represented under each category, that category was labeled as general (all cases in the partner or survivor group, with a maximum of five), typical (more than half cases in the partner or survivor group, so three or four cases), and variant (less than half cases in the partner or survivor group, so one or two cases). An external auditor reviewed data at each step of this process and ensured that analysis was proceeding as accurately as possible (Hill et al., 1997; 2005).

Participants

Interviewees. Interviewees for this study were members of five couples totaling 10 participants, all women partnered with women. Criteria for participation was determined by couple characteristics, cancer type and course, age, and ethical standards of research. More specifically, inclusion criteria were: (a) one woman in a couple that is made up of two women, (b) relationship with their partner is romantic in nature, (c) both partners are willing to participate in the study, (d) one partner has been diagnosed with any stage of breast cancer within the last five years at the age of 45 years or younger, (e) the couple was living together at the time of diagnosis and currently, in the United States, (f) the individuals are each between 30 and 50 years old currently, and (g) English speaking.

Judges. The five members of the research team, also referred to as judges, were split into two separate teams. Each team was comprised of three people, the PI was on both teams with two additional judges. The first team analyzed the interview data for the cancer survivors' group of five participants. Including the PI, this team of three was comprised of three cisgender women, one who identified as bisexual and two who identified as heterosexual. They were all students pursuing graduate education, one doctoral student in counseling psychology, one doctoral student in research methods and statistics, and one masters student in counseling psychology. One of them had previous personal experience with breast cancer, in her mother. Two of these judges had prior experience conducting qualitative research.

The second team concurrently, but independently, analyzed interview data for the partners/caregivers' group of five participants. Including the PI, this team was comprised of three cisgender women, one who identified as bisexual and two who identified as heterosexual. They were all students pursuing graduate education, two doctoral students in counseling psychology, and one masters student in counseling psychology. Two of them had previous personal experience with breast cancer, one in her mother and the other in her sister. Two of these judges had prior experience conducting qualitative research. All five judges were enrolled at the same large, private university in Denver, Colorado. All five judges identified as White and were in their late 20s to late 30s. It was the intent of the PI to involve judges with diverse identities and experiences who could provide a variety of unique perspectives regarding the data. Judges were required to have an interest in couples research or chronic health-related issues, such as cancer. Judges were trained for this research role, which is described below.

Auditor. The Consensual Qualitative Research method utilizes an auditor who reviewed the work during the coding process and provided feedback to the coding teams of judges. The auditor for this dissertation was the Chair of this dissertation, a 44-year-old, White, bisexual, cisgender woman, who is a counseling psychologist and is an Associate Professor within a Counseling Psychology master's and doctoral program. This auditor has extensive prior experience with the CQR method.

Measures

Demographic questionnaire. Once individuals consented to participation in the study and before their interviews, they were asked to complete a questionnaire. This was sent via email and conducted using the Qualtrics^{XM} survey platform (Qualtrics^{XM}). The questionnaire asked about their perception of their communities' acceptance of intimate relationships between women, current age, race, occupation, income, hours worked/week, educational background, gender identity, and sexual orientation. They were also asked questions about their current relationship including, how, when and in what context they first met their partner, the timeline of their relationship, including the date their relationship became romantic, date moved in together, date/time period of any other major milestones in the relationship such as break-ups/separations and/or milestones indicating increased commitment to the relationship (e.g., moving in together, engagement, marriage, children and children's ages). All participants were asked about the role that the cancer survivors' partner took in the cancer healthcare process since the time of their partners' diagnosis. Lastly, only cancer survivors were asked about their cancer diagnosis, cancer stage, date of diagnosis, cancer treatments received, last date of treatment, and current treatment stage.

Mutual Psychological Development Questionnaire. Participants were asked to complete the Mutual Psychological Development Questionnaire (MPDQ) scale before the interviews, which they received via email and completed in Qualtrics (Genero, et al., 1992a; Qualtrics^{XM}). The MPDQ is a measure of perceived mutuality in close adult relationships that consists of 22 self-report items and measures six dimensions of mutuality: empathy, authenticity, engagement, diversity, zest, and empowerment (Genero et al., 1992a). This measure was conceptualized based on tenets of Relational Cultural Theory (RCT) (Jordan et al., 1991). The authors of the questionnaire defined mutuality as bidirectional, between individuals in a close relationship (Genero et al., 1992a). The scale has two relationship perspectives (subsets), reflective of the interdependence of mutuality, one that measures perception of your partner's empathic responsiveness, and the other that measures perception of your own empathic responsiveness (Genero et al., 1992a). The 22-item scale is divided into two subsets of 11 questions each, such that every individual taking the scale completes all 22 items and psychometrics are based on the 22 items. These subsets each reflect all six conceptual elements of mutuality. Each subset has some positively and some negatively phrased items. The inter-item reliability ranged from .89 to .94. The first subset begins with this prompt, "When we (spouse/partner and self) talk about things that matter to my spouse/partner, I am likely to…", and is followed with 11 items such as: Be receptive; Get impatient; Feel moved; Have difficulty listening. The second subset begins with this prompt, "When we (spouse/partner and self) talk about things that matter to me, my spouse/partner is likely to…", and is followed with 11 items such as: Pick up on my feelings; Show an interest; Keep feelings inside; Change the subject. Each response is scored on a Likert scale with 6-points, ranging from (1) "Never" to (6) "All the time" (Genero et al., 1992a). Then all scores are added and divided by the total number of items. Mutuality scores on the measure may range from one to six, with higher numbers indicating a higher level of perceived mutuality. The MPDQ has two equivalent forms (A and B), and this study utilized Form A only.

Initial validation was conducted in 1992 with two studies, the first of which evaluated psychometric properties and the second assessed test-retest reliability with the administrations taking place two weeks apart. Seventy five percent of respondents completed the survey in an introductory psychology class and others were recruited from community health centers and continuing education classes, all in the Northeast of the United States. Study 1 included 345 respondents, wherein 80% of the sample was White, 77% of the sample identified as women with mean age of 30.6, and 23% were men with mean age of 24.2 years. Seventy percent of the total sample reported being married or partnered. Only responses from heterosexual identified participants were included in the analyses, excluding sexual minority participants, and the authors do not provide an explanation for this research decision (Genero et al., 1992a).

Genero and colleagues (1992b) designed this measure to negatively correlate with depression measures and to correlate highly with measures of adequacy of social support, relationship satisfaction, and relationship cohesion. Those predictions were all supported in the validation study. Some participants in the validation study responded based on a relationship with a spouse/partner and other responded based on a relationship with a friend.

Regarding construct validity, the MPDQ Form A for spouse/partner was correlated with social support ($r = .43$, $p < .001$) using the Multidimensional Scale of Perceived Social Support (MSPSS; Zimet et al., 1988). Using the Dyadic Adjustment Scale (DAS; Spanier, 1976), spouse/partner mutuality was highly correlated with relationship satisfaction ($r = .70$, $p < .001$) and cohesion ($r = .75$, $p < .001$). An inverse relationship with depression was found using the Center for Epidemiological Studies in Depression (CES-D; Radloff, 1977).

Multiple regression analyses were conducted to assess concurrent validity (Genero et al., 1992a). Relational cohesion and satisfaction were most predictive of spouse/partner mutuality, and social support was more predictive of friend mutuality. Social support was not predictive of spouse/partner mutuality. Spouse/partner mutuality was found to be highly predictive of depression in women, but not men (Genero et al., 1992a).

A second validation study with 81 people from suburban communities was conducted over two times points, over a 2-week time lapse. Of these participants, 95%

reported being married and were between 20 and 80 years old. The Form A test-retest alpha for spouse/partner was .87-.90 (Genero et al., 1992a).

The MPDQ has been utilized in research studies, including dissertations, focused on women partnered with women. One article used Relational Cultural Theory to address concerns of lesbian couples who were going through fertility treatment (Rausch & Wikoff, 2017). Others looked at correlates of relationship satisfaction for lesbian couples (Donaldson, 1993), mutuality and relationship satisfaction in the formation of lesbian relationships (Ganiron, 2007), and internalized homophobia in lesbians (Sutherin, 2002). In this dissertation study, the purpose of using this measure is to gather information about the mutuality within each couple, but this will not be used to make statistical inferences as part of the findings of the study. Since its development, this scale has been used extensively in studies about close relationships and women, and it was developed with the contributions of Jean Baker Miller, who is a founder of Relational Cultural Theory (Liang et al., 2002).

Semi-structured interview. Participants completed one audio-taped, semi-structured individual interview separate from their partner (interview questions can be found in Appendix). Interviews explored the following in the context of breast cancer, 1) impact of breast cancer on younger survivors and their women partners with regard to the Relational Cultural Theory (Jordan, 2018) concepts of authenticity, mutuality, relationship awareness, connection, and disconnection, 2) barriers and supports to the sense of connection with their partners, 3) how minority stress may affect the couple's relationship dynamic and ability to feel connected to one another, and, 4) lasting relational changes within the couple. The interviews were planned for approximately 60-90 minutes in length; however, they typically took 75-120 minutes. Participants were asked to choose between completing the interview using the phone or the audio-only feature of Zoom technology. All participants choose audio-only Zoom. Finally, participants were asked to reflect on their experience in the interview and to share any additional thoughts or feelings about the research process.

The interview protocol was developed in stages. Prior to beginning this project, the PI was a part of a research team that conducted a meta-ethnography about the impact of breast cancer on the relational well-being of lesbian and queer women. The findings of the meta-ethnography were used to guide the development of the interview protocol. The PI reviewed the body of research on breast cancer, relational cultural theory, minority stress and intersectionality, couples functioning, and women partnered with women, and used this knowledge to inform the initial set of questions. After receiving feedback from the dissertation Chair and writing the literature review section of the manuscript, the questions were revised. Again, the PI consulted with the Chair, as well as peers and a professor of a qualitative research course and made additional revisions.

As recommended by Hill and colleagues (1997; 2005) four pilot interviews were conducted. The pilot study participants were only selected because they did not qualify for the actual study. The pilot participants were a WPW couple, one of whom has a chronic health problem, and a heterosexual couple, in which the younger woman previously had breast cancer. The value of a pilot interviews was for the PI to practice interviewing and asking follow-up questions, testing technology, and receiving feedback from the participants on questions asked regarding clarity, relevance, and content.

Procedures

Participant recruitment. Participants were recruited by posting solicitations with various organizations as well as by asking people to forward eligible participants. These methods are purposive and partial snowball sampling approaches. Some of organizations that the PI approached regarding recruitment included the Young Survival Coalition, the Tigerlily Foundation, National LGBT Cancer Network, National LGBT Cancer Project, Rocky Mountain Cancer Centers, and Cancer Support Community. The missions of Young Survival Coalition and the Tigerlily Foundation are both dedicated to serving young survivors of breast cancer. National LGBT Cancer Network and National LGBT Cancer Project are dedicated to cancer care and support for sexual minority populations. Rocky Mountain Cancer Centers and Cancer Support Community serve individuals throughout the lifespan and with a broad range of cancers. Interested individuals were asked to contact the PI directly. PI recruitment efforts also included creating Facebook and Instagram pages for this study and networking with organizations and influencers with related interests, to share information about the study. The study details were also shared with over 1,000 people via a post on the PI’s LinkedIn page.

After potential participants made contact with the PI and indicated interest in participation, the PI conducted a screening based on the inclusion criteria and briefly explained the purpose of the study. If they continued to be interested, the PI sent an initial email inviting them to participate in the study. This email included the purpose and structure of the study, the risks and benefits of participation, and eligibility requirements for participation. Once participants confirmed continued interest, they received a second email including a copy of the interview protocol, and a web link to the demographic questionnaire and the mutuality measure, both of which had to be completed before participants' eligibility was confirmed and the interview was scheduled. Participants were required to indicate their informed consent by completing the first page of the Qualtrics^{XM} survey that hosted the demographic questionnaire and the Mutual Psychological Development Questionnaire. Please see the Appendix for copies of these emails, the consent, and questionnaires.

Interviews. Once informed consent was completed, the PI contacted eligible participants by phone to schedule the interview. Interviews were conducted individually, rather than as a couple. Research suggests that this format offers a safe space for participants to articulate their honest perspective of sensitive experiences within their romantic relationship (Loaring et al., 2015). The semi-structured interviews were conducted by the PI using the audio-only feature of Zoom technology. These were audio-recorded as recommended by the CQR method, and took approximately 75-120 minutes (Hill, 2012). Before each interview began, participants were reminded of the purpose of the study and that the interview would be audio-recorded and transcribed. Limits of confidentiality were reviewed, as the investigator is a mandated reporter, and verbal informed consent was established. As recommended by Hill and colleagues (1997), the PI wrote down impressions of each interviewee and the interview process as it unfolded.

Confidentiality and transcription. To protect confidentiality, a code number was assigned to each interview transcription by the PI, which was used throughout the remainder of the study. Interviews were transcribed verbatim except for fillers and stutters, and names and other specific identifying information were removed to protect confidentiality. Participants were emailed their transcript in order to review and approve it before data analysis began. They will also receive a copy of the final manuscript once the dissertation study is completed.

CQR process. As individual interviews were completed, they were transcribed. This was done by the PI and other members of the research team, who were required to complete IRB training. In all cases, the PI checked the transcriptions for accuracy.

Training judges. Judges met with the PI for training on the CQR method, during which a PowerPoint presentation about the CQR research process was reviewed. Before this training meeting, judges were required to read two seminal articles about the Consensual Qualitative Research method to familiarize themselves with the main concepts and procedures (Hill et al., 1997; 2005). These articles were discussed in detail and questions from the judges were answered by the PI. In addition, judges were asked to read several published CQR studies that were recommended by the founders of CQR for training purposes (e.g., Hill et al., 2003; Knox et al., 2003). This content was discussed as a group during the first two to three coding meetings, and on an ongoing basis as needed, to ensure understanding of the CQR coding process.

Bracketing biases/expectations. Prior to coding, which is the data analysis phase of the study, research team members recorded and discussed their biases and expectations that might influence their perspectives about the data, in order to bracket them. The following questions were asked to prompt judges to reflect on their biases related to the topic of this dissertation: What values or beliefs do you have about this topic? How might your demographics, values, or beliefs impact your expectations about the findings of this study? Biases are defined as “personal issues that make it difficult for researchers to respond objectively to the data” (Hill et al., 1997, p. 539). Team members wrote down their demographic data and their reactions, thoughts, and feelings about the research topic. Importantly, the research team wrote down how their personal characteristics might lead to biases about the research questions. Hill and colleagues (1997) define expectations as “beliefs that researchers have formed based on reading the literature and thinking about and developing the research questions” (p. 538). All team members also wrote down their expectations about each research question. During a group meeting, team members discussed their expectations and biases. Judges were asked to bracket, or set aside, their expectations and biases during the data analysis phase. To facilitate this, team members were encouraged to return to the interview data as evidence of their interpretation of coding and to hold each other accountable to actively discuss biases as they arose.

An abbreviated description of the expectations and biases of the research team is included here, in order to put the team into context with the findings. The majority of judges reported that immediate family members had breast cancer, and several judges acted as caregivers for them. Additionally, several judges worked with cancer survivors or their family members providing psychotherapy or other clinical services. Judges reported that these personal and professional experiences may influence their perspectives on the data. Judges agreed to share personal reactions to the data to inform the coding process. Moreover, judges shared their values or beliefs regarding the dissertation topic. Regarding the population, judges stated that the couples' identity as women partnered with women would likely impact their experience within the healthcare system, including possible experiences of discrimination or marginalization. Some judges had more positive perspectives on the healthcare system than others, which were informed by personal experiences, including with cancer care of family members. Judges discussed their biases regarding the impact of healthcare crises, in that these may impact ones' worldview, personality (cognitive and other domains), and relationships. More specifically, judges expected that cancer would impact roles within the relationship and that these roles would have to be communicated to people outside the couple. Judges expected that people outside the couples would make assumptions about their relationship based on their identity. Separately, judges thought that couples' might be treated differently by others than before cancer, meaning that cancer would impact their social circle and ability of the couple/family to be a part of their broader community. Based on personal identities, judges described relative privilege and power in society. Judges recognized an assumption that couples would be out and open about their personal and couple identities in healthcare and other settings. Overall, judges described a positive view of women and women couples and discussed how this bias could impact coding.

Addressing power differentials among judges. Per recommendations by Hill and colleagues (2005), research team interactions were intentionally addressed and attended to, to manage power imbalances and group dynamics within the coding teams. The ideal atmosphere is one where all judges feel comfortable sharing their understanding of the data and personal reactions. For instance, we rotated the order of who talked first as one way to include everyone and reduce undue influence (Hill et al., 2005). Further, those with more designated power, such as the PI, did not take on the role of expert within the group. It is best practice for power issues to be addressed openly before coding begins and throughout the study, as needed, and this was done (Hill et al., 2005). As well, judges were encouraged to discuss their communication style and potential barriers to them being assertive about sharing their interpretations during coding. Judges described a variety of preferred communication styles in group settings. Several judges stated they had a tendency to speak up first, and often, while others reported being quieter or preferring time to process information and multiple ideas before sharing their own perspective. Additionally, judges described potential barriers to sharing their coding interpretations in a group setting, which included a desire to share power, defer to others, or be open to many different interpretations that are presented. Overall, judges reported a desire to attend to the group dynamics during coding meetings and to make space for one another to influence the coding process. The PI attended to who spoke up most and least often, attempting to address these group dynamics when appropriate. The PI and judges agreed to discuss our communication as coding progressed. This approach appeared to be successful, as judges stated they felt comfortable contributing in the group setting and with the coding process overall.

Developing domains. One team of judges coded the interviews of the cancer survivors, and the other team of judges coded the partner interviews. The PI was on both coding teams. Developing domains (i.e., broad themes) was the first step of the CQR process. For this step, teams reviewed the first several interviews together and noted the main topics, or themes, that arose across interviews. These topics became the domains, which were revised on an ongoing basis as more interviews were reviewed and integrated at the domain level. Studies typically have 5-10 domains. In this study, one group ultimately had five domains and the other group had six domains. As each coding team became more adept and the domains more solidified, members began to code each interview for domains individually. The research teams tried not to double-code any data to avoid conceptual overlap between domains. Then the team came together and discussed their coding as a group; revisions were made until consensus about the domains in each interview was reached.

Constructing core ideas. The second step of CQR was constructing core ideas, which means to summarize the content of each domain by interview case, also known as boiling down or abstracting (Strauss & Corbin, 1990). All the interview content for each domain was compiled into one document by the PI and distributed to the teams. Each team member created their own core ideas for each domain, with the goal of staying as close as possible to the interview content and minimizing interpretation (Hill et al., 1997). Basically, each text entry under each domain was summarized or abbreviated, such that a block of text spoken by a participant is abbreviated to three or fewer brief lines, which consisted of mostly the interviewees' own words.

Then team members met to discuss their core ideas until consensus was reached regarding core ideas for each domain. During the core idea coding, it is sometimes necessary to revise the domains to most accurately capture the data from the interviews. As team members developed core ideas, they kept the context of the domain in mind, as well as the context of that particular interview.

Auditing of domains and core ideas. After all domains and core ideas were established by the coding teams, the consensus version documents were provided to the auditor who reviewed the coding against the raw data from the interviews. The auditor ensured that data was accurately placed within the domains, all important data had been captured, and that core ideas were representative of the details within each domain. They also suggested different titles of domains or wording of core ideas, so they were adequately descriptive, yet concise. The auditor provided their comments to the coding teams who reviewed the suggestions together and decided whether to integrate or decline the auditor's comments. Communication between the coding teams and the auditor continued until consensus was reached, at which point these coding phases were completed.

For this study, the auditor was provided materials for the cancer survivor interviews separately from the partner interviews. However, they may have chosen to look at the coding for both groups in a holistic way in order to understand how the data from the two groups was similar or different. The auditor and PI collaborated about their understanding of the data.

Cross-analysis. Up until the cross-analysis phase, the research team had only looked at the data within single cases, or interviews, and had not interpreted data or conceptualized it at an abstract level. The cross-analysis phase is the first time that team members reviewed data across cases. To prepare for the cross-analysis phase of coding, the PI created two documents, one for the team coding cancer survivor interviews, and one for the team coding partner interviews. Each document included all the interview material from that participant group along with the domain and core idea coding that was previously done. These documents were used for the cross-analysis coding phase.

The research teams looked at all the core ideas within each domain, for all participant interviews in that group (survivor or partner), and created categories based on how the core ideas grouped into categories (Hill et al., 1997). Category creation was derived from the data and was generated together as a team for some domains. For some domains, category creation was done individually as a first step before discussion with the team. As with the other phases, discussion continued until consensus was reached, and when differing opinions arose the data was reviewed for clarification. Each core idea was ultimately placed within a category. Categories were divided or combined as the process continued to accurately reflect concepts within the data.

Auditing of cross-analysis. At this stage, the auditor looked at every core idea and determined whether it properly fit under the specified category. Like with the domains and core ideas, the auditor made suggestions about the titles and scope of the categories. The auditor and PI collaborated about their understanding of the data. The research teams integrated the auditor's feedback until consensus was reached.

Reporting the data. After the cross-analysis phase was complete, categories were labeled according to how much they represented the sample. Hill and colleagues (2005) recommend that the terms general, typical, and variant be applied according to their level of representation in the sample. General is used when all or almost all of the participant interviews had the category represented. For this study, all participants in a group (five) were required for the General code. Typical is used for categories that are represented in at least half the cases and up to the number for general. For this study, three or four participants in a group (out of five) were required for the Typical code. Variant is used for categories that are less common, existing in up to approximately a quarter of the cases. For this study, one or two participants in a group (out of five) were required for the Variant code. Given the small sample size in each group for this study, the labels of General, Typical, and Variant are less meaningful than in studies where the total sample being coded together is 10 to 20 cases; however, the labels are still useful as an indicator of how commonly each category was endorsed by participants. In CQR, miscellaneous categories can be created to represent a single case.

Chapter Three: Results

The 5 domains that emerged from the data for the survivors' group were: (1) Connection in the Relationship - Before, During, and After Cancer; (2) Disconnection in the Relationship - Before, During, and After Cancer; (3) Survivor Responses to Cancer-Related Circumstances; (4) Interpersonal and Organizational Influences on Cancer Experience and (5) Interactions with Healthcare System and Providers. The 6 domains that emerged from the data for the partners' group were: (1) Connection in the Relationship - Before, During, and After Cancer; (2) Disconnection in the Relationship - Before, During, and After Cancer; (3) Community Involvement, Advocacy, and External Support Systems; (4) Partner's Role as Caregiver; (5) Partner's Internal Experience and (6) Interactions with Healthcare System and Providers. Before the qualitative dissertation study results are described in detail, background data about the participants will be shared, including demographic information and cancer information. Results from the quantitative measure about mutuality offer background information on the individual participants and couples and will be contextualized. Table 3 in Appendix H portrays how the domain results are associated with the research questions. More specifically, Table 3 depicts the domains that do not directly answer a research question but provide overall context to the results, and portrays which domains answer each research question. Table 4 in Appendix I includes all the domain and category results for the survivor and partner groups, as well as the frequencies of each result, and illustrative quotations. The qualitative description of results starts with domain results that contextualize the findings and are specific to either the survivor or partner experience. Next, the findings related to each research question are described. Under each research question below, the relevant survivors' group results will be presented first, followed by the relevant partners' group results. Lastly, please note that it was necessary to protect the identities of participants within the context of the couples, so that participants could not identify what their partner shared during the interview. As a result, participant identification was changed for the manuscript and a specific description of each couple is not included.

Background Data

Participants' background information will be described briefly. For each participant, gender, age, sexual orientation, racial ethnic/background, annual income, and education was collected. For survivors only, time since diagnosis and breast cancer stage was collected additionally. For couples, length of romantic relationship was collected. To avoid repetition, the results and significance of the scores on the Mutuality Psychological Development Questionnaire (MPDQ) will be presented in the discussion chapter only.

Demographic information. Table 1 in Appendix F presents the participants demographic information. Of the 10 participants, all identified as women. Participants ranged in age from 25 to 50 years old: one 25-30, one 30-35, two 35-40, three 40-45, and four 46-50. Among the survivor group only, at the time of the interviews, one was 30-35, one 40-45, and three 46-50. Regarding sexual orientation reported for all 10 participants, one identified as gay, one as bisexual, one listed only "female," six as lesbian, and one as undefined, as she does not ascribe to any kind of label. One participant identified as

Hispanic, one as Black, and eight as White. In terms of annual household income, five participants reported income between $25,000-50,000, one reported $50,000-75,000, one reported $75,000-100,000, one reported $150,000-175,000, and one declined to answer. Four participants completed a college degree, and six completed a graduate degree. Regarding time since diagnosis, one participant was less than one year, two were 1-2 years ago, one was 2-3 years, and one was 5-6 years. One survivor was diagnosed with stage 0 breast cancer, three were diagnosed with stage 2, and one was diagnosed with stage 3. Three of the couples had been romantically involved for 1-5 years, one for 10-15 years, and one for 15-20 years.

Domains to Situate Survivors and Partners in the Context of Cancer

Three domains emerged from the data that did not directly answer the research questions but provide important contextual information about the survivor and partner experiences. These domains are Survivor Responses to Cancer-Related Circumstances; Partners' Internal Experience; and Partners' Role as Caregiver. These will be described first as they are not directly related to the research questions, followed by the results that more explicitly answered each research questions.

Survivors' Domain - Survivor Responses to Cancer-Related Circumstances. This domain describes how the survivors reacted emotionally, behaviorally, physically, and cognitively to the cancer experience and survivorship. Generally, the results included in this domain represent how the survivors individually responded to cancer and/or how cancer impacted them personally. The categories in this domain are: a) cancer-related emotional reactions, b) altered view of partner or relationship, c) lifestyle changes and d) post-traumatic growth.

Cancer-related emotional reactions. (General). This survivors' category covers the range of emotional responses that survivors described. Generally, survivors reported a wide array of emotions throughout their experience. Within the sample, some similarities can be found in responses at different stages of the process. This section is organized into emotional reactions around the time of diagnosis, during treatment, and post-treatment. Around the time of diagnosis, some survivors reported being calm or lacking a significant emotional response to their diagnosis, which they attributed to shock. Other survivors reported immediate and intense emotional distress due to their diagnosis, which they reported made it difficult to function day to day.

In the treatment period, survivors described feeling anger, intense fear, and frustration about their illness and physical side effects. Additionally, survivors experienced ongoing anxiety, as well as panic attacks or other emotional breakdowns during the treatment period. Survivors cited COVID-19 restrictions as a source of distress and loneliness during treatment because partners could not attend medical appointments, and one survivor who was still in treatment at the time of the interview reported continued disbelief about what she was experiencing.

Generally, survivors described fears about cancer recurrence once their treatment ended. They continued to deal with cancer-related issues and to feel preoccupied about health concerns. One described the ongoing presence of cancer in her life post-treatment by saying, "Does this mean I'm done? They don't ever go 'you are cancer free' so I am kind of like, am I clear? I feel like I'm always gonna be this cancer patient, you know, where I'm always being checked on. I go in every six months to see my oncologist" (P9). Similarly, the youngest survivor in the study emphasized that she will be dealing with the impact of cancer on her life for a long time and stated that others do not appreciate the emotional toll. Along with recurrence fears, survivors struggled emotionally related to their body image post-cancer, which impacted their relationship. Survivors also expressed a sense of pride related to their resilience and recovery process.

Lastly, survivors reported shifts in their perception of their body due to cancer, including positive and negative emotional changes. Some survivors reported increased acceptance, or a feeling of freedom related to their body. They shared the belief that with or without breasts survivors are beautiful and inherently valuable. On the other hand, survivors reported emotional distress about their appearance, and physical changes that caused pain and numbness in reconstructed breasts.

Altered view of partner or relationship. (General). This survivors' category describes how survivors' idea of their partners and/or relationship was impacted by cancer. These results are focused on the impact of the altered perception on survivors, specifically, and not on their partner or relationship, which will be discussed in the more relationally oriented domains, answering those research questions. Survivors reported seeing their partner differently, particularly being more aware of their perceived weaknesses or vulnerabilities. For example, survivors reported more awareness of their partners' tendency to be controlling or demanding, and to suffer from mental health and substance use difficulties due to stress. One survivor stated about her partner, "her mental health has definitely declined" since the cancer diagnosis (P9).

Generally, survivors described an altered view of their relationship. Their changed perspectives were related to changes in their physical/sexual relationship with their partner, and a sense of the relationship being less comfortable or unbalanced. Survivors viewed their relationship as less sexual overall, which contributed to a feeling that something was amiss or unaddressed. Survivors identified the sexual aspect of their relationship as something they hoped would improve over time.

Survivors felt the weight of expectation or pressure after the acute recovery period, particularly related to completing domestic tasks and physical intimacy. Survivors described being on edge or feeling inadequate due to their illness period, and like they needed to do more to make up for all the work their partners did as a caregiver. One survivor described their new view of the relationship by saying, "before all this happened, it was pretty equal as far as both of us contributing to the relationship. I feel a little bit inadequate, I guess, in the relationship right now" (P18). Many survivors reported a desire to regain their capacity and to seek equality with their partner. They felt that their relationship was off balance due to cancer and survivors seemed to feel that they needed to prove themselves or perform in various areas to re-establish themselves as capable.

Lifestyle changes. (Typical). This survivors' category describes how survivors/couples responded to cancer by changing their lifestyle. Typically, survivors improved their health behaviors, including improved sleep routines, healthier eating, more self-care/relaxation activities, less substance use, and quitting smoking. Several survivors noted that cancer slowed them down in terms of daily activities and made their life simpler and more insular. Survivors endorsed less socialization outside of the couple. One survivor described the new values that drove lifestyle change for her and her partner. She stated, “We’re proud of how far we’ve come as far as coping with daily stress and making changes in our lives so that we don’t have to live stressed out all the time. Making our health and our food a priority. It’s pretty cool. We’re a different couple than before and the cancer was most definitely the catalyst for all that because it wakes you up. It shakes your foundation” (P17).

Post-traumatic growth. (Typical). Post-traumatic growth “is the experience of positive change that occurs as a result of the struggle with highly challenging life crises” (Tedeschi & Calhoun, 2004, p. 1). Research on this phenomenon identified five areas where post-traumatic growth may be evident, including positive changes regarding appreciation of life, relationships with others, new possibilities in life, personal strength, and spiritual change (Tedeschi & Calhoun, 2004). In this survivors’ category, almost all survivors noted post-traumatic growth as a result of cancer. The participant who did not describe any of these changes was only midway through treatment and stated that she has not been able to process the experience yet. One survivor reported a rich experience of post-traumatic growth. She stated, “my body tried to kill me in slow motion and I escaped and survived a near death experience… Everything frivolous just falls away. You can see what’s really important and what you want to do” (P17).

Typically, survivors reported increased personal strength, self-identifying as a fighter, resilient, stronger, and more independent than before cancer. New possibilities were recognized and pursued by survivors. For example, they noted how precious time and life are and started to live more in the moment. They began to align their energy with their priorities more frequently, as well, which included pursuing new education, work, and advocacy opportunities. Typically, survivors reported closer relationships with their partner and loved ones and a desire to foster important relationships.

Partners' Domain - Partners' Internal Experience. This partners' domain describes how partners reacted internally to their survivors' cancer diagnosis and process. Categories within this domain describe common emotional responses for partners, empathy as a WPW, and post-traumatic growth for partners. Although the data in this domain does not explicitly answer one of the research questions, it does provide insight into the partner experience. A primary interest of this study was to describe and bring light to the partner experience in cancer care, particularly for partners in WPW couples who are underrepresented in research. The categories in this domain are: a) common emotional responses to diagnosis and active treatment, b) empathy as a WPW during breast cancer and c) post-traumatic growth for partners.

Common emotional responses to diagnosis and active treatment. (General). This category describes common emotional responses for partners to their survivor's diagnosis and active treatment. They described surprise/shock after diagnosis, and difficult emotions during the intense treatment/caregiving period including helplessness, anxiety, confusion, dissociation, loneliness, guilt, anger, grief, and sadness. Generally, partners described a range of negative and intense emotions related to their survivors' cancer process that impacted their well-being.

Partners described a variety of responses after diagnosis. Some reported disorientation due to the contrast between their own strong emotional responses, and their survivors' less obvious reaction to the news. They felt fear and surprise, or shock, initially. Many attributed the intensity of their response and shock to their survivor's young age, and lack of knowledge about the prevalence of breast cancer in younger women. Overwhelming anxiety and sadness were also reported early in the process. At least one partner described a minimal emotional response to the diagnosis. She was focused on getting through each day; however, she was anxiously preoccupied with the long-term implications of the disease process on their relationship trajectory and connection.

During treatment, partners described loneliness, grief, anger, and sadness most frequently. One partner described her loneliness during the treatment period, which was exacerbated by the COVID-19 pandemic, "The isolation was pretty profound. Those winter months were incredibly, incredibly lonely. We would just be home alone together and for the weeks she had chemo she would sleep for like 20 hours a day, for a week, and I was just there" (P15). Partners also reported grief during the treatment period, including unpredictable and frequently changing emotions. One partner described it by saying, "I guess just watching her go through all the…it's like having somebody die in your family. It really is. All those emotions, there's no track. That whole thing about 'oh, you go through these stages,' well those stages come and go as they please" (P10). In addition to loneliness and grief, partners described feeling angry about the cancer and their powerlessness to change the situation. Generally, partners reported a need to attend to their mental health with therapy, medication, or self-care strategies to manage their own distress and get through the toughest period.

Empathy as a WPW during breast cancer. (General). This partners' category describes the role of empathy for partners in a WPW relationship during breast cancer. Generally, due to their shared identity as women, partners reacted to their survivors' diagnosis with fear about their own risk of breast cancer. Based on personal illness experiences, partners also empathized with their survivors about the discomfort of treatment processes and the helplessness of illness. Partners used this empathy to relate and connect throughout the process.

Generally, partners understood their survivor's relationship to their body and related emotional responses. More specifically, partners understood their survivor's connection with their breasts and the distress related to losing them during breast cancer surgery. Partners felt that their shared identity as women allowed them to empathize more deeply and to provide better care than a male partner may have been able to do. One partner described this by saying, "If a dude got his dick cut off, he sure would be upset about it, but somehow, he can't understand how it feels to have your breasts removed. I'm glad she had a female partner during her experience, because at least I could empathize. My body is more the same" (P15). Many partners shared the same sentiment, and another described the benefit of empathy this way, "Because I have breasts and know what it would feel like to lose a part of your body due to something you can’t control, I certainly have more empathy for what she was going through emotionally” (P10).

Post-traumatic growth for partners. (General). This partners’ category describes how all partners experienced various aspects of post-traumatic growth because of the cancer experience. Generally, partners expressed a new appreciation for life due to the cancer process and confronting the mortality of a loved one. Several partners stated they had reevaluated their life and reprioritized what was most important to them, with work, money, and school becoming less of a focus. One partner described how interacting with other cancer survivors influenced her change in perspective and increased appreciation. She stated, “Meeting people that just got a three-month time limit [on life], and to see them smile and say ‘oh, I’m going to have lunch with my daughter’ and stuff like that, it really humbled me as a person and taught me how to genuinely care for what we have” (P16).

Generally, partners described positive changes in their relationships with others due to cancer. Partners described focusing more on their relationship with their partner, being intentional about communication, and getting along better as a result. They reported appreciation for people in the cancer community and finding joy in helping other survivors and partners. Increased empathy for others improved relationships for partners. Examples of personal strength were shared, especially related to partners’ realization of their capacity as an effective caregiver.

New life possibilities and spiritual or existential changes were also present for partners. Generally, partners reported realizing and pursuing new possibilities for their life due to cancer-related changes. For several partners, these new possibilities were in the form of work-related adjustments, either seeking new opportunities or minimizing stress related to work so they could focus on more enjoyable activities. Several partners reported more reliance on spirituality for coping or increased spiritual awareness. One partner completely changed her lifestyle. She reported two years of sobriety from alcohol that was followed by a spiritual enlightenment. She found a sense of clarity and peace about the past and what she wishes she could have done differently during her survivor's cancer experience. Generally, partners reported finding meaning in their survivor's cancer experience and their role as a caregiver. Partners felt as though they were meant to experience these challenging times and to grow from going through cancer with their survivor.

Partners' Domain - Partner's Role as Caregiver. This partners' domain describes partners' role as caregivers including how prior caregiving experiences impacted them, caregiver duties, learning to be a caregiver, navigating competing demands, and difficulty separating from their role as caregiver. The categories in this domain are: a) the impact of prior exposure to cancer on caregiving experiences, b) caregiver duties: domestic, physical, medical, managing relationships, emotional support, c) assessing survivor needs, confusion about how to meet survivor needs, and experiencing helplessness, d) navigating competing demands of caregiving and work/school responsibilities and e) the impact of changing roles, responsibilities, and power dynamics on caregivers.

The impact of prior exposure to cancer or caregiving experiences. (Typical). Typically, partners reported previous exposure to cancer and caregiving, as their mothers or mothers-in-law had also been diagnosed with cancer. Having prior exposure to cancer impacted each of the partners differently when it came to caring for their loved one. One partner cared for her ex-mother-in-law who had breast cancer ten years prior to her survivor. She said, “I was very familiar with the treatment. I was very hands on with her recovery. So strangely, it left me oddly prepared to know what we were getting into” (P15). This partner recalled that her mother-in-law was extremely private about her cancer experience, which she did not think was good for her mother-in-law's well-being. That observation guided the partner and her survivor in their effort to be open about their experiences throughout cancer, which they ultimately found very beneficial. Another partner reported that her mother recently died from cancer. She regretted not being there more for her mother and had a lot of guilt. She thought of her survivor’s cancer as an opportunity to learn this caregiving lesson again and try to get it right, as she put it. Lastly, one partner’s mother was diagnosed with breast cancer shortly after her survivor was diagnosed, so their cancer periods overlapped. Going through everything with her survivor made her more confident when supporting her mother.

Caregiver duties: domestic, physical/medical, managing relationships, emotional support. (General). Generally, partners described aspects of their caregiver duties. Additional domestic chores seemed to be the most disliked duties, including laundry, shopping, preparing meals, cleaning, and managing bills/finances. Partners also reported physical/medical duties including making and attending medical appointments, handling insurance issues, taking notes/tracking information, handling wound/scar care, providing medications, and gatekeeping or monitoring certain activities for survivors to aid healing. On the relationship front, partners handled additional childcare, communicating with family and friends, coordinating offers of assistance, and caring for pets.

Partners spoke with the most feeling about the emotional support they provided to survivors. They seemed to be simultaneously the most proud and uncertain about this type of care. Partners reported wanting to take emotional pain away and attempting to protect their loved ones from emotional stress. They described listening and seeking to understand their survivors’ point of view. Determining what type of emotional care or response would be appropriate in various situations was attended to by partners, often with the goal of maintaining good rapport. They empathized with many of the emotional reactions of survivors. Sharing personal coping strategies or encouraging their survivor to engage in self-care was one form of emotional caregiving. One partner tried to balance her own desire for information and connection with her survivor because she also wanted to respect her survivor’s right to privacy. She described her desire to respect her survivor’s autonomy during the caregiving process by saying, “It feels almost intrusive to make her tell me everything that is going on in her head, because I’m already carrying her to the bathroom and washing her in the shower. So, to take away that layer, like I’m all up in her business. I want to respect some level of privacy” (P16). Partners reported regretting when they were not able to provide appropriate emotional support to their survivors.

Generally, partners reported benefits from their caregiving experiences. They felt capable and proud of their abilities as caregiver. Receiving positive feedback from others was rewarding and positively reinforced their efforts. Learning more about themselves and their survivors was another cited benefit. Several reported gratitude for their survivor relationship during this difficult time.

Assessing survivor needs, confusion about how to meet survivor needs, and experiencing helplessness. (Typical). This partners' category describes how partners learned to become caregivers, including the confusion and helplessness they experienced along the way. Typically, partners likened the experience to feeling like a new mother, lacking the skills and confidence to take care of their survivor at first. Partners used their instincts to guide their caregiving efforts and interactions with their survivor. Partners focused on providing the basic needs of food and drink. They described their attempts to elicit information from their survivor, how they tried to coax and reward them into helpful behaviors and away from harmful activities. Partners reported confusion at times and feeling frustrated and rejected when their survivor did not respond well to their attempts at care. Typically, partners stated that their helplessness about what to do was the hardest part of caregiving. Caregivers noted that if their survivors had been more communicative about their needs or preferences it would have made things easier. One partner described the difficulty she had when there was nothing she could do to help. She stated, "It's just feeling kind of helpless. Like there's nothing you can really do except sit there with her, feeling like you don't really know what to do. That's the hardest part" (P11).

Navigating the competing demands of caregiving and work/school responsibilities. (General). In this category, partners described how they navigated competing demands in their own life after their survivors were diagnosed with breast cancer and how the experience impacted them personally. Generally, partners described an increased workload and responsibilities due to the cancer diagnosis. They continued to work, attend school, and uphold other personal tasks while also caring for their partner. One partner described how she handled the pressure to do everything. She stated, “It almost feels like it hasn’t totally hit me yet because I just sort of went into survival mode about it. It’s just such a whirlwind. I’ve been compartmentalizing everything so that when I’m in school or work, I’m just doing school or work and when I’m seeing her, I’m just seeing her. There’s not really any overlap” (P11). Partners felt pressure to continue working to make money for the couple, even though they were struggling personally. They tried to cancel less important activities so that they could prioritize caregiver duties above all else.

Partners shared this pressurized experience of navigating multiple demands and not having any time to care for themselves. One partner remembers wondering “how do I find the balance there,” but not being able to access more balance, and continuing to work very hard (P16). Several partners reported inability to cope with all the demands, at times, resulting in significant emotional distress and unhealthy coping strategies including excessive substance use and lashing out in anger. Generally, partners felt that their survivors did not realize how much time and energy it took for them to do all the caregiving, or how exhausted and stressed they felt.

The impact of changing roles, responsibilities, and power dynamics on caregivers. (Typical). This partners' category describes how the change in roles in their relationship, as well as new responsibilities and power dynamics within the couple impacted the partners/caregivers, specifically. This description of how partners experienced these changes is meant to inform the later description of how these changes impacted the couples' well-being and functioning. Typically, partners reported difficulty letting go of their caregiver role after active treatment. More specifically, one noticed that it was hard for her not to tell her survivor what to do, especially when her survivor started working again. Therapy helped them navigate this communication problem. Partners noted how they frequently slipped into an emotional caregiver role, exerting energy to remind survivors to ask for help as they needed it. Partners attributed this role to experiencing fear and recognizing that recovery did not happen as expected. For some, partners viewed their caregiver roles as necessary because survivors were unwilling to express their needs. One partner captured this by saying, "I couldn't get her to breach her silence of what she wanted to herself for anything. So, I was having to make all the decisions" (P20). Partners became used to observing their survivor, anticipating needs, and seeking to take care of issues as they arose, and it was not easy for them to change these behaviors.

The proceeding domains provided contextual information about how the survivors experienced cancer and how partners experienced cancer. The focus of this study was on the relational impact of cancer; however, understanding the unique experiences of the groups, separately, was described to inform understanding of the relational content that will be described next. The research questions will be listed with relevant domains and categories (study findings) underneath that answer those questions.

Research Question 1: What is the impact of breast cancer on younger survivors and their women partners with regard to authenticity, mutuality, relationship awareness, connection, and disconnection?

Research Question 4: What lasting relational changes do the couple report due to cancer?

Within both the survivor and partner groups, a domain emerged from the data that captured the origins of connection in the relationships and relational processes that contributed to ongoing connection for the couples. These domains are called Connection in the Relationship – Before, During, and After Cancer. Likewise, a domain emerged in both groups that shed light on relational processes that contributed to disconnection between partners. These domains are called Disconnection in the Relationship – Before, During, and After Cancer. Categories regarding the processes of authenticity, mutuality, and relationship awareness (or lack thereof) are embedded within the connection and disconnection domains for both groups. Results in the connection and disconnection domains also describe lasting relational changes for some couples, and how cancer impacted their perceived level of closeness and commitment to one another. Domain and category results related to disconnection with the relationships will be presented first, followed by domain results related to connection.

Disconnection

Survivors' Domain - Disconnection in the Relationship - Before, During, and After Cancer. One domain emerged from the survivor group data that captured the disconnection in the relationship, before, during, and after cancer. This domain includes how survivors describe the nature of disconnection in their relationship, dynamics that created or maintained disconnection, and specific examples. The categories in this domain are: a) conflict due to changes in relationship dynamics and roles, b) lack of authenticity and communication difficulties contribute to maladaptive relational patterns, c) challenges of interdependence and lifestyle discontinuity and d) challenges with physical intimacy contributed to disconnection.

Conflict due to changes in relationship dynamics and roles. (Typical). This survivors' category describes how cancer created new roles of patient/survivor and caregiver/partner and altered existing power dynamics. Disconnection was described during the treatment phase, as well as after acute illness. One common theme during treatment was disconnection related to poor adjustment to roles. Survivors experienced disconnection because their partners were resentful and overwhelmed with their caregiving responsibilities. One survivor stated, "she'd go in the kitchen and start cleaning and suddenly she'd be slamming cabinets and grumbling… she had to shoulder a lot of the burden and I'm sure there was some resentment. Then I would feel guilty that she was doing all the housework so I would try to do some, and she would get mad at me" (P19). Several survivors reported this pressure to carry more weight in the relationship to ease the burden on their partner or avoid disappointing their partner.

Additionally, many survivors reported that partners had a hard time expressing how difficult caregiving was for them, which made it challenging for survivors to provide emotional support or garner more resources for their partner.

Another role that partners took on during the active treatment period was communicating with their survivors' family. Three survivors reported strained relationships with their family members due to interactions that occurred during this period, which survivors were not aware of until later. One survivor's partner was discouraging help from other family members and the survivor reflected on this period by saying, "I wasn't really sure what was going on, why they weren't talking to me about it or coming around" and the current situation as, "well, my daughter and I are now estranged" (P17). Survivors experienced disconnection and confusion about what happened and anger toward their partner for how the situations unfolded.

Several survivors reported that the couple had problems moving away from rigid roles after active treatment, which contributed to disconnection. Survivors felt like the weaker or less capable woman in the relationship due to dynamics created during cancer and were actively trying to change this through actions or conversations with their partner. Partners perceived their survivors as still needing significant support. Survivors reported that their partners continued to exert control over their health and medical interactions, which they did not always appreciate. Questioning from partners about physical health felt hypocritical and overbearing during the recovery period. Survivors had to defend their right to make independent decisions, which was met with irritation from caregivers. One survivor described relationship conflict related to her decision to change a medication without talking to her partner first. She stated, “She found out like a month later and she got really upset because I hadn’t talked to her about it. But it’s really none of your business, I’m an adult woman” (P17).

Lack of authenticity and communication difficulties contribute to maladaptive relational patterns. (General). This survivors’ category describes how lack of authenticity and openness within the couple and other communication difficulties created and maintained problematic ways of relating to one another. All survivors endorsed examples in this category. Survivors described how their partners withheld authentic feelings, which contributed to frustration and disconnection for survivors. For one couple, the stress of cancer contributed to more frustrated communication including yelling at one another about issues that were not truly the cause of the stress. The survivor is accustomed to her partner’s anger, but the problem was exacerbated by cancer. One survivor described her desire to know what her partner is going through, and the frustration of being closed out. “One stressful thing I can think of is just, you know, her not wanting to share things just because she feels like it's not important compared to what I'm going through, but I'd rather her tell me. I want to know what's going on in her life. Yeah. I don't want to be shut out in that way” (P18).

Survivors also reported withholding authentic communication. Several survivors reported holding back from communication with partners to avoid raising distressing topics, including about recurrence fears. This was framed to avoid stressing their partner; however, it seemed likely that survivors did not want to discuss these topics themselves or preferred to avoid situations where they would have to emotionally care for their partner when they were feeling so ill. Indeed, survivors reported difficulty communicating due to exhaustion, illness, and other symptoms impacting speech, like mouth sores from chemotherapy, which was a general barrier to connection for couples. Communication difficulties related to symptom management was a source of disconnection for survivors, particularly related to eating and drinking water. Survivors reported that their partners did not understand or adequately empathize with their inability to eat or drink, again, often due to illness, sores, and lack of taste. Survivors felt they explained their reasoning but that the issue continued to cause conflict and disconnection. Survivors reported taking things personally when pushed to eat or drink, and that their partners took things too personally, including when prepared food was declined. One survivor described relationship conflict related to her inability to eat by saying, "In her [partner's] mind, I should be able to choke stuff down. I can't just eat something and swallow it. She eventually, you know, doesn't push it, but it's always hard" (P18).

Lastly, a source of disconnection for one survivor was related to how her partner spoke to others about cancer. She felt resentment and distance when her partner used "we" language such as "we are going through cancer," because she felt that her partner was minimizing her experience and pretending to understand. This caused the survivor to hide her authentic experience and lose interest in her partner's experience. Several survivors stated that they did not know how the cancer experience, or aspects of it, was impacting their partners day to day life or internally. For example, one survivor stated, "I guess that's one thing we don't really talk about is how it's affecting her every day. I don’t know if she would tell me that, or if it’s a thing that affects her every day” (P18). This lack of authentic communication contributed to disconnection.

Challenges of interdependence and lifestyle discontinuity. (Typical). Four survivors shared how cancer caused them to become more interdependent with their partner, and that this created challenges. The interdependence resulting from cancer also made it more difficult for the survivor and couple to access their preferred lifestyle and enjoyable activities, thereby contributing to disconnection. Survivors described a desire for more privacy and independence during their recovery period. One survivor stated that going through hardships together and focusing on one another so frequently was getting in the way of taking care of herself. She explained this as, “We are working on kind of like separating ourselves from each other so that we're not as entangled. I don't think we've lost ourselves in each other, but I think that we've, like, been in lockstep together maybe long enough to where it's like, okay, well, now we have to make sure that we're taking care of ourselves” (P9).

Several survivors reported a change in their lifestyle due to cancer. One previously active survivor reported having to ration her energy and prioritizing preferred activities, like art, over chores, which caused disconnection with her partner. Overall, changes in functioning for survivors from day to day was a source of confusion and frustration for partners, as they could not anticipate what activities survivors could or would want to do, including chores and social events. Survivors’ preferences in terms of socializing changed, and this was difficult for partners to navigate. One survivor described how a previously enjoyed weekly social event became a hassle for the couple;

the survivor was reluctant to attend, and her partner was overly accommodating to encourage her to be there. The survivor recalls saying, “I literally don’t care. And, also, I’m going to leave because I can’t handle this… Maybe I was grumpy and angry about stuff when other people were happy, including [partner]” (P12). An additional external factor related to lifestyle was COVID-19. The pandemic changed the social landscape for almost all the couples and forced them to spend more time together than they otherwise would have. Survivors reported that COVID-19 made it hard for partners to cope in their normal ways on their own.

Challenges with physical intimacy contributed to disconnection. (Typical). This survivors’ category describes cancer-related challenges with sex and physical intimacy as described by survivors that contributed to disconnection in almost all the couples. Common issues included less frequent and less gratifying sex, as well as physical or emotional discomfort during intimacy, and loss of shared pleasure. One survivor reported that the couple is worried about the future of their sexual and romantic life because losing her breasts made such a large impact on their intimacy. Another survivor described how cancer changed the couples’ perspective about sex by saying, “I’m very comfortable being breastless around my partner and she is too. There’s no… it’s not a physical… it’s just like there’s a tenderness between us where sex just seems sort of like, vulgar” (P17). Her desire is gone, and she is not bothered by this, but is worried that her partner probably does want to have sex. Many couples reported not being able to rekindle their physical intimacy for some time after cancer.

Survivors described how the lack of physical intimacy contributed to feelings of disconnection. This was captured in one survivor's statement that, "When I first got diagnosed, I had a problem with my chest being touched, and that upset her. Even I didn't want to touch that area, but she took it personally. I made myself, allowed myself, to be touched in those areas. I realized that she needed to be close to me to feel close to me" (P18). The process of reconstruction presented challenges to physical intimacy, as many survivors reported lack of feeling or pain in their breasts afterwards. Due to these issues, avoidance of physical intimacy was endorsed by many survivors, and one described it as the elephant in the room.

Partners' Domain - Disconnection in the Relationship - Before, During, and After Cancer. Like the survivor group, one domain emerged from the partners' data that captured relational disconnection before, during, and after cancer. This domain includes the nature of disconnection from partners' perspective, dynamics that created or maintained disconnection, and specific examples. The categories in this domain are: a) emotional distress for partners causes disconnection, b) changes in survivor negatively impact partner and cause disconnection, c) problematic communication patterns: withholding, lack of communication, angry outbursts, d) disconnection related to lacking physical intimacy, e) new relational dynamics within couples due to survivor and caregiver role adherence disrupts connection and f) focus on issues within the relationship prevents connection.

Emotional distress for partners causes disconnection. (General). This partners' category describes how emotional distress experienced by partners influenced disconnection within the couple. Partners endorsed feelings of worry and fear related to medical information and the uncertainty of their survivors' future health. Partners expressed helplessness, confusion, feeling overwhelmed, and shutting down related to their responsibilities as a caregiver. Partners described not having anything left emotionally to care for themselves or survivors, but they had to continue. Emotional distress was heavy at times for all partners. One partner described how she is unable to manage emotional distress at certain times of the month due to period related hormonal changes, "I feel like, sometimes, I feel I'm carrying this burden on my own, and I just need to deal with it. But then it gets too heavy, and it's really tied to my cycle. When I'm really irritated and agitated and it kind of comes out of my control" (P11).

Changes in survivor negatively impact partner and cause disconnection. (Typical). This partners' category describes how changes within survivors due to cancer such as body image, self-esteem, and emotional distress impacted partners and contributed to disconnection. Almost all partners stated that changes in the survivors' physical appearance negatively impacted survivors' self-esteem and overall well-being. Partners reported providing reassurance and listening to survivors' negativity and complaints, which was tiring at times; yet nothing seemed to help to improve survivors' self-esteem. New and significant difficulty eating for one survivor caused disconnection as she was very distressed by this, so her partner felt guilty for enjoying food around her and they lost a prior source of connection, sharing meals. One partner described how cancer-induced changes in her survivor resulted in disconnection. She stated, "cancer just kind of put a boulder on top of my wife. We lost our loving relationship right after 'no evidence of disease' and that was I feel based mostly on the chemotherapy and she just wasn't the same person. The self-esteem was gone. Not feeling good about your body, you know, can really put a stranglehold on your relationship" (P20).

Problematic communication patterns: withholding of one or both partners, lack of meaningful communication, and angry outbursts. (Typical). Partners described how problematic communication patterns within the couple caused and/or maintained disconnection. Partners recognized how they withheld from their survivors and the perceived survivors withholding from them at various points, before diagnosis and during treatment especially. Partners reported that their survivors did not ask for help when needed/recommended, leaving partners confused about how their survivor was doing, what they were experiencing and how they should try to help. One survivor described this pattern by saying, "I wish that she would have had more of an opportunity to speak up about her feelings, and how she felt while she was going through cancer, the things that were on her mind, the things that she wouldn't talk about, the things that she couldn't talk about, the things that she shouldn't talk about. I wish she would have known that all of those things are perfectly acceptable to talk about at any time" (P20).

Partners also withheld opinions to avoid nagging and withheld their personal stressors from survivors as to not overburden them. A survivor shared this example of why she does not share her internal experience, "I don't share a lot of what's going on with me, as far as what stresses me out because I just don't really want her to worry about it. I don't really feel support from her, but at the same time, I don't ask for it either" (P11).

Partners also described a lack of meaningful communication with their survivors. Some partners expressed a need to each care for themselves, which contributed to neglecting attention, intimacy, and compassion for each other. One partner reported uncertainty about what her survivor knew about her experience and that their communication tended toward superficial topics. Most partners described angry outbursts in the relationship, stemming from perceived survivor resentment, small domestic annoyances turning into arguments about bigger issues, and issues festering for some time and then blowing up when one partner could not hold in her emotions anymore.

Disconnection related to lacking physical intimacy. (Typical). Partners described how lacking physical touch, intimacy, and sexual interactions contributed to disconnection during cancer and well after treatment, for some. Overall, partners described that sex and physical intimacy were a lower priority due to cancer, and that it was a good source of connection previously, as one partner put it, "Our sex life is non-existent right now. We used to have a really good sex life, and that's just not happening. We have really good chemistry and that was a big part of our relationship" (P11). Several partners reported holding back on initiating intimacy because of survivors' withdrawal or rejection, whether spoken about or not, which led to sexual frustration. Many partners stated that physical changes in survivors did not change their attraction or desire for survivors, although they reported that survivors did not really believe them. One partner reported that she had a hard time seeing her survivor in a sexual way for a while, which was challenging for the relationship, and she did not want to threaten the healing process with physical intimacy.

New relational dynamics within couples due to survivor and caregiver role adherence disrupt connection. (General). This partners' category describes problems that arose for the couples due to shifted dynamics, after one was a caregiver and the other was a survivor. Generally, during the treatment period, partners described issues related to their somewhat authoritarian role as the caregiver. For instance, caregivers tried to keep their survivors safe and prevented them from doing certain activities, which partners felt was interpreted as anger or with resentment by survivors. Partners felt a sense of responsibility in this role. Survivors' shifting levels of dependence on caregivers complicated this situation further, as survivors wanted more autonomy and were able to care for themselves more effectively on some days yet required more physical or emotional help on other days. Partners observed that the chemotherapy schedule often contributed to this fluctuation in functioning. One partner stated that her cancer-related opinions as caregiver were frequently dismissed, which disrupted their connection. In several cases, partners provided caregiving that was problematic or not aligned with what their survivor needed. They wished that survivors could be in their shoes for a day.

Partners described a general sense of difficulty re-adjusting their relationship dynamics after cancer, and that it took time in fits and starts. One survivor abruptly dismissed a partner as their caregiver, a rejection that was very hurtful and unexpected. This partner felt that their relationship was more as friends and companions during treatment and that they lost their loving relationship. They were newly separated at the time of the interview.

She said, “You know, she stopped seeing me as her wife, her partner, her friend. You know, because I was the caregiver. I’m so much more than that” (P20).

Focus on issues within relationship prevents connection. (Typical). This partners’ category describes how when couples focused on issues within the relationship, they tended to feel more disconnection. Examples include cohabitation irritations, conflict about treatment or recovery issues, codependency, or lack of boundaries. Several partners reported a goal of regaining some separation from one another post cancer. One partner stated that their survivor was diagnosed with codependency by her psychotherapist early in the COVID-19 pandemic and their cancer experience, which has created significant confusion and distress for the couple regarding their relationship. Partners reported that tension with extended family members, exacerbated cohabitation issues, and ongoing medical problems for both partner and survivor were sources of continual disconnection. One partner reported, “Medical issues are what creates are biggest bonder and our biggest disconnector. Bonding in the way that we both do kind of jump in, try and tackle it. But we’re also in a sense feeling hopelessness as the caregiver” (P16).

These results related to disconnection in the relationships highlighted how a lack of authenticity, empathy, and ability to adjust to new cancer-related circumstances contributed to significant disruption for couples. Partners and survivors described similar challenges and frustrations from different perspectives that led to disconnection between them. Couples described lasting changes in their relationships and interactions because of cancer-related disconnection.

Research Question 1: What is the impact of breast cancer on younger survivors and their women partners with regard to authenticity, mutuality, relationship awareness, connection, and disconnection?

Research Question 4: What lasting relational changes do the couple report due to cancer?

Connection

Survivors' Domain - Connection in the Relationship - Before, During, and After Cancer. Research questions 1 and 4 explored connection in the relationships. Within both the survivor and partner groups, a domain emerged from the data that captured the origins of connection in the relationships and relational processes that contributed to ongoing connection for the couples despite cancer. The results from the survivors' group about connection will be presented first, followed by the partners' group results. This domain includes how survivors describe the nature of connection in their relationship, dynamics that created or maintained connection, and specific examples. The categories in this domain are: a) relationship history and the impact of cancer on closeness and commitment, b) relationship awareness: understanding and interacting through the lens of cancer, c) authentic, open, and frequent communication, d) mutual empathy and empowerment are avenues for connection, e) couple coping contributes to connection and f) the downside of connection.

Relationship history and the impact of cancer on closeness and commitment. (Typical). This survivors' category explains the relationship history of the couples and how cancer impacted their level of closeness and commitment. Couples had been together for varying amounts of time before cancer and were in different commitment stages. Three of the five couples became more committed to one another during the cancer process, as two couples were married, and one couple became engaged since the cancer diagnosis. The other two couples maintained their commitment level, one as married and the other as dating. One of the married couples was temporarily separated at the time of the interview.

Some more background information about the couples may be beneficial to understanding the overall group of participants. Two of the couples had known each other for 20+ years. The survivor in the longest romantic relationship reported that their longevity contributed to communication, understanding, and expected resilience through difficult times. They saw cancer as a rough period that did not fundamentally change their relationship. For the other long-term couple, cancer changed everything, and the survivor reported that it was impossible to return to their dynamic prior to cancer. The other three couples had been romantically involved for approximately 5 years or less, several significantly less. One of these couples was newly engaged at the time of the interview and described the positive impact that the cancer experience had on their relationship. "We are officially engaged. It's almost like we're marching forward, but we're marching forward into something new. I don't think there's a way to go back to whatever was pre-cancer… but I also don't think that's necessary or good. We learned so much through this process and we want to take that into our lives in the future" (P12). Another couple had been together for three years and was newly married. Her diagnosis was only about a year after meeting her partner. The fifth couple had also been together for a comparably short time and had not discussed any formal commitment to one another in the future. Many of the survivors reported that the couple approached cancer and other issues as a team, tackling challenges together. Two of the survivors were previously married to men. Two survivors have children, one from their prior marriage to a man and one from their current marriage with their woman partner.

In all cases, couples reported increased closeness because of cancer. Several factors were cited as making the couples closer and their relationships stronger: more time together, getting to know each other better, practicing more patience, and sharing an us against the world mentality, which they attributed to going through cancer together. Many survivors stated deep appreciation for the commitment of their partners through cancer, and their willingness and ability as caregivers. As one survivor explained, “It was an extended period of time of her taking care of me in that very specific way, I think, was another form of closeness, like I have no idea how she did it” (P12). These factors were particularly potent for the survivor group in terms of an increased sense of closeness.

Relationship awareness: understanding and interacting through the lens of cancer. (General). This survivors’ category describes how, generally, couples thought about their partner and their relationship through the lens of cancer and how their behavior changes due to the context of cancer created lasting changes for the couples. Survivors described how new types of physical intimacy including caregiving and related communication was utilized. The category also includes intentional changes to accommodate cancer, how new interests, activities, and values were pursued, and how cancer-related changes at the individual and couple level were approached.

Survivors described how they worked together with their partners to adjust their types of intimacy and activities. One survivor described their shared understanding of how and why their romantic life had changed for the worse and since there are no immediate solutions, they were addressing it together so they could maintain a safe and secure sex life. Generally, survivors reported expanding the definition of intimacy and being aware of other ways they could feel connected during cancer treatment, such as cuddling, which was beneficial for their connections.

Couples became aware that cancer created the necessity for new shared activities and values to maintain their relationship and enhance connection. Survivors reported practicing deep breathing and yoga together, exploring spirituality, listening to music, going for drives, and playing with pets. A renewed focus on overall health was reported by survivors. Love and intimacy during caregiving was a point of connection for many survivors. Generally, survivors shared that acknowledging how things have changed since cancer was helpful for their connection. For example, one survivor said, “she obviously hasn’t been getting one hundred percent from me and I can’t contribute one hundred percent because of what I’m going through. I tried to put myself in her shoes and I know it can be frustrating when you’re not getting what you need in a relationship. We’ve talked about it, and she understands” (P18).

Authentic, open, and frequent communication. (General). This survivors’ category describes how authentic, open, and frequent communication was utilized to enhance or repair connection. All survivors described examples in this category including the purpose of their communication within their relationship. Generally, survivors reported increasing the frequency of their communication due to cancer and working on openness when communicating. One survivor described how cancer changed their ability to communicate honestly. She stated, “Let’s take an honest question like this and be able to sit down and talk about it, no, I don’t think we would have been able to do that or have been interested in even tackling something like that, because it would be too honest. If anything has happened in our relationship [since cancer], it has gotten a lot more honest” (P17). Survivors stated that practicing authentic communication was challenging, but overall beneficial to their relationships. Survivors stated that when their partners approached communication in an easygoing manner it was easier for them to be open about emotional topics such as physical intimacy as well as practical topics like financial budgeting. Generally, survivors reported feeling connected when they expressed worries about their partners’ commitment because of cancer and received reassurance about their partners’ love and affection.

One survivor epitomized the complexity of open, frequent, and authentic communication when managing the physical and emotional impact of cancer, while also attending to their partner’s emotional needs. This survivor described how she and her partner are both emotional and sensitive people, so she approached communication with this in mind to avoid unintentionally hurting her partner’s feelings. She tried to be responsive to her partner’s phone outreach during the day, even when she felt very sick, and initiated difficult conversations when her partner seemed to be upset, which helped resolve tension.

Mutual empathy and empowerment are avenues for connection. (General). This survivors' category describes how exhibiting an attitude and behaviors of mutuality supported connection during the cancer process. All survivors shared examples of how both they and their partner exhibited empathy and empowerment. Generally, survivors stated that their partners, due to their shared identity as women, really understood their distress about changes with their bodies and appearance during cancer, and when survivors were trying to decide on a flat or reconstructed surgical outcomes. As explained by one participant, "The biggest advantage to being with a female partner was that she really was able to understand where I was coming from and that kind of agonizing over what [surgical] decision to make. She was very quietly supportive and was able to weigh in as far as, I know what you're feeling" (P9). Generally, survivors described having empathy toward their partners during the cancer process, as well. Survivors expressed empathy for the fear their partners experienced given their own risk of breast cancer and regarding the challenges of caregiving, including navigating care coordination and challenging conversations with friends and family.

Several survivors described being empowered by their partners to take the lead in cancer-related advocacy work and to practice self-care. Generally, survivors empowered their partners related to caregiving decisions during illness, despite the vulnerability this required. One survivor stated that she typically did not like to relinquish control, but that when it came to caregiving decisions, she told her partner "I trust you one hundred percent, I'm okay with it, so it was definitely a learning moment for us" (P12).

Couple coping contributes to connection. (General). This survivors' category describes how survivors endorsed adaptive coping mechanisms to enhance connection during cancer. Generally, survivors stated that using humor was beneficial for connection during stressful treatment moments, as well as for adjusting to new situations after cancer. Survivors endorsed enjoying time together and relaxing as effective for coping. Others reported that spending time apart ultimately increased coping and connection as well. Survivors stated that reflecting on their journey as a couple was a form of coping, along with appreciating strengths. Participating in cancer advocacy work or support groups together contributed to connection for several couples.

Cancer was a catalyst for proactively addressing maladaptive individual and couple coping problems that existed before cancer. For example, survivors described coping by avoidance, shutting down/withdrawal, yelling, working too much, and substance use. As a result of cancer, these tendencies were brought to the surface. One survivor reported concerns for both herself and her partner that they decided to address due to the cancer and is a source of connection. She stated, "So we both are now in recovery. She's stopped drinking and I'm a recovering co-dependent. It's been really refreshing" (P17).

The downside of connection. (Typical). This survivors' category describes how the cancer experience led to too much connection between some of the couples. Typically, survivors described enmeshment, over reliance, lack of boundaries, codependence, and fear of separation, as well as how they understood this issue and made attempts to remedy it. Survivors reported that going through such a challenging experience together made them feel codependent or enmeshed with each other. Survivors reported being overly reliant on their partner after becoming accustomed to so much support during active cancer treatment and feeling anxious during separations or when alone. Coexisting with this feeling of too much closeness was survivors' desire for more equality in their relationships. Survivors worked with their partners to set boundaries, respect personal space, and try not to ask too much of their partners. One survivor explained, "I think we're still trying to figure out how to get back to an equal, a fully equal partnership. I'm thinking, like how do I reduce my reliance upon [survivor] in this moment" (P12)?

Partners' Domain - Connection in the Relationship - Before, During, and After Cancer. Like the survivor group, one domain emerged from the data that captured the connection in the relationship, before, during, and after cancer from the perspective of the partners. Research questions 1 and 4 explore connection in the relationship and seven different categories, or subthemes, will be described below along with exemplary partner quotations to describe these findings. The categories in this domain are: a) history of connection, shifts in commitment, and longevity of relationship; b) relationship awareness, intentionality, and accommodation during cancer; c) mutual empathy and empowerment contributes to closeness and connection; d) authenticity and beneficial communication; e) managing stress and healthy couple coping engenders connection; f) connection via physical engagement and finding new avenues and g) developing relationship strength and resilience due to adversity.

History of connection, shifts in commitment, and longevity of relationship. (General). Partners described the initial connection they had as a couple, what their relationship was like before cancer, and how cancer impacted their activities and social life. Generally, partners shared how the vulnerability of cancer made their relationship more emotionally deep, serious, or accelerated their commitment to one another. Three of the five partners reported increased commitment to one another in the form of marriage engagement or marriage right after diagnosis, during treatment, or briefly thereafter. One couple had not discussed their future together, and one couple had been married for nearly two decades. Partners commented on how the longevity of their relationship was a factor in their cancer experience; however, it did not seriously disrupt their sense of commitment regardless of relationship length. One partner described this by saying, "We've had the luxury of having been together for a long time so we've also had a lot of experience before this. I don't think there's an overreaching arc [of change from pre to post cancer] and this could just be a product of us having been through so much for so long, it feels like one big hurdle we are still kind of hurtling over" (P10).

Relationship awareness, intentionality, and accommodation during cancer. (General). Partners described how they made adjustments to their relationship patterns, expectations of one another, and interactions during cancer in order to make continued connection possible given the circumstances. Generally, partners reported intentionality around being less social with friends, traveling less, and focusing more on their survivor during cancer. The COVID-19 pandemic was also a factor for many partners, as they were very aware of the risks of infection and took extra precautions to protect themselves and their survivor, which increased isolation for partners.

A number of partners described intentionality in seeking connecting even when they were not feeling very close and minimizing distractions like phone and work stress. One partner described the benefit of being more intentional about spending time together, "we've been able to just have our evenings together a lot more than we did in the past. It feels almost like comfortable dating again sitting on the couch and watching TV. I realized not checking my phone is not something that I'll regret on my deathbed" (P10). Partners explained awareness within the couple of how tasks and domestic work was being divided and reflecting on the situational factors causing increased workload for partners.

Mutual empathy and empowerment contributed to closeness and connection. (General). Generally, partners described how the cancer experience elicited empathy and empowerment within the couple, and/or how these features are a part of their relationship fundamentally. For partners, empathy sprung from shared grief related to the physical impact of cancer and breast loss. Partners also reported that shared backgrounds, family issues, and lived experiences created the basis for empathy. One partner described this for her and her survivor, "The overlap of mental illness in our families, life experiences, growing up in a conservative place, and less wealthy, I think that creates a lot of compassion for both of us for the other one and really helps us support each other in more fundamental ways" (P15). Partners described being a source of empowerment for others in their life due to how they approached cancer together. Generally, partners felt empowered with the love and care from their survivors. Advocacy for one another, particularly in medical settings, and providing positive encouragement to one another were empowering, as well.

Authenticity and beneficial communication. (Typical). Partners described how authentic sharing of thoughts and feelings during the cancer process encouraged connection. Typically, this type of beneficial sharing was evident regarding vulnerable situations and more practical issues. Partners described external factors that contributed to authentic communication, including needing to collaborate on physical caregiving and making decisions about how to navigate the health crisis. One survivor described how cancer increased their communication and authenticity, “We’ve kind of reached that point of you’ve seen me in a place that I’ve been my lowest and that I’ve been helpless and don’t really know what to do. Even in the short time that we’ve been with each other we’ve had conversations that I haven’t ever had with family members. It makes it feel like we’ve known each other for so much longer” (P16).

Typically, partners reported more ongoing dialogue as a result of cancer, including checking in to see if they are on the same page frequently. Partners explicitly reported fighting less often and being more sensitive about how they are communicating compared to before cancer. One partner stated the positive impact of more thoughtful communication, “We’re probably more careful with each other, maybe due to understanding each other better, we’re less likely to say the things that incite and more likely to say the things that affirm” (P15). Several partners reported that preparing for authentic communication opportunities was helpful. For several partners, preparing for this interview was a helpful prompt for authenticity and for another partner talking with a child therapist helped them prepare for communicating with their kids about cancer and changes to expect for a period of time.

Managing stress and healthy couple coping engenders connection. (General). Partners described a variety of strategies they used with their survivors to navigate stressful situations and cope as a unit. Generally, partners noted how they used humor and lighthearted interactions to cope and connect with their survivor, at home and during medical treatment. One partner described the benefit of using this strategy at home, “We were very lighthearted and very, very playful at home. So that was helpful in kind of easing up some of the seriousness of everything” (P16). Another partner reported the benefit of lighthearted interaction while they were together in the medical treatment facility, “There wasn’t a need for deep conversation. It could be unemotional and like, ‘oh my gosh look at that lady’s red shoes, aren’t they gorgeous’. It was very lighthearted conversation, which was way more beneficial” (P20). Partners shared additional coping strategies that enhanced connection, including figuring out how to manage wound care and pain together, grieving together, practicing calm communication during crises, and sharing relaxing activities. Several partners utilized effective thinking strategies to cope, including assuming positive intent and that their survivor was doing their best, and for another thinking about cancer as a temporary problem was effective on tough days.

Connection via physical engagement and finding new avenues. (General). This partners’ category describes how identifying new ways to connect physically was helpful for partners in remaining connected to their survivors. Two subcategories emerged from the data in this partners' category, and they are: 1) closeness via physical caregiving, and 2) adjusting physical intimacy. Generally, partners described wound care as a time to check in and provide emotional care at the same time. Along the same lines, the physical caregiving process during bathing increased intimacy and comfort with vulnerability for partners. One partner described the impact of physical caregiving on connection by saying "It did make me feel stronger as a partner, as well, and it made me feel like we did come closer and that we just kind of figured it out as we went… just trying to shower but not get this part of your body wet or making sure we put the bandages on the right way" (P16). The second subcategory was connection by adjusting physical intimacy. Generally, partners described a lack of sex or playful touching due to pain, so they planned other ways, such as holding hands, cuddling, and more casual but frequent touches during day-to-day activities to maintain connection. One partner described the intentionality behind their new ways of connecting by saying, "Since her recovery we've been working on, not necessarily different erogenous zones but different places to touch and touching regularly. Sometimes it's been requesting it, holding hands or shoulders or gentle kisses or caresses. It's not overly, you know, sexual" (P10). Several partners stated that sex is still a good way for them to connect after their survivor healed from surgery, but that they have made adjustments to account for lack of feeling and discomfort for their survivor due to surgery.

Developing relationship strength and resilience due to adversity. (Typical). Typically, partners described how overcoming cancer-related obstacles helped them build strength and resilience for themselves and their relationship. Further, partners stated that tackling problems together and overcoming hardship as a unit is a part of their love story. One partner shared a good metaphor for overcoming challenges, “We have a great partnership and we really, we’ve been through a lot together, even beyond cancer, and I think that’s made us… it feels like it was forged in fire” (P15). Partners also noted how along with resilience from cancer they also recognized the fragility of life, one another, and the relationship, which contributed to more and deeper appreciation for getting through adversity. One partner stated, “It is a bit of, wow, something could happen to either of us at any given moment, so maybe we should try to enjoy what we have as much as we can” (P10).

These results have described the myriad ways in which survivors and partners were connected throughout the cancer process, and the processes that contributed to their connections. Couples described strong relationship foundations. They adjusted to cancer with intentionality and learned new ways of communicating, coping, and being intimate to maintain connection. Despite hardship due to cancer, many participants described increased closeness and commitment resulting from the experience.

Research Question 2: What are the barriers and supports to the sense of connections between women partnered with women in the context of breast cancer?

Research question 2 explored the barriers and supports to the sense of connection between WPW in the context of breast cancer. Within both the survivor and partner domains, a domain emerged from the data that captured the external factors that contributed to more or less connection for the couples. The relevant domain for the survivor group is called: Interpersonal and organizational influences on cancer experience. The relevant domain for the partner group is called: Community involvement, advocacy, and external support systems. The results from the survivors' group will be presented first, followed by the partners' group results.

Survivors' Domain - Interpersonal and Organizational Influences on Cancer Experience. This survivors' domain describes how people (e.g., friends, family) and organizations (e.g., cancer organizations, work, school) provided support to the survivor and/or couple during cancer. It also includes lack of support or interruption of support from these sources. For survivors, external support and/or lack of support impacted their connection with the partner, which will be highlighted throughout the description of these results. The categories in this domain are: a) sources of support impacting cancer experience, b) sociocultural issues contribute to difficulty navigating adjustment to cancer and c) loss of support, lacking support, unhelpful support, and barriers to support.

Sources of support impacting cancer experience. (General). This survivors' category describes two primary sources of support for survivors, which are broken into two subcategories that are: 1) support stemming from personal relationships (family, friends, neighbors, etc.) and, 2) support stemming from organizations (support groups, nonprofits, religious community, school, work, etc.). Generally, survivors endorsed having at least one type of support. Survivors reported that family members were useful sources of support, including mothers, sisters, cousins, parents, as well as nieces and nephews. Family members who previously had breast cancer were especially helpful to survivors as they navigated the treatment decision-making process. Survivors reported that financial support and childcare assistance from family members were also much appreciated, decreased stress, and allowed them to spend more relaxed time as a couple, increasing connection. One survivor described the high cost of health insurance for she and her partner and receiving financial support from family by saying, “It was crazy expensive and very quickly we went through money. Our family sent us money and it was lovely, but it was also like, this is not sustainable” (P12). Friends were cited as helping with transportation to appointments, emotional support, and support related to reconstruction decisions.

Survivors reported a variety of organizational supports including virtual and in person breast cancer support groups, employers, graduate schools, and religious communities. One couple was well supported by a lesbian couple who they met in a cancer group. Survivors reported great appreciation for employers and graduate schools who exhibited financial generosity and flexible support throughout treatment. A religious community was surprisingly helpful for one survivor and provided connections to other survivors, a meal train, and childcare support. One survivor described the empathy the couple received at a camp for cancer survivors and their caregivers. She said, “It was so awesome. It was the best. I didn’t realize I was going to be the most recently treated and everybody was like, oh, man, you guys had to go through that during COVID, that sucks” (P12). The connection within couples was enhanced due to the supports described. For example, the opportunities for survivors and partners to experience support together allowed them to process their cancer-related experiences, reduce isolation, and receive empathy from others. Generally, for survivors, receiving support outside of their relationship eased the caregiving and emotional burden on their partners and relieved tension in the relationship.

Sociocultural issues contribute to difficulty navigating adjustment to cancer. (General). This survivors' category describes sociocultural challenges related to cancer that negatively impacted adjustment for survivors and couples. Generally, survivors reported difficulties with assumptions about their appearance, toxic positivity, negative social media stories, heteronormative assumptions, insensitivity of strangers/acquaintances, and lacking resources for WPW coping with cancer. Survivors were bothered by insensitive language use related to cancer including referring to survivors as a "fighter" and "warrior" and they struggled when others commented on their age as a survivor, as in, "but you're so young".

Overall, survivors reported heteronormativity as a primary problem. Survivors noted the lack of support groups for their partners and few other WPW in groups they attended. Survivors reported difficulty finding any literature or blogs about women partnered with women and cancer, and nothing about physical intimacy for WPW. Heteronormative content made them feel alone. One survivor described how heteronormativity made her feel when she stated, "I have to wave the lesbian flag. It just feels uncomfortable and like I'm some kind of figure representing a group and I just have a question about myself that I'm hoping somebody has an answer to" (P12). Survivors stated that their WPW identity impacted them in medical and non-medical settings, as they found assumptions of heterosexuality difficult to navigate, and corrections disruptive to connections with others. Unfortunately, some survivors found a lack of acceptance within the lesbian community, as well. One survivor stated that, “the lesbian breast cancer support group is incredibly unsupportive of people who don’t go flat! That forced me into the straight groups for advice. Very negative vibe for me” (P19). Along the same lines, one survivor reported receiving support from trans friends and straight friends who had undergone elective mastectomies and found this challenging since their experiences in pursuing a desired outcome were so different from her own.

Generally, survivors described how sociocultural issues contributed to their difficulty accessing supportive resources related to their cancer experience. Further, sociocultural issues negatively impacted their interactions with providers, strangers, and friends, inhibiting a sense of connection. Survivors experienced increased isolation, confusion, and inauthenticity due to these challenges, all of which may have a negative impact on mood and interpersonal relationships, including with partners and family members.

Loss of support, lacking support, unhelpful support, and barriers to support. (Typical). This survivors’ category describes challenges and disappointments related to support during cancer. Typically, examples are related to family members and online support networks. Survivors described a range of challenging family relationships, including parents who were dysregulated because of their own cancer history and family failing to show support because they were partnered with a woman. Others noted disappointment and frustration about the type of support their families offered, which was complicated by partners’ interferences with their family relationships and fears that their families would be demanding rather than supportive. One survivor described the negative impact of unhelpful family support on her emotional well-being as, “my parents are wonderful people and we’re very close, but I’m constantly taking care of them. I’m ready to put it behind me emotionally and they’re still hung up on it, like ‘should you get second opinions, are you sure you don’t need chemotherapy or radiation or tamoxifen, what’s your prognosis? It’s very worrying” (P19). Unhelpful support from family members and related distress or anxiety may cause conflict in relationships. Additionally, survivors noted that a barrier to support was feeling uncertain about sharing in online support networks due to awareness of more conservative members, and fear of judgement of her WPW relationship. Fear of judgement about being in a WPW relationship can engender internalized stigma and negatively impact the couple connection.

Partners’ Domain - Community Involvement, Advocacy, and External Support Systems. This domain describes support outside the relationship that was accessed or unavailable during the cancer process. The categories in this domain are: a) involvement with cancer or community organizations, b) helpful support from friends and family, c) couple connection enhanced by interactions with external sources, d) support and challenges related to work and school systems and e) unhelpful support from friends and family. It describes how partners and couples interacted with community organizations, family, friends, school, work, and advocacy efforts.

Involvement with cancer or community organizations. (Typical). This partners’ category discusses ways in which partners/couples were involved with cancer or community organizations, and the function of their involvement. Typically, partners described advocacy and giving back to others in the cancer realm. The formality of partner advocacy efforts ranged, as one supported her survivor to increase the rights of breast cancer patients in the medical setting and another spread awareness about preventative screening via social media among their large social network. Partners reported that collaborating with their survivor on advocacy efforts helped them connect and supported their survivor's healing. Partners shared their own experiences and that of their survivor in their advocacy efforts to benefit others. One partner stated that her survivor made an impact in an advocacy community that was fighting for "new coding on the medical billing paperwork, to have an option that reads 'flat' mastectomy," as her survivor did not receive the surgery she wanted (P20).

Partners explicitly stated that they or their survivor had received support from a cancer organization. One cited effective support groups for survivors about exercise, processing the cancer experience, and personal growth after cancer, which she believes helped the survivor's self-esteem. Another partner described attending an outdoor "cancer camp" that she and her survivor went to with other survivor/caregiver pairs, and they found it tremendously helpful. Partners also gathered helpful information from cancer organizations on social media, although social media content was also distressing, at times. Partners noted that being younger in the cancer community improved their ability to benefit from social media. Typically, partners reported that their survivors benefited most from involvement with organizations, and they did not describe any partner-specific support received.

Helpful Support from friends & family. (Typical). This partners' category represents partners' description of helpful support received from friends and family.

Partners reported receiving either financial assistance, emotional assistance, or food preparation assistance from friends and family of the couple. One partner reported the benefit of receiving emotional support from her own family, “My parents have been really supportive of just me and my process, which I think has helped me be more present for her [survivor]” (P11). Another benefit of support for partners was having more time to take care of themselves and learning more about their survivor’s family. Typically, partners reported that the couple received some help from friends and family but did not report an overwhelmingly supportive response from their personal networks.

Couple connection enhanced by interactions with external sources. (General). This partners’ category focuses on how the connection between couples was enhanced by interactions with healthcare providers in treatment settings, family and friends, and strangers. Many partners reported feeling respected as a unit and more connected to their survivor because of positive interactions with healthcare workers. Specifically, partners reported more connection after talking about their cancer-related life decisions with providers, connecting with nurses during treatment, and receiving advice, reassurance, and praise for their caregiving.

Outside of the healthcare settings, partners reported that helping family members and receiving help from family united the couple. One partner described how domestic support helped the couple, “her [survivor’s] mom does a lot for her and stuff for me too that makes it nicer for the two of us, so we don’t really have to worry about cleaning and taking care of the dog, and it gives us more time to connect and have quality time” (P11). One partner reported that their neighborhood is full of established, long-term couples who share stories of hardships they have overcome. This insight from other couples has been reassuring, as one partner notes, “It’s very nice to know that it is a strong relationship and everything else that we can encounter will be much smaller than the things that we’ve hit already” (P16).

Support and challenges related to work & school systems. (Typical). For this partners' category, partners described the support and challenges they experienced with work and school while managing home life and caregiving responsibilities. The most supportive aspect of work and school was when flexibility was availability. Partners reported that flexibility in these settings allowed them to prioritize caregiving and continue to make money or progress toward their educational goals. On the other hand, partners reported work-related challenges that negatively impacted the cancer experience, including loss of income due to pursuing a less stressful/toxic position, loss of benefits shortly after their survivor was diagnosed due to COVID-10 related job loss, and job inflexibility that regrettably caused a partner to miss medical appointments. One partner described the efforts she made to accommodate cancer-related healthcare needs as she was losing her job. “When I was getting fired, I looked at my boss and was like [survivor] has cancer. He agreed to cover the cost of COBRA insurance for a few months in the severance package, and I took money from retirement accounts but didn’t get as much cash as we needed to” (P15)**.**

Unhelpful support from friends & family. (Typical). Some partners reported unhelpful support from family and friends. Two main subcategories emerged from the data in this category, which are: 1) family issues/dynamics exacerbated by cancer, often increasing stress for partners, and 2) lack of support/access to support, or burden of requesting it. Regarding the family issues/dynamics subcategory, several partners stated that their survivor had codependent relationships with their family members, which made it challenging for them to navigate family relationships while caring for the survivor. One partner described the challenging dynamics, "Survivor wasn't able to tell them, hey, can you come over and do such and such for me? Or for us? So, by not being able to do that, that did leave me with a lot to do" (P20). Partners described the internal struggle and relationship strain of dealing with family members who provided unwanted company or help. At times, family was present, but caused more work or provided unwanted help, resources, or input. They stated that relationship strain, conflict, and hurt feelings continued after cancer treatment.

The second subcategory describes lacking access to support for partners, or the perceived burden of requesting support as a partner. Typically, partners found it burdensome having to ask for specific types of help and coordinating help from others. They felt that the caregiving process was up to them, and others did not know what to do. Partners stated that the COVID-19 pandemic made it more challenging to access support from friends as they could not do their normal activities easily. One partner stated, "We only see each other because of COVID so that's intense that we only see each other, a lot. You know, I don't really have social contacts outside of the relationship right now" (P11).

Overall, support from friends, family, healthcare providers, work, school, cancer organizations, and strangers facilitated their connection as a couple. On the other hand, unhelpful support, sociocultural issues, and difficulty accessing relevant help were disconnecting factors for couples going through cancer. At times, couple connection benefitted from direct and tangible support; however, more often it seemed that survivors and partners described how the perception of support was equally as important to them and served as a connection factor. In contrast, couples who were more isolated and feeling a lack of comradery around them seemed to experience more disconnection.

Research Question 3: How does minority stress affect the couple's relationship dynamic and ability to feel connected after cancer?

Research question 3 explored the impact of minority stress on the couple's relationship dynamic and their ability to feel connected after cancer. Within both the survivor and partner groups, a domain emerged from the data that captured interactions with the healthcare system and providers. Some examples of minority stress will be described; however, these domains also describe generally beneficial and non-beneficial interactions, as well as examples of inclusion and acceptance in medical settings, which were more prominent in the data than minority stress experiences. Survivors and partners shared their personal identities and how privilege and power intersected with their experience in the cancer setting. The results from the survivors' group will be presented first, followed by the partners' group results.

Survivors' Domain - Interactions with Healthcare System and Providers. This domain describes beneficial and non-beneficial interactions between the survivor/couple and the healthcare system or providers from the perspective of survivors. The categories in this domain are: a) beneficial communication content and process by providers, b) non-beneficial or lacking communication by providers, c) history of LGBT oppression, fear of discrimination, and microaggressions experienced during cancer, d) perception of acceptance by providers in the context of WPW identity and partners integration in care, e) intersectionality of identities and cancer and f) healthcare structure negatively impacted care for WPW. The first two categories about beneficial and non-beneficial interactions were not identified by survivors as being related to their sexual orientation and/or WPW relationship. The other three categories are related to survivors' sexual orientation and/or WPW relationship, including how the history of LGBT treatment in medical settings impacted approach to treatment, perceived acceptance by providers, and intersectionality of identities in the healthcare setting. The impact of interactions with the healthcare system on couple connection will be addressed.

Beneficial communication content and process by providers. (General). Generally, in this survivors' category they described beneficial communication between providers and survivors/partners regarding diagnosis, treatment, recovery, emotional distress, and couple issues. The most frequently appreciated beneficial communication was when providers reassured survivors about treatment efficacy, or that a preferred treatment approach would only minimally increase risk of recurrence. Often these conversations occurred in the context of high emotion, and survivors appreciated when providers attended to emotions effectively by providing information, help in decision-making, and reassurance. One patient described her recurrence worries related to nipple sparing surgery, how her surgeon addressed it, and her appreciation for the outcome. She stated, "I did skin sparing and nipple sparing surgery. So, it's really great because they're pretty much what they were before. The doctor said that for the most part, it didn't increase my likelihood of recurrence. She was like, I can send you all the research you want, but it doesn't increase recurrence that much" (P12). Survivors reported other beneficial communication strategies including anticipating the concerns of the patient, active listening, responding quickly to requests, and allowing space for the couple to consider their options. One nurse encouraged a survivor to take a planned vacation before her diagnostic biopsy, which she did, and was very grateful for that suggestion. Overall, survivors expressed positive feelings about their healthcare and providers.

Non-beneficial or lacking communication by providers. (Typical). Typically, survivors described non-beneficial or lacking communication with providers regarding prognosis, treatment, next steps, side effects, and intimacy/couple issues. Several survivors recalled poor communication when their diagnosis was delivered, experiencing it as awkward and cold. Along similar lines, survivors were uncomfortable communicating with male plastic surgeons due to mistrust that the surgeon would prioritize their own preferences over the patient preferences during reconstruction. Several survivors reported frustration regarding not receiving enough guidance and information to feel confident about their reconstruction decisions. Typically, survivors and partners were disappointed when they realized that providers had underestimated the time and hardship of recovery. They complained that information was provided too quickly by providers and that they yearned for more thoughtful conversation about reengaging in physical intimacy during the recovery process.

One survivor felt that her treatment course had been decided for her and was not provided with adequate information about treatment side effects or how to handle them. This lack of communication resulted in significant suffering before she sought treatment for side effects. She learned that she was on the harshest chemotherapy regime later in the course when she was struggling to function at all day to day due to illness. She stated, “It would have been nice to know, to be aware beforehand and know what to expect. I was feeling, you know, kind of wimpy. I was getting dehydrated to the point where I could barely move” (P18). After learning about her harsh treatment, she reached out and learned that she could request hydration services that helped her feel better.

History of LGBT oppression, fear of discrimination, and microaggressions experienced during cancer care. (General). Generally, survivors reported that their approach to cancer care was impacted by experiences of poor treatment or microaggressions in medical settings due to their sexual orientation, even if these experiences were previous to their cancer diagnosis, or they had not experienced this personally. Knowledge of historical mistreatment of LGBT communities in healthcare negatively impacted survivors as they approached cancer care. One survivor described the cognitive toll that fear of discrimination took on her when she did not receive promised outreach from several providers, “We kind of speculated, was it because we’re gay? That’s always in the back of our minds” (P18). Survivors recounted the negative healthcare experiences of gay family members and friends, during the AIDS crisis and more recently, which put them on edge. Survivors feared healthcare complications and poor outcomes as a result of discrimination.

Several survivors experienced discrimination from providers related to their desire to receive a flat closure mastectomy. One survivor was denied a flat closure mastectomy, which she learned after her surgery, and another was shocked when a provider stated that waking up flat would be too psychologically damaging. They attributed these provider behaviors to sexism and discrimination against lesbian or gay identified women. These discriminatory experiences negatively impacted their treatment and recovery processes.

Perception of acceptance by providers in the context of WPW identity and partners integration in care. (General). This survivors' category describes survivor perceptions of how they and their partners were treated by providers during their cancer care, specifically related to their WPW couple identity. Generally, survivors felt their providers were open and accepting of their relationship, and meaningfully included partners into their care approach. One survivor described their sense of acceptance this way, "They would address her and ask her questions, specifically. She was very much a part of all my care and decision-making processes. They addressed both of us, so it felt inclusive in that sense" (P12). Survivors felt that their relationship was validated or legitimized after being accepted in the healthcare setting, and they reported feeling more connected as a couple due to their providers' approach. Survivors who were not married to their partner were especially appreciative of the warm reception they received as a couple.

Only one survivor described feeling that her partner was not accepted or included by the medical team; however, she did not necessarily attribute her treatment to sexual orientation or their WPW relationship. During the interview, the survivor began to wonder if WPW identity was a contributing factor to how her partner was treated during her cancer care. The survivor described an uncomfortable situation at medical appointments and stated, “She wasn’t at all [integrated into care]. They literally didn’t even look directly at her. It felt like she was an extra chair. They would literally trip on her, like actually physically trip on her. I don’t know if that’s the same with straight people. Do they not trip on husbands? It got to a level that was weird sometimes, and it was with everyone. It added a level of surrealness to the experience that I wish hadn’t been there” (P19).

Intersectionality of identities and cancer. (Typical). This survivors’ category describes how personal identities including socioeconomic status, race, privilege, age, and marital status intersected with the identity as a cancer patient/survivor to create unique experiences and challenges for survivors and couples. Typically, survivors reported that privileged identities including being highly educated, White, in a higher socioeconomic status, and living in certain preferred geographic locations made their cancer experience easier. They reported that these privileged identities allowed them to access good health outcomes, more support within the healthcare system and at home, more time off and ability to focus on recovery. One survivor stated, “Race, I mean, there couldn’t be more data showing that my race [White] ensured a good outcome here” (P19). Financial advantages provided couples the opportunity to live in areas that were generally more liberal and accepting of a variety of identities and had good healthcare options. On the other hand, one survivor described how lack of personal transportation caused stress and made accessing cancer care more challenging. This category also includes how provider gender identity intersects with patient gender identity and impacts patient perception of care and safety. Typically, survivors reported more comfort and trust in female healthcare providers than male providers, due to their gender identity.

Healthcare structure negatively impacted care for women partnered with women. (Typical). This survivors' category describes systemic issues in healthcare that negatively impacted care for WPW. Typically, survivors reported a variety of structural issues. Lack of easy access to services including flat closure mastectomy, physical therapy, patient navigation support, and mental health services in the oncology setting were common complaints. Lack of information and research about cancer and women partnered with women was another problematic structural issue. Survivors seeking information found heteronormativity bias in many sources, as one participant noted, "all of the literature was very oriented toward heterosexual people" (P19). Sexual orientation and behaviors were not captured in some medical records, so survivors were repeatedly asked about their orientation, birth control methods, and possibility of pregnancy. One survivor expressed her frustration about repeated questions of this nature (e.g., pregnancy; birth control) by saying, "It often came up with nurses on intake, and then again with the doctors, and I was thinking, what the hell is wrong with you? Do you have something you put on the file" (P19).

Partners' Domain - Interactions with Healthcare System and Providers. This domain describes affirming and non-affirming interactions between the partner/couple and the healthcare system or providers, as well as barriers to accessing care, couple decision-making prompted by healthcare interactions, and how personal identities impacted their healthcare experience. The category titles for this domain are: a) affirming interactions between partner/survivor/couple and the healthcare system or providers, b) non-affirming interactions between partner/survivor/couple and the healthcare system or providers, c) logistics, challenges, and barriers when navigating the healthcare system and accessing services, d) couple decision-making or responses prompted by healthcare and e) partner/couple identities intersecting with healthcare system. The impact of healthcare interactions on connection within the couple will be noted.

Affirming interactions between partner/survivor/couple and the healthcare system or providers. (Typical). Typically, partners reported receiving affirming care in oncology settings. Partners described a variety of affirming interactions with their healthcare providers. Many partners stated that providers utilized the term that the couple preferred, often partner. Partners used many words to communicate how providers were affirming in their general approach to the partner/survivor/couple, including open, accepting, natural, accommodating, inclusive, respectful, and welcoming. These affirming interactions contributed to partners feeling closer to their survivor and having more connection between them.

Providers, including social workers, radiation doctors, and surgeons, communicated their accessibility for questions. Partners were appreciative of the reassurance they received from doctors regarding the plan of care, their confidence in the treatment approach, and the expected outcome. One partner was especially appreciative of provider communication after her survivor’s surgery, as she could not be in the hospital due to COVID. She stated, “It was very easy to access her [surgeon], and I was really thankful for it. The day of the surgery, both surgeons called me after they were done with their part to tell me about how it went. It felt really natural and really respectful” (P15).

Several partners found providers to be particularly encouraging of their role and their ability as a caregiver. One partner described the impact of this approach on her involvement in care. She stated, “They [surgeon, oncologist, nurses] have always been really friendly, and answered my questions, and just treat me as her partner even though we’re not married. That’s made me feel more connected to her and what she’s going through. It allowed me to play a larger role [in her care]” (P11).

Non-affirming interactions between partner/survivor/couple and the healthcare system or providers. (Typical). Typically, partners shared explicitly negative and discriminatory experiences they had outside of the cancer experience in the healthcare system. These experiences were related to their sexuality and racial/ethnic identities, which caused them to feel dismissed, overlooked, and less than human. One partner never received her own medical care due to fear of discrimination or mistreatment due to her sexuality. These prior experiences and perceptions caused them to worry about the cancer care process and made them wonder whether strange or uncomfortable interactions with providers were due to their sexual orientation. Partners reported heteronormative assumptions outside of oncology in the broader healthcare system, which was bothersome; however, they attributed this to healthcare workers not listening, rather than mal intent.

Only one partner described non-affirming care and a lack of inclusivity during the cancer care process. However, this partner stated that she was not engaged or seeking engagement during her survivor's medical appointments, which she thinks is why providers ignored her. She stated, "They didn't pointedly tell me anything. I don't know if it is different with a male partner, but I frankly don't feel… it wasn't my body, so I let survivor take the rein on all those questions" (P10).

Logistics, challenges, and barriers when navigating the healthcare system and accessing services. (Typical). Some partners described logistical challenges and barriers when navigating the healthcare system. This category includes examples of difficult procedural challenges and accessing care. Typically, partners reported challenges scheduling, changing, or cancelling appointments for their survivors. They cited inefficiencies in the system that made the appointment process burdensome and time-consuming. At times, partners were denied access to their survivor's health information and needed to complete tedious processes to be added to the record. One partner attributed these scheduling and access issues, at least in part, to being an unmarried WPW. She also noted that phone operators often did not listen well and assumed she was making requests related to a male and/or husband, which was frustrating and slowed down the process.

Several partners reported challenges accessing care, due to transportation issues and the COVID-19 pandemic. One partner described her feelings navigating the bus system with her survivor on the way to appointments, as they did not have a car. She stated, "I was just like, almost like I had this fragile bird that I was trying to get to the other side of town, and everybody was just everywhere. So, I think, it just, it was stressful because of that high alert" (P16). COVID-19 made accessing appointments very difficult for some, and delayed care for one survivor. Her partner explained, "there was a lump and so we watched it, but also with the COVID lockdowns it wasn't easy to get appointments" (P15). Also due to COVID, partners reported privacy concerns, as providers were taking appointments from their homes with family members able to listen in on their video calls.

Couple decision-making or responses prompted by healthcare. (Typical).

Typically, partners reported making or confirming big life decisions due to the cancer process. For example, partners reported that because of cancer, they discussed serious commitment to one another sooner than they otherwise would have. Couples considered domestic partnership and marriage upon diagnosis, although several partners did not feel ready for these commitments initially. Partners reported discomfort when healthcare providers assumed a higher level of commitment than was agreed within the couple. One partner told a provider, "I haven't married the lady yet" to make their relationship status clearer. For couples, there was some pressure to formally get married due to health insurance needs and a desire to be seen as a serious couple within the healthcare system. One partner stated, "getting a domestic partnership was as much about having some power over her health experience as it was to get insurance" (P15). Lastly, one partner reported having to make a quick decision about their intention to have children in the future. Although they had previously agreed not to, cancer forced them to think about their decision in a different way.

Partner/couple identities intersecting with healthcare system. (Typical). Typically, partners described how personal identities intersected with the healthcare system. Similar to the survivor group, partners endorsed fear of discrimination in the healthcare setting due to their being partnered with a woman. They feared negative health consequences for their loved one and being denied involvement in care as the partner. Also like the survivors, partners felt more comfortable and safer with female health providers, and one felt that their shared womanhood allowed them to speak frankly as a group during appointments.

Typically, partners who endorsed different identities from their survivors described divergent experiences in the healthcare system. Couples had different perspectives about their experiences, at times, and responded differently from one another. Partners discussed how the more privileged person in the relationship in terms of race and/or educational attainment tended to be more questioning, proactive, and demanding in healthcare settings. The woman with less privileged identities, although frustrated, were reluctant to advocate for themselves and were more accepting of the information and services offered. Partners reported some couple conflicts regarding these differences and how the couples learned to help one another overcome these barriers. For example, after attending cancer appointments with her White survivor, one Black partner noticed the discrepancies in how providers responded to them and treated them medically. Struggling with her own health issues, she started bringing her partner to her appointments. She described her observations as follows, “I’ve known about the disparities in the healthcare system when it comes to treating African American people, especially African American women. When I started to bring [White] survivor to appointments, things started to change, the whole dynamic changed because then it was someone else here advocating for me" (P16). Power and privilege based on personal identities and sociocultural forces impacted partners and survivors in the healthcare setting, contributing to minority stress for some study participants. These factors caused both connection within couples, and disconnection.

Chapter Four: Discussion

The purpose of this study was to explore the relational impact of breast cancer on younger women partnered with women. To investigate this topic, individual interviews were conducted with five couples, 10 participants total, in which one member of each couple had been diagnosed with breast cancer. Using consensual qualitative research (CQR), five domains emerged from the survivor group data: (1) Connection in the Relationship - Before, During, and After Cancer; (2) Disconnection in the Relationship - Before, During, and After Cancer; (3) Survivor Responses to Cancer-Related Circumstances; (4) Interpersonal and Organizational Influences on Cancer Experience and (5) Interactions with Healthcare System and Providers. Six domains emerged from the partner group data: (1) Connection in the Relationship - Before, During, and After Cancer; (2) Disconnection in the Relationship - Before, During, and After Cancer; (3) Community Involvement, Advocacy, and External Support Systems; (4) Partner's Role as Caregiver; (5) Partner's Internal Experience and (6) Interactions with Healthcare System and Providers. As outlined by Hill and colleagues (1997, 2005), categories were created that captured themes across participants within each domain.

The findings from the current study are discussed in the following way. First, an analysis of the participants' background information will be discussed, including demographics, cancer information, and mutuality in the relationships as quantitatively captured using a mutuality scale. The impact of age and developmental stage of the couples will be discussed to contextualize the rest of the discussion. From there, each of the research questions will be answered. In this chapter, rather than separating the discussion for the survivor and partner groups, it will be integrated where relevant to emphasize the relational nature of the findings and the similarities in the experiences of survivors and partners. Results that were unique to the survivor or partner group will be discussed for that group only, highlighting the different cancer experiences for survivors and partners. The discussion will be organized by constructs or overarching themes under each research question. The limitations of the study and implications for practice and research will be discussed last.

Analysis of Background Information

Contextualizing the demographics. In the current sample of 10, White participants (n = 8, 80%) are overrepresented. Of the five survivors, the majority of them identified as White (n = 4, 80%) and one identified as Hispanic (n = 1, 20%). Research on demographics and breast cancer diagnoses indicate that African American women are more likely than White women to be diagnosed with breast cancer before age 45 (Howlader et al., 2009), which contrasts with this study's sample. Additionally, participants in the current sample are highly educated. College degrees were earned by four participants (n = 4, 40%) and graduate degrees were earned by six participants (n = 6, 60%). Half of the total sample (n = 5; 50%) reported salaries above 50K and half (n = 5, 50%) reported salaries between 25-50K. In this sample, all couples discussed the impact of cancer on their financial well-being, with some couples reporting greater financial stress than others. Based on these demographics, it is evident that this sample of younger WPW holds privileged identities, particularly based on race and education level, granting them more power in societal systems than those with less privileged identities. Privilege and power based on identity can contribute to the quality of healthcare that can be accessed, treatment by providers in healthcare systems, and the ease with which complex systems can be navigated. So, this sample may not have experienced some of the hardships of the cancer experience that other couples with less resources or privilege might experience during cancer.

For survivors, their time since diagnosis at the time of the interview varied from under one year to just over five years and only one survivor was still in active treatment. Having some variability in the cancer timeline within the sample was interesting in that some couples were describing hardships related to the treatment phase and others could be reflective about the post-treatment phase and the adjustment of their relationship that came later. Regarding the stage of breast cancer, one survivor reported stage zero, three survivors reported stage two, and one survivor reported stage three. It is notably that despite the variation in cancer stages and treatment phases the participants shared many of the same experiences. Age and stage of disease has been shown to impact adjustment to cancer, with younger survivors and those with less severe disease utilizing a "fighter" coping mentality and patients with more severe disease experiencing more hopelessness and having a poorer overall adjustment to the illness (Nalbant et al., 2021).

In terms of relationship status, three couples were married at the time of the interviews, one couple was engaged, and one couple was dating. A population research study shows that for women with breast cancer unmarried status women have a higher mortality rate ratio than married women (Martinez et al., 2017). Studies hypothesized that married cancer patients may fare better due to better treatment received, having better overall health before cancer, or more robust support during the cancer experience (Kravdall & Syse, 2011). A recent meta-analysis on the impact of marital status on stage at diagnosis and survival of female patients with breast and gynecological cancers also found that, compared to married women, unmarried women with cancer were more likely to be diagnosed at a later stage and to have worse survival outcomes (Yuan et al., 2021). Yuan and colleagues (2021) discuss that health, physical and mental, is positively associated with marriage. In the case of cancer screening, detection, and treatment, marriage provides protective factors for women in America and Europe, where partners may encourage health behaviors like screening, detect cancer through normal interactions, and encourage prompt treatment (Yuan et al., 2021). These findings are supported by the results of this dissertation, as participants described partners' active involvement in their survivors' health, including by detecting breast lumps, encourage medication intervention, advocated for better care, and supporting overall health and recovery.

Contextualizing the mutuality scale (MPDQ) results. The scores reported by participants on the Mutual Psychological Development Questionnaire (MPDQ) Form-A (Genero et al., 1992a) are presented in Appendix G: Table 2. MPDQ scores are shown for partners, survivors, and couples. Since the sample is so small, statistical testing was not done using these quantitative results, and only means are discussed. Partners as a group rated themselves slightly higher in mutuality than their survivors as a group**.** Survivors as a group mirrored this, as they rated themselves slightly lower in mutuality than their partners as a group. Overall, partners and survivors indicated very similar levels of mutuality. Regarding MPDQ scores for couples, three couples clustered together were higher in mutuality and two couples clustered together were lower in mutuality. These findings are consistent with interview data.

Compared to the validation study for this scale (Genero et al., 1992a), the mean mutuality score for couples in this dissertation study (3.63), which was lower than the mean mutuality scores for spouse/partner (4.35) in the validation study. The sample for the validation study were students enrolled in higher education courses and who were attending community health care centers (Genero et al., 1992a). The differences in mutuality between couples from the validation sample and this dissertation study may indicate that the cancer experience negatively impacts mutuality within couples. This dissertation study is the only one known that looks at mutuality scores for women partnered with women in a cancer context, indicating that this warrants further study.

Age and Cancer

Before providing a discussion of the results related to each research question, this section will address how the age of the participants and their developmental stage impacted their experience of cancer. The theory of established adulthood introduced recently by Mehta and colleagues (2020) discusses the time period of ages 30 to 45 as one of the most intense and demanding periods in life, due to maintaining so many simultaneous life demands including an intimate partnership, starting a family, pursuing higher education, or managing a career. Study participants spoke about how navigating these demands impacted their cancer experience. This information aims to contextualize the rest of the discussion.

Participants discussed some perceived benefits of being younger with cancer, including the ability to utilize online resources and social media to gather cancer related information and support. They reported that social media allowed for sharing of information to a large number of people simultaneously and removed some burden of individual communications. Survivors and partners benefited from connecting with others in this way and letting people know where they were in the cancer process and how they were doing. Along the same lines, survivors especially benefitted from online cancer resources including informational websites, online communities on Facebook and Instagram, and cancer support groups held online. They attributed their comfort utilizing these resources and connecting with people online to their younger age. Research has found that using social media and other online supports is beneficial to younger women with breast cancer, particularly for social connection with others going through similar experiences and ease of use (Corter et al., 2019). Corter and colleagues (2019) found that for younger women breast cancer survivors, managing time spent and exposure to unhelpful information was important to reduce possible harm of online supports, which was a strategy that survivor and partner participants in this study also reported. For survivors especially, web resources and social connections seemed to be important given their lack of access to in person groups at local cancer centers for WPW going through cancer. Further, seeking information and support online seemed to be perceived as a necessary and emotionally safe option, as survivors expressed frustration with lack of guidance from medical providers specific to them and their relationship context.

The cancer experience of the majority of couples in the study was also impacted by fertility concerns or the challenges of having children, which is a unique problem for younger cancer survivors. For the couple who did not have children, but were somewhat considering it, they spoke with providers about their options as coupled women. They made the point that it is already difficult to have children as coupled women, and now complicated further due to cancer. Healthcare providers recognized the importance of discussing fertility issues due to their age, and the couple reported adequate support to decide not to pursue any fertility measures. Research shows that approximately half of younger cancer patients are not provided with information or referrals regarding fertility preservation, despite this being a recommendation of the American Society of Clinical Oncology (ASCO) and a significant concern among cancer patients (Quinn et al., 2009). Couples who were raising children at the time of cancer expressed a variety of related concerns including how to talk with children about cancer and what information to share, how much to rely on older children for caregiving support, the added pressure on partners to care for children and their survivor at the same time and managing the behavior of children around the survivor. A qualitative study about the experience of women with cancer and their partners (Akyuz et al., 2008) discusses the stress and exhaustion that partners experience caring for their children and partner. Further, Akyuz and colleagues (2008) discuss how partners feared their survivors would die and the impact that would have on them and their younger children. Study participants shared these anxieties, as several partners expressed particular concern about responsibility for children if their survivor died due to cancer. For one couple, the fear of recurrence and future death of the survivor contributed to their decision to not have children together.

Partners and survivors discussed how cancer impacted their progression in school and work. Given their age range, many of the participants were focused on completing graduate degrees and progressing their careers. Three participants were in school, and all continued during cancer, including two survivors. Those attending school reported that it gave them a sense of purpose and direction that they did not want to abandon despite cancer-related challenges. Only one survivor reported stopping work for a year during cancer and other participants managed to maintain work. Although this was not a primary focus of the study, some participants reported the need for continued income and desire to advance their careers. For those who were less career-focused, they reported less focus on their jobs due to cancer. These findings are consistent with a qualitative study of young breast cancer survivors who reported a meaning making process related to work due to cancer (Raque et al., 2015). Survivors attempted to find balance between the work domain and their need for financial well-being during this period of their life (Raque et al., 2015). Research about sexual orientation and labor market outcomes indicate that compared to similar heterosexual women, lesbian women have equal or higher earnings (Mize, 2016); however bisexual women experience wage disparities that are not accounted for by other factors (Mize, 2016) and there is limited research on this population in the labor market as bisexual and lesbian women are often grouped together in studies. Therefore, WPW may experience wage and financial disparities or find it more challenging to find an accepting and comfortable workplace, making maintaining work even more critical to their well-being and survival. One partner described the impact of her sexual orientation on her work experience, reporting a more affirmative work environment where other LGBT employees were present. The potential intersection of the impact of cancer on women's careers with their sexual orientation is worth further exploration.

Research Question 1: What is the impact of breast cancer on younger survivors and their women partners with regard to authenticity, mutuality, relationship awareness, connection, and disconnection?

Research Question 4: What lasting relational changes do the couple report due to cancer?

Research question one explored the impact of breast cancer on younger survivors and their women partners regarding the Relational Cultural Theory constructs of authenticity, mutuality, relationship awareness, connection, and disconnection (Jordan, 2018). As described in the results chapter, interviews were rich with information and examples regarding these themes. Couples also described lasting relationship changes due to cancer. As the data and discussion related to these two research questions are intertwined, they will be integrated and presented together. First, the overall impact of cancer on relationship connection and commitment will be discussed in the context of existing research in this area. Next the relational processes of relationship awareness, authenticity, and mutuality will be covered including how these processes contributed to connection and disconnection. Findings related to couple coping, post-traumatic growth, enmeshment and codependence, and egalitarian relationship goals are also discussed in the context of research. Lastly, the impact of cancer on disconnection will be covered.

Relationship Connection

Partners and survivors discussed how cancer impacted connection and commitment within their relationship. Interestingly, all ten participants reported increased closeness and connection in the relationship due to cancer. A study of approximately 150 couples, cancer survivors and their partners, found that most of them, approximately 70 percent, reported increased closeness due to cancer, so the overall sample in this dissertation is more connected than has been reported previously (Drabe et al., 2012). Participants in this study discussed seeing one another at their worst, getting to know each other better, relying on one another during a difficult time, and getting through adversity together as some of the processes that engendered increased connection. On the whole, these examples show the power of vulnerability to bring people together. Relational Cultural Theory makes the argument that dominant Western culture values independence and autonomy to such a degree that reliance on others goes against much of what we learn growing up (Jordan, 2008). Indeed, survivors discussed the discomfort of vulnerability that came along with their illness. They found it challenging to accept help or ask for help and partners experienced vulnerability as they were thrust into a new and unfamiliar caregiving role. Jordan (2008), a preeminent scholar on Relational Cultural Theory, discusses how tolerating the vulnerability of others and us makes space for increased growth and connection and that denying vulnerability causes disconnection. Vulnerability can be understood “as an experience in which we are open to the influence of others at the same time that we are open to our need for others" (Jordan, 2008, p. 213). Survivors and partners described cancer as a catalyst for vulnerability, and that when they accepted the vulnerability of the situation and each other they were best able to feel close and work together through the uncertainty of the cancer experience. Thompson and colleagues (2020) conducted a systematic review on sexual minority women and cancer. They found that the impact of cancer on the intimate relationships of women partnered with women was mixed across the 18 studies they reviewed (Thompson et al., 2020). This dissertation supports the possibility for increased closeness and connection between WPW going through cancer; however, self-selection of couples into the study may contribute to a sample more likely to be doing well.

Commitment

Cancer also impacted commitment in the relationships for almost all the couples. The couples had been together for varying amounts of time, from one year at diagnosis to almost twenty years. Three couples decided to become engaged or married during the cancer period or shortly thereafter. Interestingly, these couples described the survivor as the driving force for the increased commitment. This may have been driven by fear of abandonment for survivors, although this was not explicitly stated. Some survivors reported deep appreciation for their partners because they were willing to stay with them despite cancer. Partners reported that the realization of their survivors' mortality and fear of losing them did contribute to their desire to make a serious relationship commitment. A study about the effect of cancer on marriage formation rates found that breast cancer in women results in lower marriage rates overall, but other cancer types did not impact survivor marriage rates for women compared to controls without cancer (Syse, 2008). Syse (2008) did not address the impact of cancer on marriage rates for different types of couples. The age of the study participants is also very relevant to their increased relationship commitments, as first marriages often happen at approximately age 30 during the established adulthood period (Mehta et al., 2020). Further, the findings of this study suggest that WPW may be more inclined than other types of couples to maintain or increase commitment despite breast cancer. Body image dissatisfaction has been associated with breast cancer survivorship and intimate relationship challenges (Shaw et al., 2018). However, this dissertation is consistent with other research (Sinding et al., 2007) that found SMW to be accepting of body changes in partners. Although some survivors in this dissertation reported body dissatisfaction, their partners exhibited a high degree of support and reassurance related to this psychological concern. This response may contribute to a sense of emotional safety and acceptance in WPW relationships that translates to physical connection and positive relationship outcomes.

On the other hand, research addresses relationship dissolution and cancer and the evidence appears to be mixed. One study found that the separation rate was marginally lower for couples experiencing cancer than for the general population; however, the most frequent reason for dissolution among the couples with cancer was death, indicating a lower chosen dissolution rate among couples with cancer (Nalbant et al., 2021). Another study about breast cancer survivors found that the frequency of divorce was higher in survivors than the general population (Yildiz et al., 2020). These studies were not focused on women partnered with women. One couple in this dissertation study continued to struggle for years after cancer treatment ended. They remained married but were newly, informally, separated at the time of the interviews. They did cite cancer-related changes as the primary cause of their ongoing relationship problems. As this study required both members of a couple to participate, it does not include the experiences of cancer survivors or partners who decided to formally dissolve their relationship due to cancer. It is possible that couples who are amongst the most connected and/or committed would be compelled to volunteer to participate in a study like this one. There is a need for further quantitative research on these topics that can draw greater conclusions about generalizability than this study due to the small sample size.

Relationship Awareness

Relationship awareness describes “an awareness and respect for one’s own and the other person’s limits” (Jordan, 2008). In the context of cancer, relationship awareness would be thinking about the relationship differently than before cancer, and seeing your partner differently, as they are in the context of cancer. Overall, participants in this study described having relationship awareness. This awareness was evident in how they discussed changes in their thinking because of cancer. Both partners and survivors described the limitations of the survivor and how they made intentional changes to address those limitations. Couples who seemed more at ease with their physical intimacy openly discussed the changes they could make and practiced those. They thought about intimacy differently, rather than attempting to recreate the intimacy that existing before cancer. Couples also exhibited relationship awareness by realizing their hobbies or socializing habits did not suit them anymore and sought new activities together.

Additional examples of relationship awareness were survivors stating their limitations and asking for help and partners setting appropriate boundaries related to the support they could provide. Overall couples were mindful of the need to focus more attention on their relationship than on other areas of life due to cancer. Researchers have noted that higher levels of relationship awareness helps couples maintain the connection in their relationship by talking more openly about the status and workings of their relationship, making behavioral adjustments, and being responsive to feedback about how cancer is impacting each other and their relationship (Acitelli, 1998; Brandao et al., 2017; Kayser et al., 2007). An important part of relationship awareness seems to be acceptance of the way things are now and approaching reality as a unit. This "we" approach to cancer and high level of relationship awareness serves couples well (Brandao et al., 2017).

Partners, survivors, and couples who did not adjust their thinking to fully accommodate the context of cancer endorsed conflict and disconnection. Lack of relationship awareness was evident when partners pushed physical intimacy when the other was not able to engage physically or psychologically. At times, partners had difficulty accepting the limitations of their survivors that contributed to guilt, irritation, and resentment for survivors, and more sustained disconnection for couples, a relational dynamic that has been supported by prior research on heterosexual couples navigating cancer survivorship (Silver, 2004). Some survivors reported feeling unseen or like their partners did not realize what was happening with them.

Some findings regarding relationship awareness did differ between the two participant groups. Survivors spoke more about adjusting to survivorship as a couple and their awareness of changes that were needed in the present or future to adjust to the impact of cancer. These included expanding their definition of intimacy and exploring new activities. On the other hand, partners spoke more about the personal sacrifices or adjustments they made to accommodate their survivors' cancer. These included reducing their own enjoyable activities such as seeing friends and traveling in order to spend more time with their survivor. Some noted a need to be more isolated to reduce the risk of acquiring COVID-19 during the cancer period. Lastly, partners reported awareness of their need to do more domestic work to support the relationship, and their willingness to take on these tasks. These discrepancies highlight the changes for partners that were necessary for the relationship and not necessarily due to their own inability to continue on their lifestyle. These findings are unique as the relationship awareness of WPW going through cancer together has not been explored previously.

Authenticity

Authenticity has been defined as "the ability to represent oneself as fully as possible in relationship" (Jordan, 2018, p. 29). Jordan (2018) states that in order for authenticity to benefit a relationship it must shared with the expectation of empathy from the other person in the relationship. Some survivors provided an opportunity to their partners early in the cancer process to leave the relationship, so they did not have to deal with cancer and caregiving. For this sample, partners reported being quite offended by this yet responded with empathy by reassuring their survivor of their love and care, commitment to the relationship, and shared fear about cancer, which was very comforting for survivors. This authenticity followed by acceptance and shared vulnerability for couples at the outset of cancer seemed to set the stage for increased authenticity throughout cancer for many of the couples. Couples reported more frequent checking in during cancer, less fighting, and more sensitive communication. Couples did report that communicating more authentically and openly was challenging; however, the benefits were worth it. Without prompting, survivors and partners cited the goal of personal and relationship growth via authenticity, supporting this concept of growth via connection as described in Relational Cultural Theory (RCT) (Jordan, 2018).

On the other hand, several couples struggled with authentic communication more consistently, and all couples had difficulty sometimes. Members of these couples seemed to be enacting the central relational paradox (CRP) as described in Relational Cultural Theory (Jordan, 2018). A central relational paradox occurs when true feelings are hidden to maintain connection; however, this pattern creates a hidden self and sustained disconnection longer-term (Jordan, 2018). Both survivors and partners endorsed withholding authentic communication, often to protect their loved one from additional distress. Research shows that "protective buffering" of this kind increases fear of recurrence and decreases intimacy in couples coping with breast cancer (Perndorfer et al., 2018). Participants minimized their own experiences at times to justify the withholding, and they may have in fact been avoiding their own painful experience within themselves. Research has shown the negative psychological implications for couples and individuals when avoidance, criticism, demand-withdrawal communication, and protective buffering are used (Regan et al., 2015).This pattern endorsed by some WPW did contribute to periods of condemned isolation and disengaged avoidance within their couple (Jordan, 2018; Kayser et al., 2007), a relational pattern found in heterosexual couples coping with breast cancer (cite). Individuals in disengaged avoidance relationships may experience hopelessness about the ability to connection with their loved one, also known as condemned isolation, which contributes to even fewer attempts to connect (Jordan, 2018).

Again, in addition to the common themes regarding authenticity for survivors and partners that have been described, some differences also emerged. Partners tended to focus more on the positive changes regarding authenticity in the couple, including their ability to communicate openly about cancer-related topics and the positive, lasting changes in authenticity and communication that cancer provoked. In contrast, some survivors described frustration related to lack of authenticity by partners, as well as more personal withholding. Survivors withheld authentic communication about recurrence fears, caregiving issues, and curiosity about their partners' lived experience. By not communicating that their caregiver was not attuned to their needs, they did not provide needed information and support to partners. Survivors seemed to avoid communicating on these issues to avoid hurting or distressing their partners, and to protect themselves from conflict and emotional burden that they could not endure, in part due to physical illness. These findings suggest that survivors may experience greater risk for condemned isolation than partners.

Mutuality – Empathy and Empowerment

In Relational Cultural Theory, "mutual empathy is predicated on mutual vulnerability" (Jordan, 2008, p. 218) and mutuality is defined as "being open to the influence of others while maintaining a strong sense of self' (Jordan, 2018, p. 30). In this dissertation study, all participants reported the presence of mutuality in their relationship and gave examples of how empathy and empowerment was bidirectional during the cancer process. This represents an important extension of social support research to examine the dyadic experience of support for WPW experiencing cancer. Overall, the descriptions of mutuality in the survivors and partners groups was very similar. Both groups described empathy and empowerment related to caregiving, body and body image issues, treatment decisions, and advocacy efforts. One of the most powerful examples of empathy for participants in the current study was due to their shared identity as women. Survivors felt understood by their partners regarding their body related cancer distress. Along the same lines, partners' fear of breast cancer for themselves and related distress was also a source of empathy and supported prior research that partners in WPW relationships may experience more distress than male caregivers of breast cancer patients (Sinding et al. 2007). Challenges with caregiving decisions and difficulties were also empathized with by survivors. This mutuality was a notable strength for couples in this dissertation study and was maintained from diagnosis through recovery. These findings were consistent with prior research that suggested having a shared identity as women helped WPW convey empathy and empowerment during their experience with cancer (Sinding et al., 2007).

This study contributes to the knowledge base regarding the value of mutuality in WPW relationships, as there are not many studies on this topic. Studies with heterosexual couples coping with chronic illness and cancer have found that mutuality in intimate relationships is associated with higher relationship satisfaction, higher quality of life, more self-care agency, and less depression (Cramer & Jowett, 2010; Kayser et al., 1999). For women in heterosexual relationships, but not men, partner mutuality was highly predictive of depression (Genero et al., 1992a). This points to the value of mutuality for women in relationships specifically, and the deleterious effects for women who do not experience this. Higher levels of mutuality in women partnered with women relationships versus other types of intimate relationships may be a protective and connecting factor, and more research would be needed to investigate this further and confirm the finding of this study that mutuality and empathy in WPW relationships is beneficial for the couple as well as for the survivors and partners individually.

The positive impact of mutuality on self-care agency reported by Kayser and colleagues (1999) in a study with younger women with breast cancer was replicated in the current study. Survivors and partners reported advocating for one another's self-care and an increased ability to advocate for oneself in medical settings due to the support of their partner. One study using the Actor Partner Independence Model (APIM) of couples facing breast cancer found that younger couples had significantly less relational mutuality than middle-aged couples and therefore worse coping and quality of life (Kayser & Acquati, 2019). Although not directly examined in the current study, it could be interesting to examine the intersection of age with WPW in how relational mutuality is experienced.

Couple Coping

When asked about how they connected with one another through their cancer experience, survivors and partners shared the coping strategies that worked for them.

They discussed utilizing these coping mechanisms to regulate difficult emotions, have fun, relax, process their cancer-related experiences, manage their day-to-day lives, and tackle ongoing problems in their relationship. Couples who reported more overall mutuality appeared to utilize more of these positive coping strategies that are shown to be beneficial for both people in a couple and for the couple functioning overall (Badr et al., 2010).

Survivors and partners reported that the utilization of humor and light-hearted interactions was especially helpful for them when navigating cancer. Humor has been found to be a protective factor from distress related to breast cancer (Roussi et al., 2007); however, it is not frequently endorsed in the breast cancer research, perhaps due to it not being frequently included in research measures (Melton, 2016). A study of breast cancer survivors found humor to be an active coping strategy associated with acceptance, and positively reframing distressing situations (Melton, 2016). WPW described their use of humor in similar ways, often to break the tension during difficult treatment or caregiving moments or to find a silver lining in their situation.

Partners described three helpful coping strategies that were unique from the findings of the survivors' group, which were sharing grief, problem solving, and adaptive thinking, which will all be described further. Partners reported that sharing grief with their survivor related to breast cancer was a beneficial form of coping. This often involved sharing sadness about how cancer impacted their survivors' body and the negative impact it had on their sexual relationship. Grief of this kind may not be widely recognized, and thus has been termed "disenfranchised grief" (Pillai-Friedman, 2014).

Making space for disenfranchised grief may be an important aspect of authentic reactions to cancer in WPW.

Partners also reported that problem solving with their survivor related to pain management and wound care was especially helpful. This type of problem-solving coping likely reduced the pressure that caregivers felt to handle all aspects of caregiving on their own. Talking about caregiving strategies with their survivor likely also reduced their sense of helplessness when their survivor reported pain. In terms of psychological intervention to assist couples with adaptive coping, research has found that focusing on the interdependence aspects of coping is most useful clinically (Regan et al., 2015). Building upon the concept of mutuality, this implies that interventions should address how responses and behaviors of each person in the couple is interrelated and creates the overall couple coping dynamic (Regan et al., 2015). Along those lines, partners reported that adaptive thinking was beneficial for their coping and allowed them to best support their survivor. They thought about the benefit of their support to their survivor, In addition, they focused on taking it one day at a time and reminded themselves that the situation would change with time. These thoughts helped regulate negative emotion and allowed partners to continue to carryout their responsibilities.

The findings of this dissertation regarding relationship awareness, authenticity, mutuality, and coping extend prior research (Kayser et al., 2007) about couples' functioning and cancer using the lens of Relational Cultural Theory (Jordan, 2018). Kayser and colleagues (2007) found that heterosexual couples whose relationship included more relationship awareness, authenticity, and mutuality were likely to have a mutually responsive relational dynamic, and less of these relational processes resulted in a disengaged avoidance dynamic (Kayser et al., 2007). This dissertation found the same relational processes to be beneficial for WPW facing breast cancer, which is a unique contribution of this study. Likewise, three of the five couples who endorsed more frequent use of these relational strategies also described a more content and responsive relationship, whereas the other two couples were experiencing the negative effects of disengaged avoidance and the central relational paradox (Jordan, 2018). In this study, all couples utilized some adaptive relational strategies as well as maladaptive relational strategies, replicating research demonstrating that the degree to which positive interactions are present over time impacts relationship satisfaction and long-term relationship outcomes (Jordan, 2018).

Post-Traumatic Growth

Post-traumatic growth (PTG) after a very challenging life experience is represented by positive changes in various life domains including increases or improvements in the following: appreciation of life, relationships, life possibilities, personal strength, and spirituality (Tedeschi & Calhoun, 2004). Post-traumatic growth has been documented in sexual minority women after breast cancer (Boehmer et al., 2014). Survivors in this dissertation study also reported PTG in a variety of domains, most notably increased personal strength, appreciation for life, and investment in important relationships. Interestingly, research has shown that patients' PTG was associated with their partners' emotional and cognitive processing of the breast cancer experience, indicating an interdependent post-traumatic growth process for couples

(Manne et al., 2004). This finding was replicated in this dissertation study, as partners reported a similar experience of PTG as their survivors and were more focused on engaging in valued activities and relationships after cancer. Partners also reported spiritual changes and making meaning of their difficult cancer experiences by focusing on their personal growth through their caregiving role. In a study of PTG after breast cancer, younger age predicted PTG for both patients and partners (Manne et al., 2004). In addition to younger age, Manne and colleagues (2004) found that PTG for partners of breast cancer survivors was also predicted by variables such as emotional processing and positive reappraisal. Although a causal relationship cannot be determined due to the qualitative nature of this study, the prevalence of PTG among this younger dissertation sample who endorsed emotional processing and positive reappraisal supports prior research of Manne and colleagues (2004).

Perhaps most interestingly regarding post-traumatic growth in this dissertation study is the positive impact of cancer and PTG on couples’ relationships. Couples not only reported personal growth, but also growth of their relationship, including increased resilience and confidence in overcoming adversity together. Some couples jointly shared more appreciation for their life together. Research has shown that more positive coping among breast cancer couples is associated with PTG (Suo et al., 2021). Couples who endorsed more mutuality, authenticity, and relationship awareness regarding cancer also coped better with cancer-related distress and reported more PTG characteristics post-cancer. Zwahlen and colleagues (2010) looked at PTG in partners and cancer patients and the effects of role (patient or partner), gender (different combinations of male vs. female survivor/patient), and dyadic processes. They found that although all three factors impacted the total PTG scores, the intra-couple processes were most likely to impact PTG outcomes than role or gender factors (Zwahlen et al., 2010). Researchers found significant variability in benefit finding across couples. In fact, 30-47% of variance in total PTG scores was attributed to the couple specific processes (Zwahlen et al., 2010). It would be beneficial to explore these processes in more depth, and focus a study on women partnered with women, specifically. One systematic review and meta-analysis of PTG in cancer patients found that spirituality, positive coping, and optimism were associated with PTG, so perhaps similar constructs are helpful for couples (Shand et al., 2015). A limitation of the couples' studies is that only couples who were described as male-female were included in the final analyses due to a small number of same-sex couples who participated (Manne et al., 2004; Zwahlen et al, 2010).

Enmeshment and Codependence

There is a historic body of research related to lesbian or women couples and the concepts of enmeshment and codependence, also called fusion, which is outlined by Ackbar and Senn (2010). Research about the consequences of enmeshment in lesbian relationships often painted a negative and dysfunctional picture and was born out of a comparison with heterosexual relationships; therefore, suggesting pathology in lesbian relationships where none necessarily existed (Krestan & Bepko, 1980; Lindenbaum, 1985, Mencher, 1990). Some researchers (Ackbar & Senn, 2010; Green & Werner, 1996) sought to understand the positive and negative aspects of this style of relating within lesbian relationships and to consider the level of satisfaction in the relationship as an important indicator of the degree to which high levels of closeness is beneficial for any couple. Although Relational Cultural Theory (Jordan, 2018) focuses on the strengths of how women relate to one another and emphasizes the importance of closeness for growth in relationships, the theory does not necessarily give credit to the body of research related to enmeshment or fusion in intimate relationships between women. It is possible that the perceptions of the women partnered with women participants in this dissertation study were influenced by the negative stereotype of enmeshment within lesbian/WPW relationships. It is also possible that the cancer experience changed how the survivors, partners, or couples experienced the closeness in their relationship, as either more positive or negative than before cancer, therefore changing their satisfaction in the relationship.

Almost all survivors and more than half of partners described relationship complications due to being too connected with their partners, particularly after cancer. Participants used words like enmeshment, lack of boundaries, codependence, and overreliance to describe the state of their WPW relationship. More specifically, some survivors reported challenges prioritizing and attending to their own needs, or frustration related to a lack of perceived freedom in the relationship to pursue their own interests. Enmeshment has been described as “a lack of self/other differentiation” and “a style of high closeness and caregiving” (Green & Werner, 1996, p. 5). Research conducted from a feminist relational perspective challenged what the authors (Frost & Eliason, 2013) stated was an assumption in the psychology literature of problematic fusion or closeness among women partnered with women. Frost and Eliason (2013) compared desired levels of closeness within different types of couples (same-sex men, same-sex women, and heterosexual) and they found that WPW did report problematic closeness in WPW relationships, which has been found in other studies (Fitzgerald, 2004; McDaniel, 1995); however, the WPW did not report more closeness than other types of couples. This research (Fitzgerald, 2004; Frost & Eliason, 2013; McDaniel, 1995) supports the findings of this dissertation in that WPW participants did report problematic closeness in their relationship. It is important to note that high levels of relationship closeness and dependence on others may not be problematic and should not be deemed so in a clinical (or other) setting unless it is being reported as problematic by those in the relationship.

For dissertation study participants, some of the desire for more space or individuation in their relationships could be due to how much autonomy was lost by survivors and partners during the cancer process. Survivors likely felt more helpless and reliant on their partner during this period. For many of the survivors, a part of the healing and recovery process was reestablishing their independence and renewing their sense of self. Two survivors who described being more dependent on their partners even prior to cancer reported coming into their own after the cancer process, and perhaps felt more constrained by the relationship expectations than they did previously. On this topic of enmeshment and codependence, partners mainly discussed a desire to regain some separation from their survivor. This sentiment was shared across groups and participants described their common goal of a more equal or balanced partnership.

Egalitarian Ideals

One of the most frequently reported relationship values across participants was striving for a sense of equality or balance within the couple. A review article on same-sex relationship strengths identified positive relationship characteristics of same-sex couples, one of which was egalitarian ideals (Rostosky & Riggle, 2017). The researchers identified that for the couples in action they “contributed equally, treated one another as equals, had equal power in the relationship” and were not bound by rigid gender roles (Rostosky & Riggle, 2017, p. 5). In this dissertation study, participants from both groups described striving for these egalitarian ideals in their own relationship, further supporting the research that this value is particularly important to coupled women (Kurdek, 2001, 2003). In one study, women couples who reported dividing labor and childcare responsibilities equally were more likely than other types of couples to report that equal division was ideal (Patterson et al, 2004). Many couples endorsed that physical intimacy and sex was a frequent and important source of connection for them prior to cancer. Couples in this dissertation study stated that before cancer, their behaviors were more consistent with their egalitarian ideals, and that the disruption of this balance was problematic for their connection, which has been noted elsewhere with regard to the impact of cancer (Rolland, 1994). One contribution of this study is the deleterious effects of an unbalanced partnership for WPW cancer survivors and their partners. This study emphasizes the strengths of WPW in their ability to identify their ideal, the negative impact of decreased equality, and their intentionality in working toward their ideal after cancer. In a psychotherapy context, providing support for WPW in their relational goals would likely be beneficial.

Physical Intimacy

As described previously, physical intimacy changed significantly due to cancer for couples who participated in this dissertation study. Both partners and survivors endorsed some negative implications of cancer on their sex life and fear about how it would change in the future, which is consistent with other research on cancer and WPW (Brown & McElroy, 2018).

Despite this, most couples became creative with finding other ways to maintain intimacy and generally worked together to address the issue. Research on sex within WPW relationships is scarce or not well understood. The research that exists often conceptualizes sex in WPW relationships using a heteronormative context that is not necessarily appropriate or relevant (Scott, 2016). A recent dissertation study found that lesbian couples seem to conceptualize sex more broadly compared to the general public in terms of sexual acts (Scott, 2016). This dissertation study seems to support this finding, as couples in this sample endorsed openness and creativity regarding how to foster and rebuild their positive sexual connections after cancer. Lastly, the younger age of these couples was a relevant factor in their stress about physical intimacy, and research supports the negative impact of cancer on sexual dysfunction, body imagine, and intimacy for younger survivors (Young Survival Coalition, 2020). This dissertation study highlights the importance of physical intimacy and sex for WPW after cancer and provides information about how WPW approach intimacy concerns post-cancer.

Some concerns about physical intimacy were different between the survivor and partner groups. Most notably, survivors lamented the loss of shared pleasure and safety in sexual interactions, in part due to body image concerns. This may speak to the egalitarian ideals of women couples and reflect the importance of balance and equality within intimate interactions (Rostosky & Riggle, 2017). At times, partners tended to avoid initiating intimacy despite desiring more contact so as not to cause relational distress for their survivor, a finding that has been noted in other research on lesbian couples (Scott & Rhoades, 2014). This dissertation study extends that finding and applies it to the cancer context, as well.

Lasting Changes

The preceding sections described the lasting relational implications of breast cancer for younger WPW as found in this dissertation study. To summarize, here is a list of these findings: increased closeness and connection, increased commitment and/or seriousness of their relationship, increased authenticity for almost all couples even in the face of relational hardship, increased confidence in their ability to problem solve and overcome hardship together, increased attention to their most important priorities and relationships (post-traumatic growth), increased awareness of the interdependent nature of their relationships including benefits and drawbacks, increased awareness of egalitarian relationship ideals, and changes with physical intimacy. It is important to note that the couples were at different points in their cancer experience (treatment, recovery, longer-term survivorship) and yet they shared many similar experiences, as evidenced by the frequency of general coding across domains and groups. Additionally, survivors and partners described similar experiences, with some divergence that shed light on how their role in the couple impacted them. Miller and Striver (1997) described how in growth-fostering relationships, “people are able to bring themselves more fully and authentically into connection,” a pattern that was evident for many couples in this study (Jordan, 2018, p. 30). The founder of Relational Cultural Theory, Jean Baker Miller, discussed various outcomes of these types of relationships including clarity described as “a better understanding of self, other, and the relationship” (Jordan, 2018, p. 30). All the individual participants and couples in the dissertation study gained this clarity through their cancer experience that impacted them personally, as well as their interactions and decisions as a couple.

Research Question 2: What are the barriers and supports to the sense of connections between women partnered with women in the context of breast cancer?

Research question two explored the barriers and supports to the sense of connections between women partnered with women in the context of breast cancer. The findings that emerged from the data answering this research question was focused on factors outside of the couples’ relationship that impacted their connection. The supports that facilitated increased connection for the couples will be discussed first, followed by the external barriers that inhibited connection for the couples.

Supports Facilitating Couple Connection

Partners and survivors received support that facilitated their couple connection during cancer. Their primary sources of support were from organizations, family and friends, and healthcare providers. The type of support garnered from each source will be briefly described, followed by the impact on couple connection and relevant research related to each type of support. The focus of this research question is on how external support or barriers impacted the couple connection so that is the focus; however, differences between the partners and survivors' groups in terms of supports or barriers will be briefly described if relevant.

Organizational support contributed to couple connection. Partners and survivors received various types of support from organizations including cancer organizations, religious organizations, their workplaces, and school institutions. The most helpful sources of support for survivors and partners was different; however, all support received influenced the well-being of the couples. Most of the support gathered from cancer organizations was directed toward survivors. Survivors reported that cancer support groups, community events, and advocacy opportunities organized by cancer organizations helped them learn about their diagnosis and treatment, connect with other survivors, and process their cancer-related stress and grief. Additionally, external support for survivors empowered them to help others and advocate for changes in the cancer field for younger survivors and women partnered with women couples.

Notably, only one survivor reported interacting with another WPW survivor via a cancer organization. She and her partner became friends with this couple, and they were a good source of support for one another. Mereish and Poteat (2015b) found that social support for sexual minorities is more beneficial when received from other sexual minorities in some circumstances. In this dissertation study, it was helpful for the WPW couple to share stories and experiences with another WPW couple. Overall, survivors reported that their efforts to gain personal support in the cancer community was beneficial to their relationship because they felt better overall, so emotional distress was not negatively impacting their interactions with their partner as much. Research on the benefits of cancer support groups has found that survivors report better relationships with their partners and caregivers and are significantly less anxious and depressed (Cain et al., 1986). Involvement in these organizations gave survivors an avenue to express their feelings in an environment where others could empathize due to shared lived experiences. Research has found that survivor support groups benefit relationships with loved ones as they relieve the burden of care for others and survivors experience mutuality in these groups (Ussher et al., 2006).

For couples in this dissertation study who described less mutuality and where survivors felt less understood by their partners, it was validating for survivors to hear of similar experiences in groups. Additionally, hearing about more difficult relationship circumstances helped survivors and partners feel better about their own relationship struggles. Couples were able to connect and relate to each other regarding the hardships of other couples. Partners reported gratitude and relief for their survivors' involvement in helpful cancer organizations.

Notably, no partners endorsed receiving support from cancer or community organizations on their own; however, partners enjoyed joining their survivor for advocacy activities and couples reported that this was a positive source of connection. Advocacy gave couples a sense of control and empowerment regarding their cancer experience. One couple who attended an outdoor retreat for young adult cancer survivors and caregivers found it to be hugely beneficial for their couple connection. One reason for this may have been the active nature of the retreat, as they were able to connect with survivors and partners who were also healthy (except for cancer) and enjoyed being active together. Each felt validated and supported and the experience was connecting because it helped them make meaning of their cancer experience, which has been associated with adaptive adjustment in couples with cancer (Skerrett, 1998). The findings of this dissertation supports other research about the benefit of support from cancer organizations for survivors and couples (Cain et al., 1986; Ussher et al., 2006), as well as lacking organizational supports for partners. Findings suggest that partners in younger WPW relationships may find it even more difficult to access beneficial organizational support for themselves as many other partners of breast cancer survivors are older men (Mereish & Poteat, 2015b). Online sources of support for younger partners, partners in WPW relationships, and WPW are likely to be the best avenue for accessing women with similar experiences, as the support specific to WPW is currently inadequate (Lisy et al., 2018).

Family/friend support contributed to couple connection. Receiving support from family and friends was also beneficial for couple connections. Family and friends helped with caregiving of the survivor and their children for some couples. They also aided with food, domestic chores, emotional support, transportation to appointments, and advice regarding cancer. In this dissertation study, participants reported less than five family or friends who helped them on a regular basis, fewer for many couples. Many of the couples cited COVID-19, in addition to cancer, as reasons that they did not engage in their regular social activities which reduced their normal access to social support from friends and family. Research shows that social support often decreases for breast cancer survivors and that this predicts poorer self-reported well-being (Fong et al., 2016).

Family and friend support that was received helped the couples connect in one primary way. Support reduced stress and tension for the couples and allowed them to spend more enjoyable quality time together. In heterosexual and same-sex couples, stress has been shown to negatively effect relationship satisfaction (Randall & Bodenmann, 2016). As study participants reported, cancer increases stress for couples (Rajaei et al., 2021), so utilizing support from loved ones outside the relationship was important for their connection and ability to relax. The findings of this dissertation highlight that the source of support for the couples was most frequently the survivors' close friends and/or family members. This suggests that for survivors who did not report a large and/or supportive network, those couples might receive less overall support. Research related to coupled women has emphasized the importance of social support from friends, often other sexual minority women (Galupo, 2007), but that was not found in this dissertation. This study and prior research emphasizes the critical importance of partner support for sexual minority women who have breast cancer (Boehmer et al., 2005; Hill & Holborn, 2015; Katz, 2009; Paul et al., 2013).

Healthcare provider support contributed to couple connection. Survivors and partners reported receiving support from healthcare providers that contributed to increased connection for them as a couple. Survivors reported disclosure to their providers of their status as a woman partnered with a woman, and partners were typically present for this disclosure. Some participants in this dissertation reported the expectation of acceptance by providers based on where they lived. Research has shown that sexual minority women who live in structurally supportive states, meaning states that have nondiscrimination legislation in place, disclose their identity/relationship status more frequently to their providers and report higher satisfaction with their care (Baldwin et al., 2017). Couples in this dissertation study lived in five different states, four of which have explicit nondiscrimination laws (Movement Advancement Project, 2022). Further, participants were asked to rate how accepting their current community is of WPW relationships on a zero to 10 scale, with 10 being completely accepting and the mean of all responses was 7.89 out of 10, indicating a high perception of community acceptance for this dissertation study sample. Survivors and partners in this study described an overall perception of acceptance by their healthcare providers. Particularly at the beginning of treatment, they felt relief and gratitude for the accepting and inclusive approach of providers, which is consistent with other research on lesbian, gay, and bisexual patients with breast cancer (Brown & McElroy, 2018). Both survivors and partners stated feeling respected, validated, legitimized, and seen as a unit by their care teams.

Partners especially stated that the support received from providers helped them to feel more connected to their survivor and the overall cancer process, empowering them to be more involved caregivers throughout. By involving partners in care, survivors received better support and connection at home. These interactions seemed to be especially powerful in a positive way for participants who had not previously felt fully accepted by their family members or communities regarding their relationship with a woman. The findings of this dissertation contribute to knowledge of the positive impact of affirmative cancer care on relationships for WPW. A recent review article (Kent et al., 2019) stated that the current literature focused on sexual and gender minorities and cancer care delivery is small but growing, with the current study adding to this literature.

Barriers Negatively Impacting Couple Connection

Survivors and partners reported some barriers to their connection during the cancer process that originated outside of the couple. These included problematic dynamics with family and lack of external support for partners. These dissertation findings will be put in the context of prior research and unique contributions of this study will be highlighted.

Lacking support for partners contributed to couple disconnection. Caregiver distress and lacking support for caregivers of all genders has been documented in cancer care (Decadt et al., 2021), and this issue seems to be exacerbated for sexual minority women partners. Research in the area of group support for caregivers is typically regarding partners within heterosexual couples (Cipolletta et al., 2019; Manne et al., 2003), so this is an area where further research and intervention development would be beneficial. Women partners noted their discomfort in a group setting with male caregivers, so many of the support groups were not options for them.

In addition to difficulty finding support care that was specific to the needs of WPW, partners in this study cited having many demands on their time and did not endorse a high level of support from external sources, whether in the cancer community or their personal lives. Partners seemed to feel that their well-being was secondary to their survivors so they were not seeking self-care or support for themselves as they normally would if they were directly experiencing hardship. This was a common experience for the partner/caregiver participants in this dissertation and this finding has been documented in other research of cancer caregivers (Dionne-Odom et al., 2018). Indeed, Boehmer and colleagues (2005) found that support people (79% partners, but also friends and other family) of sexual minority women with breast cancer had significantly lower perceived support than the patients themselves. Resentment among partners due to these dynamics did contribute to disconnection for the couples in the study and to poorer reported well-being for partners. This would be an important area of future research so as to better understand the experience of caregiver self-neglect and needs for WPW.

Problematic family dynamics contributed to couple disconnection. Another barrier to connection for couples during cancer was problematic dynamics with family members. Three primary dynamics existed that caused problems for survivors and partners in this dissertation study. Firstly, some couples reported that family members were not offering enough support. They had conflict about whether to ask for more support, who should ask for it, what support to ask for, and how that support should be managed. Secondly, survivors and partners reported conflict and disconnection regarding receiving misguided support from family members. They fought over how to navigate repeated offerings of unwanted support and how to repair family relationships when partners and the survivors’ family member had conflict. Lastly, some couples reported stress due to family members requiring emotional support from the survivor and partner who were navigating cancer and other research supports the impact of family stress on WPW (Iwasaki & Ristock, 2007). This was a source of frustration for the couples and a drain of emotional resources. There is not much research about how broader family dynamics negatively impact connection between WPW coping with breast cancer, so this finding may be a unique contribution of the study. It may have been disorienting for family members when survivors and/or partners were not able or willing to maintain in their role of supporting others during the cancer period. Further, due to the younger age of this dissertation sample, some participants were in the situation of caring for parents or other family members as well as their own dependents and themselves during cancer, a caregiving situation referred to as the sandwich generation (DeRigne & Ferrante, 2012). Other studies have addressed social support for sexual minority women (Heiden-Roots & Bono, 2019; Hill & Holborn, 2015; Kent et al., 2019; Lisy et al., 2018) and found that "satisfaction with support, rather than overall level of support, predicted commitment and relationship satisfaction in all couples" (Rostosky & Riggle, 2017, p. 7). This dissertation seems to support these findings, as survivors or partners who were not satisfied with the support available to the couple tended to more dissatisfied and unsure of future commitment. This dissertation extends the research by Rostosky & Riggle (2017) about same-sex relationship strengths into the cancer sphere.

Research Question 3: How does minority stress affect the couple's relationship dynamic and ability to feel connected after cancer?

Minority Stress

Research question three explored the impact of minority stress on the couple's relationship dynamic and connection during and after cancer care. The findings that emerged answering this research question were focused on proximal stressors, intersectionality, affirmative care, and structural stigma. These topics will be discussed in the context of minority stress in the cancer care context and the impact on couple connection.

Proximal stressors and couple connection. Based on Meyer's theory of minority stress (2003), proximal stressors were present for participants in this dissertation study. Especially before cancer treatment began, they endorsed fear of rejection and/or discrimination in the healthcare setting, which was a source of anxiety for both survivors and partners. Caldwell and Peplau (1984) found that lesbian partners were more vigilant than gay male partners regarding discrimination due to their relationship. Survivors and partners in this study made plans together for how to avoid discrimination in the healthcare setting, including by presenting themselves as very committed to one another. Couples also developed strategies for communicating with healthcare providers, including clearly expressing their desire to have their partner involved in their care. In most cases, couples came together when dealing with proximal stress to combat it as a unit. A theory called positive marginality (Unger, 1998) has been used to refer to the strengths and resiliency of people who hold an 'outsider' social status and this framework has been applied to research about the strengths of same-sex couples (DeVries, 2015). Along the same lines, research has found that same-sex couples exhibit relational resilience, in part due to uniting against societal stigma (Lev, 2015). This dissertation supports these findings and relational strengths of WPW in a healthcare context.

On the other hand, it is important to note that prior healthcare experiences and proximal stressors negatively impacted survivors' and partners' expectations for their cancer care and contributed to couple disconnection. Several participants in this dissertation study reported low expectations for their healthcare and assumptions of poor care due to their identity as a sexual minority. This sentiment was represented more in the partner group. Research has shown that sexual minority women avoid routine care due to proximal and distal minority stress (Bonvicini & Perlin, 2003), and some study participants endorsed this behavior. This particular issue caused disconnection for several couples, particularly when one partner refused all routine care due to minority stress, and her survivor felt this was risky given her own cancer diagnosis at a young age that would not have been caught without routine care. These findings support the need to create more affirmative cancer care spaces so that sexual and gender minorities feel adequately safe to seek care and have positive healthcare experiences (Raque et al., 2021). Raque and colleagues (2021) described how this can be accomplished in cancer care with interventions at multiple levels including through changes in cancer care leadership priorities, organizational culture, documentation, physical environment, patient encounters, and more research.

Intersectionality and couple connection. Survivors and partners described how their unique identity informed their experience of cancer care. Regardless of group, participants in this dissertation study endorsed a preference for healthcare providers who also identified as being a woman. They stated having more trust in women providers because they felt that their healthcare requests would be honored. Medical mistrust due to historical mistreatment has negative consequences including less adherence to care, avoidance or delayed treatment, and less satisfaction with care (Ball et al., 2013; Musa et al., 2009). Couples reported feeling more connected to one another when they were supported by woman providers whom they both felt comfortable with and trusted. Interestingly, no participants mentioned a preference for a provider who also identified as a sexual minority woman, perhaps because they thought it might be challenging to find providers who shared that identity.

It is important to note that some partners and survivors reported experiencing racism, heterosexism, and sexism during their cancer care and other medical care. Generally, participants in both groups stated that after receiving poor care that they attributed to health disparities, couples were able to find connection around these issues. They described supporting one another after difficult, isolating, or frustrating experiences. Couples reported joining together to advocate for better healthcare for WPW and minority women.

Affirmative care and couple connection. Survivors described affirmative care as when providers addressed their partner directly, as well as them as a couple. Partners appreciated when providers used the correct terms to refer to their relationship, such as partners or girlfriends. Dissertation study participants felt that affirmative treatment in cancer care validated their relationship and made them more connected as a couple. Partners were especially descriptive about what went well during cancer care that created an affirming environment, and it was aligned with the Multicultural Orientation (MCO). The MCO framework created and researched by Owen (2013) and colleagues (Davis et al., 2018) describes three pillars of cultural humility, comfort, and opportunities. Partners described humility of their providers as evidenced by their openness to them and their relationship. Further, they stated that providers appeared comfortable and natural when interacted with them. Lastly, partners reported that providers took opportunities to get to know them, including their lives as WPW, personally during cancer care.

Structural stigma and couple connection. Research has found that the perception of quality of care and satisfaction with health care providers for sexual minority women is related to structural support, or nondiscrimination legislation (Baldwin et al., 2017; Hatzenbuehler, 2014). The findings of this dissertation are consistent with this research, as most participants were in states with structural support and generally reported satisfaction with care and providers. The couple in a non-structural support state struggled significantly as the survivor was denied the flat mastectomy she requested, which she attributed to sexism and heterosexism in the medical system. She suffered as she sought additional more affirmative medical care and the prolonged medical process negatively impacted her relationship. To summarize, the findings of this dissertation related to minority stress for WPW in cancer care found that the couples exhibited significant relational strengths when dealing with minority stress.

Minority stress added to the burden of cancer for WPW couples, which created additional strain in their relationships; however, they were generally able to support and advocate for one another, which led to couple connection. This dissertation described important aspects of affirmative care for WPW in cancer care and the positive impact of affirmative care on the couple connection for WPW. Additionally, these findings identify ongoing problems with structural issues and minority stress for WPW in cancer care and the need for positive changes that support the well-being of sexual and gender minorities with cancer (Raque et al., 2021).

Limitations

As is often the case in qualitative interview studies, the data was self-reported by participants about their own subjective experiences using a small, non-generalizable sample (Polkinghorne, 2005). The data reflects participants' perceptions of their experiences and events, and the information was not directly corroborated by other sources. In the case of this study, some information was generally and indirectly corroborated by the other woman in the couple, either partner or survivor. However, information was not corroborated by friends, family, or medical providers who may also have direct knowledge of the experiences and events described.

Another limitation is regarding the small sample that completed the quantitative mutuality measure about mutuality (Genero et al., 1992a), thereby preventing statistical analyses. The measure was used, instead, as descriptive data. Further, the validation study for this scale excluded sexual minorities without explanation, and thus further validation of this scale with WPW is needed (Genero et al., 1992a).

The tendency for participants to respond in a way that supports social desirability is a general limitation of qualitative research and this study. Participants may have wanted to protect their own image, that of their partner, or of their relationship, therefore highlighting positive information and minimizing negative experiences. Conducting the survivor and partner interviews separately may have minimized this tendency. Further, steps have been taken to keep participant responses anonymous so that each couple cannot identify their partner's responses.

Sample size and sampling are also limitations of the study. The total sample size of 10 participants, with five in each group was half of the intended sample. Recruitment challenges contributed greatly to this outcome. More participants and data in each group may have made the most salient themes for the population even more clear. Regarding sampling, the participants in this study were predominantly White, highly educated, insured, and relatively stable in terms of financial health. They also appeared to be quite committed to their partnership. Participants were highly motivated to participant in research and to share their stories. These sample size and sampling limitations mean that the findings of this study are not necessarily generalizable to other women partnered with women experiencing breast cancer. Interviewing WPW with less privileged identities, less education, less stable relationships, and poor access to health care could result in different findings. In any case, similar studies with this population would be useful to compare results, and quantitative studies would be beneficial for generalizability.

The majority of the research team shared many demographics with the majority of the research participants, in terms of identifying as White women with relative privilege and power based on overall demographics. The lack of diversity across identities within the research team is a limitation, as our worldviews, life experiences, and graduate training likely led us to analyze the data in similar ways. Another limitation of the study may have been the PI's lack of shared relationship and illness experiences with the participants. Several participants asked about the PI's partnership status and gender of partner, as well as medical history including whether the PI had cancer. These questions were answered, albeit briefly, and interest in the overall topic was shared; however, participants may have felt more understood or compelled to share their experiences if the PI had shared identities and experiences. The interviewer attempted to build rapport and express empathy, while still maintaining an interviewer role.

Lastly, a limitation of this study is that the survivor and partner groups were asked the same interview questions. This was done intentionally, as the ability to compare/contrast experiences between the two groups was valuable and desirable to the study design. However, more divergence in the questions for each group, or a separate subset of questions for each group may have been beneficial to garner more information about the uniqueness of their experience as a partner or survivor. Further, the interview protocol may have been too large in scope, as they took longer than anticipated and there was not adequate time to ask follow-up questions for all questions. This study aimed to explore the inner workings of intimate relationships, healthcare experiences, and sociocultural factors. Perhaps more focused inquiry would have garnered a more in-depth exploration of the desired topics.

Implications for Practice and Research

Practice. This dissertation study did not directly assess clinical interventions, medical or psychological, for younger women partnered with women who experienced breast cancer. Therefore, the practice implications of the current study's findings are speculative and for cautious consideration only. This section on implications for practice can be used to inform health care providers in various disciplines, as well as system level practices, and the offerings of community organizations. It may be beneficial to guide future directions for empirical research.

Based on participants' description of their medical experiences in the healthcare system, many oncology treatment settings and providers are providing affirmative care to women partnered with women. Drawing from the experiences of participants' healthcare providers indicate that care is affirmative by honoring couple's relationships, including partners in care and decision-making, and ensuring that the language on forms and in handbooks are inclusive of various patient identities, partner identities, and couple types. For example, breast cancer survivors and partners reported that heteronormative forms, language, and assumptions during their care created feelings of isolation and was emotionally draining due to their vigilance of these situations and making decisions about how to address them.

Medical providers could also improve by attending more to the impact of cancer on intimacy for younger couples, and women partnered with women, particularly. Some study participants felt that the impact of cancer on their life as younger survivors was not acknowledged or attended to in the medical or broader community. When they asked about how to resume physical intimacy safely, they felt the topic was brushed over, or that generic statements were made that did not reflect the nature of their sexual practices with their woman partner. Further, some couples did not feel comfortable broaching this topic at all, especially with male providers. Including this topic in medical appointment check ins and/or offering psychoeducation about breast cancer treatment and intimacy may have eased the burden and stress for couples. Medical providers could consider brief screening of patients and/or couples for psychological distress during their care and providing referrals for support.

Regarding psychological practice, one implication for practice based on this study is to offer mental health support for cancer survivors and caregivers in the treatment setting. Although this topic was not specifically asked, no participants reported offers of psychological support. Several reported the lack of psychological support and that it would have been very beneficial if offered. Based on the findings of this study, a Relational Cultural Theory approach to treatment would likely be beneficial to women partnered with women going through breast cancer, to address relational distress due to cancer and promote optimal functioning in terms of mutuality and authenticity for couples.

Within a Relational Cultural Theory framework, a variety of interventions may be beneficial for women partnered with women coping with breast cancer. First of all, in couples' treatment, an emphasis on communication patterns would be useful. Therapy may start with an assessment of authenticity in the relationship and understanding strengths or barriers to authenticity in the relationship. Specifically in a new situation such as cancer, couples may struggle to be authentic due to feeling overwhelmed or uncertain even if they otherwise are open with one another. A therapist can help identify new thoughts and feelings about cancer that have not yet been shared, including how to cultivate mutuality. Psychoeducation about the central relational paradox may be useful for couples to help partners understand the long-term negative implications of withholding their true experience. Therapy could be beneficial for building mutual empathy within the relationship. Based on this study, survivors and partners may have difficulty understanding and empathizing with the hardships of the other. Further, helping couples to adjust their thinking, or to have increased relationship awareness, about their partner and their relationship could lead to better adjustment to cancer as a couple. Instillation of hope for the future and a recognition of strengths is valuable in most clinical situations, as well as modeling empathy (Freedberg, 2007). Normalizing the challenges of the cancer experience for all couples may also be beneficial, as some younger couples especially may be going through their first major hardship together and have limited confidence in their ability to progress through it.

When working with WPW in therapy, it might be beneficial to recognize the values of their particular partnership. For some WPW, balance and equality is an important relationship value that may be hard to maintain during cancer and cause distress. Utilizing a multicultural orientation (Davis et al., 2018) including approaching the clinical encounters with humility, comfort, and interest to learn about the WPW couple would be essential to providing good care and therapeutic benefit. Along the same lines, bringing each partner’s identities into the treatment may be beneficial, particularly if the intersection of identities for the couple is causing a conflict of worldview, lived experience, or behavior. Specifically, assessing and exploring experiences of discrimination for WPW and how the couple has coped with these issues would be important (Scott, 2016). Whitton and colleagues (2013) successfully piloted a workshop for women partnered with women on coping with discrimination related distress, providing support for attention to experiences with discrimination within group intervention settings. So, there is some evidence for this type of intervention in group settings, as well. Particularly if clients are experiencing discrimination due to their identities or relationship, placing emphasis on the client to change their thoughts, behaviors, or feelings could be invalidating or harmful (Jordan, 2018). Lastly, encouraging clients to become involved in advocacy work, or joining them in advocacy, is one way to promote empowerment, a sense of control, and purpose related to making systematic changes. For example, several couples in this sample reported that advocating for more awareness of the experience and treatment needs of WPW going through cancer was healing.

In this dissertation study, patients and some couples reported benefit from community support services and non-profit organizations. They found these interactions to improve well-being, reduce isolation, and promote healing. A notable absence based on these participants was community support for partners. Additionally, for those women partners who identified community support, it was not tailored to a woman partner of a breast cancer survivor. Helping partners identify affirmative community resources would likely be beneficial for partners (Puckett et al., 2017).

Research. This study focused on the relational impact of breast cancer on the relationships of younger women partnered with women, including how healthcare experiences and sociocultural issues impacted their sense of connection to one another. The limitations and findings of this study are useful in helping to identify future research directions. The homogeneity of the sample in this study regarding racial/ethnic background, education level, and perception of acceptance of WPW in their community limits the ability of this study to understand the influence of difference cultural contexts of WPW couples going through breast cancer. Despite nationwide recruitment efforts and couples from a variety of states, participants tended to be from areas that they described as accepting of their relationship. Research shows that the region in which one lives impacts lived experience (Deaux, 1993), so one area for future research is to explore the experience of WPW in regions where they may experience more discrimination or microaggressions. Their lived experiences of minority stress in daily life and/or the healthcare setting may be different from the sample included in this study and shed more light on how these factors impact couple connection. Further, another shortcoming regarding the sample for this dissertation is the small size, which limits the generalizability of the findings. A larger quantitative study looking at the impact of relational and sociocultural influences upon WPW couple connection may provide more opportunity for generalizability.

Another area for future research is regarding psychological intervention for WPW couples going through breast cancer. One potential avenue would be a needs assessment study within oncology practices to determine which couples are experiencing cancer-related relationship distress and who could benefit from intervention. Secondly, it would be interesting to research the impact of providing brief psychological support to couples, particularly WPW couples, within the oncology setting. Partners and spouses often attend oncology appointments, so this setting seems particularly ripe for couple intervention. Participants in this study did not report meeting psychologists or other mental health providers as part of their normal course of oncology treatment, and some indicated the absence of any such support. Research shows that integrated behavioral health support in oncology settings, also known as psycho-oncology, is beneficial to patients because it meets their cancer-related psychological needs, provides accessible support whenever needed during their cancer care, and does not incur a significant cost (Nekolauchuk et al., 2013). Research regarding relationship outcomes for couples, including WPW, who do access psycho-oncology support during cancer may be beneficial for increasing the accessibility of these services in cancer centers. Lastly, research should be done that considers the timing of psychological intervention in oncology settings to determine when most couples are likely to experience therapeutic change (Revenson & DeLongis, 2011). Along the same lines, research to determine the most efficacious elements of intervention for therapeutic change would be beneficial to support the activity of mental health providers in brief treatment oncology settings (Revenson & DeLongis, 2011). Cao and colleagues (2017) conducted a meta-analysis of research on sexual minority stress and same-sex relationship well-being. They suggested future research directions including further investigation of the impact of stress on same-sex couples including conditions in which these couples can flourish and successfully navigate the impact of stress, as well the circumstances in which stress will damage relationship functioning and health for same-sex couples (Cao et al., 2017).

There is room for growth in the research on posttraumatic growth for partners, survivors, and couples after cancer (Manne et al., 2004). Rostosky and Riggle (2017) studied resilience in queer populations, and more studies on PTG in this population may highlight the strengths of WPW couples, which were highlighted by this dissertation study. More research on the role of gender in PTG after cancer, and mechanisms internal or external to WPW couples that facilitate PTG after cancer would also be beneficial.

Partners and survivors in this dissertation study cited the benefits of light-hearted interactions and the use of humor with their loved one. They described these types of interactions as beneficial for personal coping and as a source of connection during difficult moments in their cancer experience. More research on the use of humor in interpersonal relationships as a coping mechanism for cancer may be beneficial. A humor and cancer study might include survivors and their loved ones, including WPW, or with friends, family members, or even medical providers. Research of this kind could be beneficial for caregivers as they navigate the seriousness of cancer with their loved one. Several partners in this dissertation study noted the seriousness of the atmosphere and not knowing if or how to alleviate that feeling. Evidence-based recommendations for the use or humor and playfulness in caregiving could be a source of comfort and levity for couples.

Lastly, future research investigating women partnered with women and cancer could utilize the Marital Adjustment Test (MAT; Locke & Wallace, 1959). This is a common and rapid measure used to assess relationship quality and whether a couple is distressed or non-distressed (Markman et al., 1993). A future study could utilize this measure related to cancer experience in order to gather information about couple adjustment and distress levels.

In summary, implications for practice described include adjustments to structural aspects of cancer care (forms, language, electronic medical record). Additionally, more individualized medical treatment for younger WPW would be beneficial. Increasing mental health accessibility for WPW couples including relational therapy and/or psychoeducation is another practice recommendation. Lastly, increasing services for partners within cancer treatment facilities and the community is needed. Regarding research, additional studies including WPW in different regions of the United States would be beneficial to gain a fuller understanding of the cancer care experience. Research regarding screening for mental health and relational concerns in cancer centers, as well as intervention and outcome studies would shed light on what would be most helpful for healthcare systems to incorporate.

Summary of Key Findings

This dissertation focused on the relational impact of breast cancer on younger women partnered with women, and investigated how relational processes within the couple, external supports and barriers, and minority stress related to healthcare experiences or broader sociocultural processes influenced connection and disconnection for the couples. Findings revealed that despite divergent cancer timelines and relationship histories, the sample endorsed similar experiences. They described relationship strengths and vulnerabilities in the context of cancer and how patterns of interaction within their relationship contributed to their well-being as couples. Couples described navigating boundaries in their relationships and seeking opportunities for authentic communication. Participants endorsed the type of support they received that engendered more couple connection, including what providers conveyed that was affirmative and what was not helpful.

References

Acitelli, L. (1988). When spouses talk to one another about their relationship. *Journal of Social and Personal Relationships, 5,* 185–199. doi: 10.1177/026540758800500204

Ackbar, & Senn, C. Y. (2010). What's the confusion About fusion? Differentiating positive and negative closeness in lesbian relationships. *Journal of Marital and Family Therapy*, *36*(4), 416–430. https://doi.org/10.1111/j.1752 0606.2010.00219.x

Adams, E., McCann, L., Armes, J., Richardson, A., Stark, D., Watson, E., & Hubbard, G. (2011). The experiences, needs and concerns of younger women with breast cancer: A meta-ethnography. *Psycho-Oncology, 20*(8), 851-861. doi:10.1002/pon.1792

Alderson. (2013). *Counseling LGBTI clients*. SAGE Publications.

American Breast Cancer Foundation. (2022). https://www.abcf.org/

American Cancer Society (2020, February 8). Breast Cancer. https://www.cancer.org/cancer/breast-cancer.html

American Psychological Association (2015). *Stress in America. Paying With Our health*. Available online at: https://www.apa.org/news/press/releases/stress/ 2014/stress report.pdf

Arena, P. L., Carver, C. S., Antoni, M. H., Weiss, S., Ironson, G., & Durán, R. E. (2007). Psychosocial responses to treatment for breast cancer among lesbian and heterosexual women. *Women & Health, 44*(2), 81-102.

doi:10.1300/J013v44n02_05

Badr, H., Acitelli, L., & Carmack Taylor, C. (2008). Does talking about their relationship affect couples' marital and psychological adjustment to lung cancer? *Journal of Cancer Survivorship, 2*(1), 53-64. doi:10.1007/s11764-008-0044-3

Badr, H., Carmack, C. L., Kashy, D. A., Cristofanilli, M., & Revenson, T. A. (2010). Dyadic coping in metastatic breast cancer. *Health Psychology, 29*(2), 169-180. doi:10.1037/a0018165

Baider, Ever-Hadani, P., Goldzweig, G., Wygoda, M. R., & Peretz, T. (2003). Is perceived family support a relevant variable in psychological distress?: A sample of prostate and breast cancer couples. *Journal of Psychosomatic Research*, *55*(5), 453–460. https://doi.org/10.1016/S0022-3999(03)00502-6

Baldwin, A. M., Dodge, B., Schick, V., Sanders, S. A., & Fortenberry, J. D. (2017). Sexual minority women's satisfaction with health care providers and state-level structural support: Investigating the impact of lesbian, gay, bisexual, and transgender nondiscrimination legislation. *Women's Health Issues*, *27*(3), 271 278.

Ball, K., Lawson, W., & Alim. T. (2013). Medical mistrust, conspiracy beliefs & HIV related behavior among african americans. *Journal of Psychology & Behavioral Science, 1*, 1-7.

Ben-Zur H, Gilbar O, & Lev S. (2001). Coping with breast cancer: patient, spouse, and dyad models. *Psychosomatic Medicine, (63),* 32–39.

Berrill, K. T. (1992). Anti-gay violence and victimization in the United States: An overview. In G. M. Herek & K. T. Berrill (Eds.), Hate crimes: Confronting violence against lesbians and gay men (pp. 19– 45). Newbury Park, CA: Sage.

Bleicher, R. J., Ruth, K., & Sigurdson, E. R. Time to surgery and breast cancer survival in the united states. (2016). *JAMA Oncology, 2*(3), 330–339. doi:10.1001/jamaoncol.2015.4508

Bodenmann, G. (1997). Dyadic coping-a systemic-transactional view of stress and coping among couples: Theory and empirical findings. *European Review of Applied Psychology, 47,* 137-140.

Boehmer, U., & Case, P. (2004). Physicians don't ask, sometimes patients tell: disclosure of sexual orientation among women with breast carcinoma. *Cancer, 101*(8), 1882–9.

Boehmer, U., & Elk, R. (2015). *Cancer and the LGBT Community: Unique Perspectives from Risk to Survivorship* (2015 ed.). Cham: Springer International Publishing.

Boehmer, U., Glickman, M., Winter, M., & Clark, M. A. (2013a). Breast cancer survivors of different sexual orientations: which factors explain survivors' quality of life and adjustment? *Annals of Oncology, 24*(6), 1622-30.

Boehmer, U., Glickman, M., Winter, M., & Clark, M.A. (2013b). Lesbian and bisexual women's adjustment after a breast cancer diagnosis. *Journal of the American Psychiatric Nurses Association, 19*(5), 280–92.

Boehmer, U., Glickman, M., Winter, M., & Clark, M.A. (2014a). Coping and benefit finding among long-term breast cancer survivors of different sexual orientations. *Women & Therapy, 37*(3– 4), 222–41.

Boehmer, U., Freund, K. M., Linde R. (2005). Support providers of sexual minority women with breast cancer: Who they are and how they impact the breast cancer experience. *Journal ofPsychosomatic Research*, *59*(5), 307–314. https://doi.org/10.1016/j.jpsychores.2005.06.059

Boehmer, U., Linde, R., & Freund K. M. (2005). Sexual minority women's coping and psychological adjustment after a diagnosis of breast cancer. *Journal of Women's Health, 14*(3), 214-224.

Boehmer, U., Linde, R., & Freund, K. M. (2007). Breast reconstruction following mastectomy for breast cancer: the decisions of sexual minority women. *Plastic and Reconstructive Surgery*, *119*(2), 464–72.

Boehmer, U., Ozonoff, A., Timm, A., Winter, M., & Potter, J. (2014b). After breast cancer: Sexual functioning of sexual minority survivors. *The Journal of Sex Research, 51*(6), 681-9.

Boehmer, U., Timm, A., Ozonoff, A., & Potter, J. (2012). Explanatory factors of sexual function in sexual minority women breast cancer survivors. *Annals of Oncology, 23*(11),2873–8.

Boehmer, U., Stokes, J. E., Bazzi, A.R., Winter, M., Clark, M.A. (2018). Dyadic stress of breast cancer survivors and their caregivers: are there differences by sexual orientation? *Psycho-Oncology, 27*, 2389-2397.

Boss, P. (2009). The trauma and complicated grief of ambiguous loss. *Pastoral Psychology, 59*(2), 137–145.

Boyd, D. R., & Bee, H. L. (2008). *Lifespan development* (5th ed.). Boston, MA: Pearson.

Brandão, T., Pedro, J., Nunes, N., Martins, M. V., Costa, M. E., & Matos, P. M. (2017). Maritaladjustment in the context of female breast cancer: A systematic review. *Psycho-Oncology, 26*(12), 2019-2029. doi:10.1002/pon.4432

Braun, M., Hasson-Ohayon, I., Perry, S., Kaufman, B., & Uziely, B. (2005). Motivation for giving birth after breast cancer. *Psycho-Oncology, 14,* 282-296. doi: 10.1002/pon.844

Breast Cancer Foundation Susan G. Komen. (2022). https://www.komen.org/breast cancer/

Breast Cancer Husband: How to Help Your Wife (and Yourself) During Diagnosis, Treatment and Beyond. (2005). *Oncology Nursing Forum*, *32*(2), 384.

Brown, M., & McElroy, J. (2018). Unmet support needs of sexual and gender minority breast cancer survivors. Supportive Care in Cancer, 26(4), 1189-1196. doi:10.1007/s00520-017-3941-z

Caldwell, M. A., & Peplau, L. A. (1984). The balance of power in lesbian relationships. *Sex Roles, 10*(7-8), 587-599. https://doi.org/10.1007/BF00287267

Cao, H., Zou, N., Fine, M., Liang, Y., Li, J., & Mills-Koonce, W. (2017). Sexual minority stressand same-sex relationship well-being: A meta-analysis of research prior to the U.S. nationwide legalization of same-sex marriage. *Journal of Marriage and the Family, 79*(5), 1258-1277. doi: https://doi org.du.idm.oclc.org/10.1111/jomf.12415

Casellas-Grau, Ochoa, C., & Ruini, C. (2017). Psychological and clinical correlates of posttraumatic growth in cancer: A systematic and critical review. *Psycho Oncology*, *26*(12), 2007–2018. https://doi.org/10.1002/pon.4426

Champion, V. L., Wagner, L. I., Monahan, P. O., Daggy, J., Smith, L., & Cohee, A., et al. (2014). Comparison of younger and older breast cancer survivors and age matched controls on specific and overall quality of life. *Cancer, 120*, 2237–2246. doi: 10.1002/cncr.28737

Cho, S., Crenshaw, K. W., & McCall, L. (2013). Toward a field of intersectionality studies: Theory, applications, and praxis. *Signs, 38*(4), 785 810.doi:10.1086/669608

Cipolletta, S. C., & Faccio, E. (2019). The effectiveness of psychoeducational support groups for women with breast cancer and their caregivers: A mixed methods study. *Frontiers in Psychology*, *10*, 288–288. https://doi.org/10.3389/fpsyg.2019.00288

Cogan, J. C. (1996). The prevention of anti-lesbian gay hate crimes through social change and empowerment. In E. Rothblum & L. A. Bond (Eds.), Preventing heterosexism and homophobia (pp. 219–238). Thousand Oaks, CA: Sage.

Cole, E. R. (2009). Intersectionality and research in psychology. *American Psychologist* *64*(3), 170–80.

Comstock, D., Hammer, T. R., Strentzsch, J., Cannon, K., Parsons, J., & Salazar, G. (2008). Relational-cultural theory: A framework for bridging relational, multicultural and social justice competencies. *Journal of Counseling &*

Development, 86, 279-287. http://dx. doi.org/10.102/j.1556-6678.2008.tb00510.x

Corter, A. L., Speller, B., Sequeira, S., Campbell, C., Facey, M., & Baxter, N. N. (2019). What young women with breast cancer get versus what they want in online information and social media supports. *Journal of Adolescent and Young Adult Oncology*, *8*(3), 320-328.

Covelli, A., Facey, M., & Kennedy, E. (2019). Clinicians' perspectives on barriers to discussing infertility and fertility preservation with young women with cancer. *JAMA, 2*(11). doi:10.1001/jamanetworkopen.2019.14511

Cramer, D., & Jowett, S. (2010). Perceived empathy, accurate empathy and relationship satisfaction in heterosexual couples. *Journal of Social and Personal Relationships*, *27*(3), 327-349. https://doi.org/10.1177/0265407509348384

Crenshaw, K. W. (1989). Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics. *University of Chicago Legal Forum, 1*(8), 139–67.

Creswell, J. W. (2012). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). Thousand Oaks, CA: SAGE Publications, Inc.

Damaskos, Amaya, B., Gordon, R., & Walters, C. B. (2018). Intersectionality and the LGBT cancer patient. *Seminars in Oncology Nursing*, *34*(1), 30–36. https://doi.org/10.1016/j.soncn.2017.11.004

Davis, DeBlaere, C., Owen, J., Hook, J. N., Rivera, D. P., Choe, E., Van Tongeren, D. R., Worthington, E. L., & Placeres, V. (2018). The multicultural orientation framework: A narrative review. *Psychotherapy (Chicago, Ill.)*, *55*(1), 89–100. https://doi.org/10.1037/pst0000160

Dean, M. A., Victor, E., & Guidry-Grimes, L. (2016). Inhospitable healthcare spaces: Why diversity training on LGBTQIA issues is not enough. *Journal of Bioethical Inquiry, 13,* 557-570.

Decadt, I., Laenen, A., Celus, J., Geyskens, S., Vansteenlandt, H., & Coolbrandt, A. (2021). Caregiver distress and quality of life in primary caregivers of oncology patients in active treatment and follow-up. *European Journal of Cancer Care*, *30*(3).

DeHart. (2008). Breast health behavior among lesbians: The role of health beliefs, heterosexism, and homophobia. *Women & Health, 48*(4), 409-427. https://doi.org/10.1080/03630240802575146

Dentato, M. P., Orwat, J., Spira, M., & Walker, B. (2014). Examining cohort differences and resilience among the aging LGBT community: Implications for education and practice among an expansively diverse population. *Journal of Human Behavior in the Social Environment, 24*(3), 316-328.

DeRigne, L., & Ferrante, S. (2012). The sandwich generation: A review of the literature. *Florida Public Health Review*, *9*(1), 12.

De Vries, B. (2015). Stigma and LGBT aging: Negative and positive marginality. In N. A. Orel, C. A. Fruhauf, N. A. Orel, & C. A. Fruhauf (Eds.), *The lives of LGBT older adults: Understanding challenges and resilience,* 55–71. Washington, DC: American Psychological As- sociation. http://dx.doi.org/10.1037/14436-003

Dibble, S. L., & Roberts, S. A. (2002). A comparison of breast cancer diagnosis and treatment between lesbian and heterosexual women. *Journal of the Gay and Lesbian Medical Association, 6*(1), 9–17.

Donaldson, C., & Raymond, Beth. (1993). *Correlates of Relationship Satisfaction for Lesbian Couples,* ProQuest Dissertations and Theses.

Doyle, D. M., & Molix, L. (2015). Social stigma and sexual minorities' romantic relationship functioning: A meta-analytic review. *Personality and Social Psychology Bulletin, 41,* 1363–1381. http://dx.doi.org/10 .1177/0146167215594592

Drabe, N., Wittmann, L., Zwahlen, D., Buchi, S., and Jenewein, J. (2013). Changes in close relationships between cancer patients and their partners. Psychooncology 22, 1344–1352. doi: 10.1002/pon.3144

Fergus, K. D., & Gray, R. E. (2009). Relationship vulnerabilities during breast cancer: Patient and partner perspectives. *Psycho-Oncology, 18*(12), 1311-1322. doi:10.1002/pon.1555

Fish, J., Williamson, I., & Brown, J. (2019). Disclosure in lesbian, gay, and bisexual cancer care: Towards a salutogenic healthcare environment. *BMC Cancer, 19*, 678-690. doi: 10.1186/s12885-019-5895-7.

Fitzgerald, S. B. (2004). Making the transition: Understanding the longevity of lesbian relationships. Journal of Lesbian Studies, 8, 177–192.

Fobair, P., O'Hanlan, K., Koopman, C., Classen, C., Dimiceli, S., & Drooker, N., et al. (2001). Comparison of lesbian and heterosexual women's response to newly diagnosed breast cancer. *Psycho-Oncology, 10*(1), 40–51.

Freedberg, S. (2007). Re-examining empathy: a relational-feminist point of view. *Social Work, 52*(3), 251-259.

Frost, D. M., & Eliason, M. J. (2014). Challenging the assumption of fusion in female same-sex relationships. *Psychology of Women Quarterly*, *38*(1), 65-74.

Galupo, M. P. (2007). Friendship patterns of sexual minority individuals in adulthood. *Journal of Social and Personal Relationships, 24,* 139–151.

Ganiron, E., & Kuba, Sue A. (2007). *Mutuality and relationship satisfaction in the formation of lesbian relationships across the life cycle: Unpacking the u-Haul myth,* ProQuest Dissertations and Theses.

Genero, N.P., Miller, J.B., & Surrey, J. (1992b). The mutual psychological development questionnaire. (Project Report, No. 1). Wellesley, MA: Stone Center Working Paper Series.

Genero, N. P., Miller, J. B., Surrey, J., & Baldwin, L. M. (1992a). Measuring perceived mutuality in close relationships: validation of the mutual psychological development questionnaire. *Journal of Family Psychology, 6*(1), 36-48. doi:10.1037/08933200.6.1.36

Gilbert, E., Ussher, J., & Perz, J. (2010). Renegotiating sexuality and intimacy in the context of cancer: The experiences of carers. *Archives of Sexual Behavior, 39*(4), 998-1009. doi:10.1007/s10508-008-9416-z

Gilbar, O., Steiner, M., Atad, J. (1995). Adjustment of married couples and unmarried women to gynaecological cancer. *Psychooncology, 4*, 203–11.

GLAAD. (2020, April 26). GLAAD Media Reference Guide, 10th Edition. https://www.glaad.org/sites/default/files/GLAAD-Media-Reference-Guide-Tenth-Edition.pdf

Goldberg, A. E., Ross, L. E., Manley, M. H., & Mohr, J. J. (2017). Male-partnered sexual minority women: Sexual identity disclosure to health care providers during the perinatal period. Psychology of Sexual Orientation and Gender Diversity, 4(1), 105–114. https://doi-org.du.idm.oclc.org/10.1037/sgd0000215

Gottman, J. M. (1994). *What predicts divorce?: The relationship between marital processes and marital outcomes.* Lawrence Erlbaum Associates.

Green, R-J. & Werner, P. D. (1996). Intrusiveness and Closeness-Caregiving: Rethinking the Concept of Family "Enmeshment." *Family Process*, *35*(2), 115–136. https://doi.org/10.1111/j.1545-5300.1996.00115.x

Harrison, O. (2021, Feb 22). Our partners, ourselves: why is it so hard to know what to call a significant other? Refinery29. https://www.refinery29.com/en us/2021/02/10286494/partner-term-relationship-complicated-meaning

Havighurst, R. J. (1953). *Human development and education*. Oxford, UK: Longmans, Green.

Heron, K. E., Braitman, A. L., Lewis, R. J., Shappie, A. T., & Hitson, P. T. (2018). Measuring sexual minority stressors in lesbian women's daily lives: Initial scale development. *Psychology of Sexual Orientation and Gender Diversity, 5*(3), 387 395. doi: 10.1037/sgd0000287

Hill, C. A. (1999). Fusion and conflict in lesbian relationships. Feminism and Psychology, 9, 179–185

Hill, C. E. (Ed.). (2012). *Consensual qualitative research: A practical resource for investigating social science phenomena.* American Psychological Association.

Hill, & Holborn, C. (2015). Sexual minority experiences of cancer care: A systematic review. *Journal of Cancer Policy*, *6*, 11–22. https://doi.org/10.1016/j.jcpo.2015.08.005

Hill, C. E., Kellems, I. S., Kolchakian, M. R., Wonnell, T. L., Davis, T. L., & Nakayama, E. Y. (2003). The therapist experience of being the target of hostile versus suspected unasserted client anger: Factors associated with resolution. *Psychotherapy Research, 13,* 475–491.

Hill, C. E., Knox, S., Thompson, B.J., Williams, E. N., Hess, S., & Ladany, N. (2005). Consensual qualitative research: An update. *Journal of Counseling Psychology, 52*(2), 196–205.

Hill, C. E., Thompson, B. J., & Williams, E. N. (1997). A guide to conducting consensual qualitative research. *The Counseling Psychology, 25*(4), 517-572.

Hilton, A. B. (1994). Family communication patterns in coping with early breast cancer. *Western Journal of Nursing Research, 16*(4), 366-391.

Ho, Sheldon, T. A., & Botelho, E. (2021). Medical mistrust among women with intersecting marginalized identities: a scoping review. Ethnicity & Health, 1–19. https://doi.org/10.1080/13557858.2021.1990220

Hoskins, C. N. (1995). Adjustment to breast cancer in couples. *Psychological Reports, 177*, 435–54.

Howlader, N., Noone, A. M., Krapcho, M., Neyman, N., Aminou, R., Altekruse, S. F. . . Cronin, K. A. (2009). *SEER Cancer Statistics Review, 1975-2009* (Vintage 2009 Populations). Bethesda, MD: National Cancer Institute. Retrieved from http://seer.cancer.gov/csr/1975_2009_pops09/

Hulvat, M. C., & Jeruss, J. S. (2009). Maintaining fertility in young women with breast cancer. *Current Treatment Options in Oncology, 10,* 308–317. doi: 10.1007/s11864-010-0116-2

Iwasaki, Y., & Ristock, J. L. (2007). The nature of stress experienced by lesbians and gay men. *Anxiety, Stress, and Coping*, *20*(3), 299-319.

Jabson, J. M., Donatelle, R.J., & Bowen, D. (2011). Breast cancer survivorship: the role of perceived discrimination and sexual orientation. *Journal of Cancer Survivorship, 5*(1):92–101.

Jordan, J. V. (2018). *Relational-Cultural Therapy (2nd Ed.).* American Psychological Association.

Jordan, J. V. (2008). Valuing vulnerability: New definitions of courage. *Women & Therapy, 31*(2-4), 209-233, DOI: 10.1080/02703140802146399

Jordan, J. V. (2000). The role of mutual empathy in relational/cultural therapy. *Journal of Clinical Psychology, 56,* 1005-1016. http://dx.doi.org/10.1002/1097 4679(200008)56:8<1005:: AID-JCLP>3.0.CO;2-L

Jordan, J. V., & Hartling, L. M. (2002). New developments in relational-cultural theory.

In M. Ballou & L. Brown (Eds.), *Rethinking mental health and disorder: Feminist perspectives* (pp. 48-70). New York, NY: Guilford Press.

Jordan, J.V., Kaplan, A.G., Miller, J.B., Stiver, I.P. & Surrey, J.L. (1991). Women's growth in connection: Writings from the Stone center. The Guilford Press: New York.

Katz, A. (2009). Gay and lesbian patients with cancer. *Oncology Nursing Forum, 36*(2), 203-207. doi:10.1188/09.ONF.203-207

Katz-Wise, S. L., & Hyde, J. S. (2012). Victimization experiences of lesbian, gay, and bisexual individuals: A meta-analysis. *Journal of Sex Research, 49*(2–3), 142 167. http://dx.doi.org/10.1080/00224499.2011 .637247

Kayser, K., & Acquati, C. (2019). The influence of relational mutuality on dyadic coping among couples facing breast cancer. *Journal of Psychosocial Oncology, 37*(2), 194-212. doi:10.1080/07347332.2019.1566809

Kayser, K., Sormanti, M., & Strainchamps, E. (1999). Women coping with cancer: The influence of relationship factors on psychosocial adjustment. *Psychology of Women Quarterly, 23*, 725-739.

Kayser, K., Watson, L. E., & Andrade, J. T. (2007). Cancer as a "we-disease". *Families, Systems, & Health, 25*(4), 404-418. doi: 10.1037/1091-7527.25.4.404

Keesing S, Rosenwax L, & McNamara B. (2016). A dyadic approach to understanding the impact of breast cancer on relationships between partners during early survivorship. *BMC Womens Health, 16*(1), 57. https://doi.org/10.1186/s12905 016-0337-z

Kent, Wheldon, C. W., Smith, A. W., Srinivasan, S., & Geiger, A. M. (2019). Care delivery, patient experiences, and health outcomes among sexual and gender minority patients with cancer and survivors: A scoping review. *Cancer*, *125*(24), 4371–4379. https://doi.org/10.1002/cncr.32388

Klein. (2014). Are You Sure You're Heterosexual? Or Homosexual? Or Even Bisexual? Journal of Bisexuality, 14(3-4), 341–346. https://doi.org/10.1080/15299716.2014.953282

Knox, S., Burkard, A. W., Johnson, A. J., Suzuki, L. A., & Ponterotto, J. G. (2003). African American and European American therapists' experiences of addressing race in cross racial psychotherapy dyads. *Journal of Counseling Psychology, 50*, 466–481.

Kranz, D., & Pierrard, M. (2018). Beyond coming out: Relations between lesbian and gay identity formation and psychosocial well-being in young and middle adulthood. *Psychology of Sexual Orientation and Gender Diversity, 5*(3), 283-293. doi: 10.1037/sgd0000270

Kravdal, H., & Syse, A. (2011). Changes over time in the effect of marital status on cancer survival. *BMC Public Health, 11*, 804-817. doi:10.1186/1471-2458-11 804

Krestan, J., & Bepko, C. S. (1980). The problem of fusion in the lesbian relationship. Family Process, 19, 277–289

Kumar, P., & Aggarwal, R. An overview of triple-negative breast cancer. (2016). *Archives of Gynecology and Obstetrics, 293*, 247–269.

https://doi.org/10.1007/s00404-015-3859-y

Kurdek, L. A. (2001). Differences between heterosexual-nonparent couples and gay, lesbian, and heterosexual-parent couples. *Journal of Family Issues, 22,* 727–754. http://dx.doi.org/10.1177/019251301022006004

Kurdek, L. A. (2003). Differences between gay and lesbian cohabiting couples. *Journal of Social and Personal Relationships, 20,* 411–436. http://dx.doi.org/10.1177/02654075030204001

Kuyper, L., & Fokkema, T. (2011). Minority stress and mental health among Dutch LGBs: Examination of differences between sex and sexual orientation. *Journal of Counseling Psychology, 58,* 222–233. http://dx.doi.org/10.1037/a0022688

Lally, R. M., Hydeman, J. A., Schwert, K. T., & Edge, S. B. (2013) Unsupportive social interactions in the weeks immediately following breast cancer diagnosis. *Journal of Psychosocial Oncology, 31*(4), 468–88.

Lambda Legal. (2020, April 26). When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT and People with HIV. http://www.lambdalegal.org/publications/when-health-care-isnt-caring

Lev, A. I. (2015). Resilience in lesbian and gay couples. In K. Skerrett, K. Fergus, K. Skerrett, & K. Fergus (Eds.), *Couple resilience: Emerging perspectives,* 45–61. New York, NY: Springer Science Business Media. http://dx.doi.org/10.1007/978 94-017-9909-6_3

Levitt, Bamberg, M., Creswell, J. W., Frost, D. M., Josselson, R., & Suárez-Orozco, C. (2018). Journal Article Reporting Standards for Qualitative Primary, Qualitative Meta-Analytic, and Mixed Methods Research in Psychology: The APA Publications and Communications Board Task Force Report. *The American Psychologist*, *73*(1), 26–46. https://doi.org/10.1037/amp0000151

Liang, B., Tracy, A., Taylor, C., Williams, L. V., Jordan, J., & Baker Miller, J. (2002). The relational health indices: A study of women's relationships. *Psychology of Women Quarterly, 26*(1), 25–35. doi:10.1111/1471-6402.00040

Lim, J. (2019). The role of post-traumatic growth in promoting healthy behavior for couples coping with cancer. *Support Care Cancer, 27,* 829–838. https://doi.org/10.1007/s00520018-4359-y

Lincoln, Y. S. (1995). Emerging criteria for quality in qualitative and interpretive research. *Qualitative Inquiry, 1*(3), 275-289.

Lindenbaum, J. (1985). The shattering of an illusion: The problem of competition in lesbian relationships. Feminist Studies, 11(1), 85–103.

Lisy, K., Peters, M. D. J., Schofield, P., & Jefford, M. (2018). Experiences and unmet needs of lesbian, gay, and bisexual people with cancer: A systematic review and meta-synthesis. *Psycho-Oncology, 27,* 1480-1489. doi:10.1002/pon.4674

Loaring, J. M., Larkin, M., Shaw, R., & Flowers, P. (2015). Renegotiating sexual intimacy in the context of altered embodiment: The experiences of women with breast cancer and their male partners following mastectomy and reconstruction. *Health Psychology: Official Journal of the Division of Health*

Psychology, American Psychological Association, 34(4), 426-436. doi:10.1037/hea0000195

Locke, H. J., Wallace, K. M. (1959). Short marital-adjustment and prediction tests: Their reliability and validity. *Marriage and Family Living, 21,* 251–255.

Manne, S., Ostroff, J., Sherman, M., Glassman, M., Ross, S., Goldstein, L., & Fox, K. (2003). Buffering effects of family and friend support on associations between partner unsupportive behaviors and coping among women with breast cancer. *Journal of Social and Personal Relationships*, *20*(6), 771–792. https://doi.org/10.1177/0265407503206004

Manne, S. L., Ostroff, J. S., Norton, T. R., Fox, K., Goldstein, L., & Grana, G. (2006). Cancer-related relationship communication in couples coping with early-stage breast cancer. *Psycho-Oncology, 15*(3), 234-247. doi:10.1002/pon.941

Manne, S., Ostroff, J., Winkel, G., Goldstein, L., Fox, K., & Grana, G. (2004). Posttraumatic growth after breast cancer: Patient, partner, and couple perspectives. *Psychosomatic Medicine, 66*(3), 442-454.

Manne, S., Siegel, S., Kashy, D., & Heckman, C. (2014). Cancer-specific relationship awareness, relationship communication, and intimacy among couples coping with early-stage breast cancer. *Journal of Social and Personal Relationships, 31*(3), 314-334.

Margolies, L., & Kamen, C. (2015). Needs of LGBT cancer survivors. In Boehmer U, Elk, R. (Eds.), *Cancer and the LGBT Community*. Switzerland: Springer International Publishing.

Markman H. J., Hahlweg, K. (1993). The prediction and prevention of marital distress: An international perspective. *Clinical Psychology Review, 13*(1), 29-43.

Math, S. B., & Seshadri, S. P. (2013). The invisible ones: sexual minorities. *The Indian journalof medical research*, *137*(1), 4–6.

Matthews, A. K. (1998). Lesbians and cancer support: Clinical issues for cancer patients. *Health Care for Women International, 19*(3), 193

203, DOI: 10.1080/073993398246368

Matthews, A.K., Peterman, A., Delaney, P., Menard, L., & Brandenburg, D. (2002). A qualitative exploration of the experiences of lesbian and heterosexual patients with breast cancer. *Oncology Nursing Forum, 29*(10), 1455–62.

McDaniel, J. (1995). The lesbian couples' guide. New York, NY: Harper-Collins.

Meads, C., & Moore, D. (2013). Breast cancer in lesbians and bisexual women: Systematic review of incidence, prevalence, and risk studies. *BMC Public Health*, *13*(1), 1-11.

Mencher, J. (1990). Intimacy in lesbian relationships: A critical re-examination of fusion. In J. V.Jordan (Ed.), Women's growth in diversity: More writings from the Stone Center (pp. 311–330). New York: Guilford.

Mehta, C. M., Arnett, J. J., Palmer, C. G., & Nelson, L. J. (2020). Established adulthood: A new conception of ages 30 to 45. *The American Psychologist*, *75*(4), 431–444. https://doi.org/10.1037/amp0000600

Melton, L. M. (2016). If I don't laugh, I'll cry: Exploring humor coping in breast cancer, *Journal of Psychosocial Oncology, 34*(6), 530 541, DOI: 10.1080/07347332.2016.1233926

Mereish, E. H., & Poteat, V. P. (2015a). The conditions under which growth-fostering relationships promote resilience and alleviate psychological distress among sexual minorities: Applications of relational cultural theory. *Psychology of Sexual Orientation and Gender Diversity, 2*(3), 339-344. doi:10.1037/sgd0000121

Merriam-Webster. (n.d.). Partner. In *Merriam-Webster.com dictionary*. Retrieved May 13, 2022, from https://www.merriam-webster.com/dictionary/partner

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129,* 674-697. http://dx.doi.org/10.1037/0033- 2909.129.5.674

Meyer, I. (2019, June 27). How do you measure the LGBT population in the US? https://news.gallup.com/opinion/methodology/259457/measure-lgbt population.aspx

Milbury, K., & Badr, H. (2013). Sexual problems, communication patterns, and depressive symptoms in couples coping with metastatic breast cancer. *Psycho Oncology, 22*(4), 814 822. doi:10.1002/pon.3079

Miller, J. B. (1976). *Toward a new psychology of women*. Boston, MA: Beacon Press.

Miller, J. B., & Stiver, I. (1997). *The healing connection: How women form relationships in therapy and in life.* Boston, MA: Beacon Press.

Mize, T. D. (2016). Sexual orientation in the labor market. *American Sociological Review*, *81*(6), 1132-1160.

Moore, W. R. (2002). Lesbian and gay elders: Connecting care providers through a telephone support group. *Journal of Gay & Lesbian Social Services, 14*, 23–41. doi: 10.1300/J041v14n0302

Morrison, S. & Dinkel, S. (2012). Heterosexism and health care: A concept analysis. *Nursing Forum (Hillsdale)*, *47*(2), 123–130. https://doi.org/10.1111/j.1744 6198.2011.00243.x

Movement Advancement Project. (2022). https://www.lgbtmap.org/equality maps/non_discrimination_laws

Musa, Schulz, R., Harris, R., Silverman, M., & Thomas, S. B. (2009). Trust in the health care system and the use of preventive health services by older black and white adults. *American Journal of Public Health (1971)*, *99*(7), 1293–1299. https://doi.org/10.2105/AJPH.2007.123927

Nalbant, B., Karger, A., & Zimmermann, T. (2021). Cancer and relationship dissolution: Perspective of partners of cancer patients. *Frontiers in psychology*, *12*, 624902. https://doi.org/10.3389/fpsyg.2021.624902

National Breast Cancer Foundation, Inc. (2022). https://www.nationalbreastcancer.org/about breast-cancer/

National Cancer Institute. (2020, February 8). Cancer Statistics. https://www.cancer.gov/about-cancer/understanding/statistics.

National Institute of Aging (2015). Health and Aging: Menopause. https://www.nia.nih.gov/health/publication/menopause

Nekolaichuk, C. L., Turner, J., Collie, K., Cumming, C., & Stevenson, A. (2013). Cancer patients' experiences of the early phase of individual counseling in an outpatient psycho oncology setting. *Qualitative Health Research*, *23*(5), 592-604.

Northouse, L. L. (1994). Breast cancer in younger women: Effects on interpersonal and family relations. *Journal of the National Cancer Institute Monographs, 16,* 183 190.

Oxford Learner's Dictionaries. (n.d.). Partner. In *Oxfordlearnersdictionaries.com dictionary*. Retrieved May 13, 2022, from https://www.oxfordlearnersdictionaries.com/us/definition/english/partner_1

Owen, J. (2013). Early career perspectives on psychotherapy research and practice: Psychotherapist effects, multicultural orientation, and couple interventions. *Psychotherapy (Chicago, Ill.)*, *50*(4), 496–502. https://doi.org/10.1037/a0034617

Parent, M. C., DeBlaere, C., & Moradi, B. (2013). Approaches to research on intersectionality: Perspectives on gender, LGBT, and racial/ethnic identities. *Sex Roles*, *68*(11-12), 639 645. https://doi.org/10.1007/s11199-013-0283-2

Patterson, C. J., Sutfin, E. L., & Fulcher, M. (2004). Division of labor among lesbian and heterosexual parenting couples: Correlates of specialized versus shared patterns. *Journal of Adult Development, 11,* 179–189. http://dx.doi.org/10.1023/B:JADE.0000035626.90331.47

Paul, L.B., Pitagora, D., Brown, B., Tworecke, A., & Rubin, L. (2013). Support needs and resources of sexual minority women with breast cancer. *Psycho Oncology, 23*(5), 578 584.

Perndorfer, C., Soriano, E. C., Siegel, S. D., & Laurenceau, J. P. (2019). Everyday protective buffering predicts intimacy and fear of cancer recurrence in couples coping with early-stage breast cancer. *Psycho-Oncology*, *28*(2), 317-323.

Peters-Golden, H. (1982) Breast cancer: Varied perceptions of social support in the illness experience. *Social Science and Medicine, 16*, 483–91.

Polkinghorne, D. E. (2005). Language and meaning: Data collection in qualitative research. *Journal of Counseling Psychology, 52,* 137-145. doi: 10.1037/0022 0167.52.2.137

Ponterotto, J. G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology, 52*, 126–136.

Puckett, J. A., Horne, S. G., Herbitter, C., Maroney, M. R., & Levitt, H. M. (2017). Differences across contexts: Minority stress and interpersonal relationships for lesbian, gay, and bisexual women. *Psychology of Women Quarterly*, *41*(1), 8–19. https://doi.org/10.1177/0361684316655964

Purdie-Vaughns, V., & Eibach, R. P. (2008). Intersectional invisibility: The distinctive advantages and disadvantages of multiple subordinate group identities. *Sex Roles, 59*(5–6), 377–91.

Qualtrics^{XM}. (n.d.). https://www.qualtrics.com

Quinn, G. P., Vadaparampil, S. T., Lee, J., Jacobsen, P. B., Bepler, G., Lancaster, J., Keefe, D. L., & Albrecht, T. L. (2009). *Journal of Clinical Oncology, 27*(35), 5952-5957.

Rajaei, A., Jensen, J. F., Brimhall, A. S., Torres, E. T., & Schwartz, A. J. (2021). Dyadic function of couples with cancer: A review. *Journal of Couple & Relationship Therapy*, *20*(3), 279-302.

Randall, A. K., & Bodenmann, G. (2017). Stress and its associations with relationship satisfaction. *Current Opinion in Psychology*, *13*, 96-106.

Raque, T. L. (2019). Relational cultural theory and cancer: Addressing the social well-being of a growing population. *Practice Innovations, 4*(2), 99-111. doi:10.1037/pri0000087

Raque, T. L., Ash-Lee, S., Mitchell, J., Joseph, E., Ross, K., Solberg, M., & Owen, J. (2020). A group positive psychology intervention for cancer survivors and caregivers: A pilot study of Activating Happiness©. *Journal of Psychosocial Oncology, 38*(6), 649-669. https://doi.org/10.1080/07347332.2020.1801943

Raque, T. L., Hoffman, M. A., Ginter, A. C., Piontkowski, S., Schexnayder, K., & White, R. (2015). The work life and career development of young breast cancer survivors. *Journal of Counseling Psychology*, *62*, 655-669. doi: 10.1037/cou0000068.

Raque, T.L., Hoffman, M. A., Shupe, E., Ginter, A. C., White, R., & Schexnayder, K., Piontkowski, S. (2018). Everything is more critical: A qualitative study of the experiences of young breast cancer survivors. *Counseling and Values, 63,* 210 231. doi: 10.1002/cvj.12089

Rausch, M., & Wikoff, H. (2017). Addressing concerns with lesbian couples experiencing fertility treatment: Using relational cultural theory. *Journal of LGBT Issues in Counseling, 11*(3), 142-155.

Regan, T. W., Lambert, S. D., Kelly, B., Falconier, M., Kissane, D., & Levesque, J. V. (2015). Couples coping with cancer: Exploration of theoretical frameworks from dyadic studies. *Psycho-Oncology, 24*(12), 1605-1617. doi:10.1002/pon.3854

Revenson, T. A., & DeLongis, A. (2011). Couples coping with Chronic Illness, in *The Oxford Handbook of Stress, Health and Coping,* ed. S. Folkman (New York, NY: Oxford University Press), 101–123.

Rolland, J. S. (2005). Cancer and the family: An integrative model. *Cancer, 104*(S11), 2584-2595. doi:10.1002/cncr.21489

Rolland, J. S. (1994). In sickness and in health: the impact of illness on couples' relationships. *Journal of Marital and Family Therapy, 20*(4), 327-47.

Rosedale, M. (2009). Survivor loneliness of women following breast cancer. *Oncology Nursing Forum, 36*(2), 175-183. doi: 10.1188/09.ONF.75-183

Ross, K. V. (2019). *Scale development: Experiences of discrimination for trans people.* Unpublished manuscript, University of Denver.

Rostosky, S. S., & Riggle, E. D. B. (2017). Same-sex couple relationship strengths: A review and synthesis of the empirical literature (2000–2016). *Psychology of Sexual Orientation and Gender Diversity, 4*(1), 1-13. doi:10.1037/sgd0000216

Roussi, P., Krikeli, V., Hatzidimitriou, C., & Koutri, I. (2007). Patterns of coping, flexibility in coping and psychological distress in women diagnosed with breast cancer. *Cognitive Therapy and Research, 31*, 97–109.

Scott. (2016). *Lesbian couple dynamics and heterosexist stressors: Building a foundation for culturally competent relationship interventions*. ProQuest Dissertations Publishing.

Scott, S. B. & Rhoades, G. K. (2014). Relationship education for lesbian couples: Perceived barriers and content considerations. *Journal of Couple and Relationship Therapy, 13*(4), 339-364.

Sell, R. (2007). Defining and measuring sexual orientation for research. In The Health of Sexual Minorities (pp. 355–374). Springer US. https://doi.org/10.1007/978-0-387 31334-4_14

Shaw, L. K., Sherman, K. A., Fitness, J., Elder, E., & Breast Cancer Network Australia. (2018). Factors associated with romantic relationship formation difficulties in women with breast cancer. *Psycho-Oncology*, *27*(4), 1270-1276.

Sheppard, L. A., & Ely, S. (2008). Breast cancer and sexuality. *The Breast Journal*, *14*(2), 176-181.

Shields, S. A. (2008). Gender: An intersectionality perspective. *Sex Roles, 59*, 301–311. doi:10.1007/s11199-008-9501-8.

Siegel, K., Gluhoski, V., & Gorey, E. (1999). Age-related distress among young women with breast cancer. *Journal of Psychosocial Oncology, 17*(1), 1-20. doi:10.1300/J077v17n01_01

Sinding, C., Barnoff, L., & Grassau, P. (2004). Homophobia and heterosexism in cancer care: the experiences of lesbians. *Cancer Journal of Nursing Research, 36*(4), 170–88.

Sinding, Grassau, P., & Barnoff, L. (2007). Community Support, Community Values: The Experiences of Lesbians Diagnosed with Cancer. *Women & Health*, *44*(2), 59–79. https://doi.org/10.1300/J013v44n02_04

Sjovall, K., Attner, B., Lithman, T., Noreen, D., Gunnars, B., & Thome, B., et al. (2009). Influence on the health of the partner affected by tumor disease in the wife or husband based on a population-based register study of cancer in Sweden. *Journal of Clinical Oncology, 27*, 4781–4786. doi: 10.1200/JCO.2008.21.6788

Skerrett, K. (1998). Couple adjustment to the experience of breast cancer. *Families, Systems, & Health*, *16*(3), 281.

Solomon, S. E., Rothblum, E. D., & Balsam, K. F. (2004). Pioneers in partnership: Lesbian and gay male couples in civil unions compared with those not in civil unions and married heterosexual siblings. *Journal of Family Psychology, 18,* 275 286. http://dx.doi.org/10.1037/0893-3200 .18.2.275

Solomon, S. E., Rothblum, E. D., & Balsam, K. F. (2005). Money, housework, sex, and conflict: Same-sex couples in civil unions, those not in civil unions, and heterosexual married siblings. *Sex Roles, 52,* 561-75. http://dx.doi.org/10.1007/s11199-005-3725-7

Sormanti, M., & Kayser, K. (2000). Partner support and changes in relationships during life-threatening illness: Women's perspectives. *Journal of Psychosocial Oncology, 18*(3), 45-66.

Stephens, C., Westmaas, J. L., Kim, J., Cannady, R., & Stein, K. (2016). Gender differences in associations between cancer-related problems and relationship dissolution among cancer survivors. *Journal of Cancer Survivorship, 10*, 865 873. doi: 10.1007/ s11764-016-05329

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques.* Newbury Park, CA: Sage.

Sue, D. W. (2010). Microaggressions in everyday life: Race, gender, and sexual orientation. Hoboken, NJ: Wiley.

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist, 62*, 271–286. doi: 10.1037=0003-066X.62.4.271 Sullivan, T. J., Feinstein, B. A., Marshall, A. D., & Mustanski, B. (2017). Trauma exposure, discrimination, and romantic relationship functioning: A longitudinal investigation among LGB young adults. *Psychology of Sexual Orientation and Gender Identity, 4*(4), 481-90.

Suo, R., Zhang, L., & Tao, H. (2021). The effects of dyadic coping and marital satisfaction on posttraumatic growth among breast cancer couples. *Support Care Cancer, 29,* 5425-5433. https://doi.org/10.1007/s00520-021-06121-z

Sutherin, S. J. (2002). Internalized homophobia in lesbians as cultural disconnection and metropolitan community churches as a community of connection. Available from

ProQuest Dissertations & Theses Global. https://du.idm.oclc.org/login?url=https://search-proquest com.du.idm.oclc.org/docview/276595564?accountid=14608

Szymanski, D. M., Ikizler, A. S., & Dunn, T. L. (2016). Sexual minority women's relationship quality: Examining the roles of multiple oppressions and silencing the self. *Psychology of Sexual Orientation and Gender Diversity, 3*(1), 1-10. doi:10.1037/sgd0000145

Tedeschi, R. G., Calhoun, L. G. (2004). Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry, 15*(1), 1-18. doi: 10.1207/s15327965pli1501_01

Thies, K. E., Starks, T. J., Denmark, F. L., & Rosenthal, L. (2016). Internalized homonegativity and relationship quality in same-sex romantic couples: A test of mental health mechanism and gender as a moderator. *Psychology of Sexual Orientation and Gender Diversity, 3*(3), 325-335. doi: 10.1037./sgd0000183

Thompson, T., Heiden-Rootes, K., Joseph, M., Gilmore, A., Johnson, L., Proulx, E. L., Albright, E. L., Brown, M., & McElroy, J. A. (2020). The support that partners or caregivers provide sexual minority women who have cancer: A systematic review. *Social Science & Medicine, 261,*https://doi.org/10.1016/j.socscimed.2020.113214.

Tigerlily Foundation. (2020, February 6). Who We Are. https://www.tigerlilyfoundation.org/about-us/

Todosijevic, J., Rothblum, E. D., & Solomon, S. E. (2005). Relationship satisfaction, affectivity, and gay-specific stressors in same-sex couples joined in civil unions.

Psychology of Women Quarterly, 29, 158–166. http://dx.doi.org/10.1111/j.1471 6402.2005.00178.x

Traa, M. J., de Vries, J., Bodenmann, G., & den Oudsten, B. L. (2015). Dyadic coping and relationship functioning in couples coping with cancer: A systematic review. *BritishJournal of Health Psychology, 20*(1), 85-114. doi:10.1111/bjhp.12094

Tracy, S. J. (2010). Qualitative quality: Eight “big-tent” criteria for excellent qualitative research. *Qualitative Inquiry, 16*(10) 837–851.

Trusson, D., & Pilnick, A. (2017). Between stigma and pink positivity: Women's perceptions of social interactions during and after breast cancer treatment. *Sociology of Health & Illness, 39*(3), 458-473. doi:10.1111/1467 9566.12486

Vaccaro, A. (2009). Intergenerational perceptions, similarities and difference: A comparative analysis of lesbian, gay, and bisexual millennial youth with generation X and Baby Boomers. *Journal of LGBT Youth*, 6(2–3), 113–134.

Walsh, S. R., Manuel, J. C., & Avis, N. E. (2005). The impact of breast cancer on younger women's relationships with their partner and children. *Families, Systems, & Health, 23*(1), 80-93. doi:10.1037/1091-7527.23.1.80

White, J. L., & Boehmer, U. (2012). Long-term breast cancer survivors’ perceptions of support from woman partners: an exploratory study with sexual minority women. *Oncology Nursing Forum, 39*(2), 210–7.

Whitton, S. W., Scott, S. B., & Buzzella, B. A. (2013). *Strengthening same-sex relationships: A relationship education program for female same-sex couples*. Unpublished Therapist Manual, University of Cincinnati.

Willging, C. E., Salvador, M., & Kano, M. (2006). Brief reports: Unequal treatment: Mental health care for sexual and gender minority groups in a rural state. *Psychiatric Services, 57*, 867–870. doi: 10.1176/ps.2006.57.6.867

Yıldız, F., & Alagüney, M. E. (2020). Is early-stage breast cancer a risk for marital dissolution? Breast cancer a risk for marital-dissolution?. *Medical Science and Discovery*, *7*(7), 566-569. https://doi.org/10.36472/msd.v7i7.400

Young Survival Coalition. (2020, February 6). Facing breast cancer in young adults together. https://www.youngsurvival.org

Yuan, R., Zhang, C., Li, Q., Ji, M., & He, N. (2021). The impact of marital status on stage at diagnosis and survival of female patients with breast and gynecologic cancers: A meta-analysis. *Gynecologic Oncology, 162*(3), 778-787. https://doi.org/10.1016/j.ygyno.2021.06.008

Zwahlen, D., Hagenbuch, N., Carley, M. I., Jenewein, J., & Buchi, S. (2010). Posttraumatic growth in cancer patients and partner-effects of role, gender and the dyad on couples' posttraumatic growth experience. *Psycho-Oncology, 19*, 12 20. doi: 10.1002/pon.1486

Appendix A: Recruitment Emails and Post for Social Media

EMAIL #1 – SHORT VERSION:
Breast Cancer + Women Couples – Dissertation Study

What is the subject of this study?
The purpose of this dissertation research study is to explore the impact of breast cancer on the romantic relationships of younger women who are partnered with women. I am seeking women couples to participate in this study.

Who is eligible for the study?
More specifically, I am looking for COUPLES to participate who meet the following inclusion criteria: (a) you are one woman in a couple that is made up of two women, (b) your relationship with your partner is romantic in nature, (c) both you AND your woman partner are willing to participate in the study, (d) one partner has been diagnosed with any stage of breast cancer within the last five years at the age of 45 years or younger, (e) the couple was living together at the time of diagnosis and currently, in the United States, (f) the individuals are each between 30 and 50 years old currently, and (g) English speaking.

Please note: Both members of the couple must be willing to participate in the study in order to be eligible!

What are participants asked to do?
Participants will be asked to complete an informed consent form and two online surveys, which will take about 15 minutes. Participants will also be asked to do a 60-90-minute individual interview with the primary researcher, Kait Ross. The interview will be audio-recorded and conducted virtually using the Zoom platform. Total participation time for the study is about 75-105 minutes.

What are the risks and benefits of participation?
I hope that talking about going through breast cancer with your partner will be meaningful. There is a minimal risk that sharing your experiences during the interview could be emotionally difficult.

What are the next steps?
If you are interested in participating, or if you have any questions or concerns, please contact me directly at Kaitlin.Ross@du.edu, or @kaitrossresearch on Instagram. I look forward to hearing from you.

EMAIL #1 - LONG VERSION:
Snowball sampling message distributed through various organizations, such as: Young Survivors Coalition, Tiger Lily Foundation, National LGBT Cancer Network, National LGBT Cancer Project, Rocky Mountain Cancer Centers, and Cancer Support Community.

Subject: Participants needed for study about how breast cancer impacts the relationships of younger women partnered with women

Hello,

Thank you for reading this email about an opportunity to participate in a dissertation research study.

How can you help?
I am writing to ask for your help in recruiting participants for my dissertation on the impact of breast cancer on the relationships of younger women who are partnered with women. You can help me by either participating in my study and/or by asking others whom you think might be interested in this study to contact me.

What is the subject of this study?
My dissertation study is a qualitative exploration of the impact of breast cancer on the relationships of younger women who are partnered with women. More specifically, I am seeking women who were diagnosed at age 45 or before, and who are currently 50 years or younger, and their partners. I became interested in this topic after learning about how chronic health conditions impact relationships, and the underrepresentation of sexual minority women and younger women in cancer research. Further, I am interested in feminist and cultural theories, and qualitative research methods because of the depth of experience that can be described within the specific context.

To investigate this topic, I will be asking participants to complete a demographic questionnaire and a questionnaire about how they experience communication within their relationship. Additionally, I will be conducting one semi-structured individual interview with each participant, at a mutually convenient time. Participants will be provided with a copy of the interview protocol approximately one week before the scheduled interview and may ask additional questions based on participants' responses during the interviews. The interview will take approximately 60-90 minutes. Interviews will be conducted over the phone, audio-recorded, and transcribed. I will follow ethical guidelines when using the data. In all written materials, al identities will be concealed to maintain confidentiality. If you decide to take part in this study, you have the right to refuse to answer any question(s) during the interview and/or withdraw from participation at any time. You will also be given a chance to review your transcribed interview to ensure its accuracy before it is finalized.

Who is eligible for the study?
I am looking for participants who meet the following criteria: (a) both members of a couple that is romantic in nature, in which both individuals identify as a woman, (b) one partner has been diagnosed with any stage of breast cancer, (c) the couple was cohabitating at the time of diagnosis and currently, in the United States, (d) the

individuals are each between 25 and 50 years old, (e) English speaking, and (f) consent to participation in the study.

What are the risks and benefits of participation?
I hope that the interview will provide you with a good opportunity to reflect on how your relationship was impacted by going through breast cancer together. There is a slight risk that sharing your experiences during the interview could be emotionally difficult or uncomfortable at moments.

Is there a monetary incentive for participants?
Participants who complete the questionnaires and the interview will be provided with a twenty-five dollar gift card to Amazon.com, contingent upon the receipt of funding for the study. This gift card will be emailed to participants once the study requirements are completed.

What are the next steps?
If you are interested in participating in the study, please contact me directly via phone or email. As a reminder, if you decide to take part in the study, you have the right to withdraw from participation at any time. If you have questions about your rights as a research subject or wish to report a research-related injury, please contact: University of Denver, Office of Research and Sponsored Programs, Administrative Office Building, at 303-871-2121 (phone) or irbadmin@du.edu (email).

Regardless of whether you are personally able to participate, I am hoping that you will help me in the recruitment process by asking others whom you think might be interested to contact me directly.

If you are interested in participating, or if you have any questions or concerns, please contact me at Kaitlin.Ross@du.edu. I look forward to hearing from you.

Thank you for your help!
Best,
Kait Ross

EMAIL #2:
Email to individuals who have expressed interest in participating in the study. I will include the EMAIL #1 below this email so that all relevant information is provided again.

Subject: Information for participation in research study about how breast cancer impacts the relationships of younger women partnered with women

Dear _________,

Thank you for expressing an interest in participating in my dissertation research study about how breast cancer impacts the relationships of younger women partnered with women. Conducting a qualitative study requires that the interviewees trust the interviewers/researchers to do a credible and reliable job with the interviews and data analysis. Without trust, the interviewees might not open up or delve as deeply into the topic as they otherwise could. Therefore, it might be helpful to have some information about the researchers. As stated previously, my name is Kait Ross and I am a doctoral study in the counseling psychology doctoral program at the University of Denver. My dissertation advisor, Dr. Trisha Raque, has researched extensively in the areas of cancer and relationships, and has extensive experience conducting qualitative research.

A copy of the interview protocol is attached for your review. As a reminder, the individual interview is expected to take 60-90 minutes. It will be conducted over the phone by me, audio-recorded, and transcribed.

Before an interview is scheduled, you are asked to follow the link below to complete the informed consent form for the study, as well as a demographic questionnaire and a questionnaire about how you experience communication in your relationship with your spouse or partner.

Participant ID Number:
Link:

Please note that since this is a dissertation study about couples, your spouse or partner will also be required to complete these surveys before your separate interviews are scheduled. Once the surveys are completed, I will reach out to you via phone to schedule your interview at a mutually convenient time.

I would be honored if you would agree to participate in this study. I think we could learn a lot from you about how your relationship with your spouse/partner was impacted by breast cancer. I hope the interview process would be meaningful for you as well. If you have decided not to participate in the study, please reply to this message to notify me. If you decide to participate and complete the consent and questionnaires, I will reach out to you soon to schedule an interview.

Sincerely,
Kaitlin Ross, MSEd
Doctoral Student
Kaitlin.Ross@du.edu

Trisha Raque, PhD
Associate Professor
303-871-4522
Trisha.Raque@du.edu

TEXT/POST FOR SOCIAL MEDIA – BRIEF

Research Study Alert Recruiting younger women couples [ages 30-50] in which one woman has been diagnosed with breast cancer, for a dissertation research study about the impact of cancer on the couple's relationship and their experiences with the healthcare system.
Questions? Interested in participating? Please contact Kait Ross
at Kaitlin.Ross@du.edu or @kaitrossresearch on Instagram
University of Denver's Counseling Psychology Department [IRBNet #1648134-1]

TEXT/POST FOR SOCIAL MEDIA - LONG

Recruiting younger women couples who have been through breast cancer, for a dissertation research study through the University of Denver's Counseling Psychology Department [IRBNet #1648134-1].

The purpose of the study is to explore the impact of breast cancer on the relationships of the couples. Participants will be asked to complete an informed consent form and two online surveys [15 minutes], and a 60-90-minute audio-recorded individual interview over Zoom. Total time commitment is 75-105 minutes.

Couples are eligible to be in the study if you meet the following criteria:
(a) you are one woman in a couple that is made up of two women, (b) your relationship with your partner is romantic in nature, (c) both you AND your woman partner are willing to participate in the study, (d) one partner has been diagnosed with any stage of breast cancer within the last five years at the age of 45 years or younger, (e) the couple was living together at the time of diagnosis and currently, in the United States, (f) the individuals are each between 30 and 50 years old currently, and (g) English speaking.

Questions? Interested in participating? Please contact Kait Ross, Kaitlin.Ross@du.edu, or her faculty sponsor, Dr. Trisha Raque, Trisha.Raque@du.edu

Appendix B: Demographic Questionnaire

Please complete this questionnaire and the Mutual Psychological Development Questionnaire at your earliest convenience. Once complete, you will be contacted to schedule your interview.

Personal demographic questions:
How accepting do you feel those in your current community are now, with regard to intimate relationships between women? (1 - 10 scale):
Current age:
Race:
Gender identity:
Sexual orientation:
Occupation:
Hours worked/week:
Approximate annual income:
Highest grade of education completed: Grade school; High School; College; Graduate school; Other
Did you have personal experience with cancer (you or another loved one) before you or your partner were diagnosed with breast cancer?

Questions about current relationship with your spouse/partner:
When, where, and how did you first meet your partner?
Timeline of your relationship:

- Date your relationship became romantic
- Date moved in together
- Date of other major milestones in the relationship, including:
    - breakups/separations
    - moving in together
    - engagement
    - marriage
    - children, including their ages
- What role has the cancer survivors' partner taken in the cancer healthcare process since diagnosis?

Breast cancer survivors only, please answer regarding your experience with breast cancer:
Cancer date of diagnosis:
Cancer diagnosis:
Cancer stage:
Cancer treatments received, including time frame:
Current treatment stage:
Last date of treatment:

Appendix C: Mutual Psychological Development Questionnaire (MPDQ) - Form A (Genero, Baker Miller, Surrey, & Baldwin, 1992a)

Directions:
We would like you to tell us about your relationship with your spouse or partner. By partner we mean a person with whom you live or with whom you have a steady relationship.

If married, how many years?
What is your spouse's age?
If not married, how long have you known your partner?
What is your partner's age?
Are you currently living with your partner? Yes/No

In this section, we would like to explore certain aspects of your relationship with your spouse or partner. Using the scale below, please tell us your best estimate of how often you and your spouse/partner experience each of the following:
1 = Never **3** = Occasionally **5** = Most of the Time
2 = Rarely **4** = More Often Than Not **6** = All the Time

When we talk about things that matter to my spouse/partner, I am likely to . . .

Be receptive	1	2	3	4	5	6
Get impatient	1	2	3	4	5	6
Try to understand	1	2	3	4	5	6
Get bored	1	2	3	4	5	6
Feel moved	1	2	3	4	5	6
Avoid being honest	1	2	3	4	5	6
Be open-minded	1	2	3	4	5	6
Get discouraged	1	2	3	4	5	6
Get involved	1	2	3	4	5	6
Have difficulty listening	1	2	3	4	5	6
Feel energized by our conversation	1	2	3	4	5	6

When we talk about things that matter to me, my spouse/partner is likely to . . .

Pick up on my feelings	1	2	3	4	5	6
Feel like we're not getting anywhere	1	2	3	4	5	6
Show an interest	1	2	3	4	5	6
Get frustrated	1	2	3	4	5	6
Share similar experiences	1	2	3	4	5	6
Keep feelings inside	1	2	3	4	5	6
Respect my point of view	1	2	3	4	5	6
Change the subject	1	2	3	4	5	6
See the humor in things	1	2	3	4	5	6
Feel down	1	2	3	4	5	6
Express an opinion clearly	1	2	3	4	5	6

Appendix D: Interview Protocol

Introduction:

Thank you for agreeing to participate in this qualitative study exploring the impact of breast cancer on relationships of younger women partnered with women. I wanted to remind you that I will be audio-recording this interview, and that the interviews will be transcribed for data analysis. Your name and any other identifying information will be removed from the transcripts, and no portions of the interview transcripts that contain identifying information will be reported verbatim. Only members of the research team will have access to the audio-recording of this interview, which will be password protected on my computer only and will be deleted upon completion of the study. Your participation in this study is completely voluntary as you have the right to refuse to answer any question(s) asked of you and/or withdraw from this study completely at any time. I will maintain strict guidelines related to the safeguarding of research material as defined by the American Psychological Association. Do you have any questions?

Do you feel comfortable and ready to begin the interview now? Hopefully, you've had a chance to review the interview protocols and are familiar with the questions that I will be asking you today. You know that I am going to be asking you a number of questions about how your relationship with your spouse or partner has been impacted by breast cancer. I realize that discussion about these topics might elicit an emotional reaction and that we will be discussing a potentially sensitive topic. I will make every effort to minimize any emotional discomfort you might experience and can provide you with information from the American Psychological Association about how to locate a mental health professional in your area (i.e., Psychologist Locator http://locator.apa.org/) if you would like. I want to let you know that I respect and appreciate your willingness to share your experiences, so please be as honest and open as possible. Please say whatever comes to your mind in response to the questions.

1. Briefly, how would you describe your relationship with your partner, and your sense of yourself in the relationship?
2. To what extent, if at all, does being a woman partnered with a woman impact your experience of cancer? (e.g., within yourself, within your relationship, related to others in your life - family/friends/coworkers, in healthcare settings, etc.)
   a) Have any other aspects of your personal context impacted your experience of cancer (e.g., age, socio-economic status, religious/spiritual beliefs, race, ethnicity, living environment)? If so, how?
3. Briefly, what was it like to find out that [you were/your partner was] diagnosed with breast cancer?
4. Describe the aspects of your relationship that were most impacted by cancer. How were they impacted? (e.g., romantic, social, leisure, physical, spiritual, sexual, financial)
5. Describe a time when you felt really close or connected to your partner since the cancer diagnosis?

    a) What did you do that contributed to the feeling of closeness?
    b) What did your partner do that contributed to the feeling of closeness?
    c) What contributes to your sharing thoughts/feelings with your partner?

6. Describe a time when you felt a lot of distance or disconnection between you and your partner since the cancer diagnosis?
    a) What did you do that contributed to the feeling of disconnection?
    b) What did your partner do that contributed to the feeling of disconnection?
    c) What contributes to holding back thoughts/feelings from your partner?
7. How did/do you and your partner approach cancer related issues or stress in your relationship?
    a) Can you describe a specific example?
    b) Did you and your partner make any intentional changes in your relationship due to cancer or cancer-related stress? How? Why?
8. What specific supports outside of your relationship helped you and your partner feel connected to one another during cancer?
9. How do you feel [you were/your partner was] integrated into the cancer care and treatment planning processes? Please provide specific examples.
    a) How were you and your partner treated by the cancer care team?
    b) How did the experience(s) with providers/the healthcare process impact your relationship with your partner?
    c) What relationship challenges did you face during your treatment process (e.g., caregiving related issues)?
10. What do you wish were different about [your/your partner's] cancer care?
11. What do you wish your partner knew about what you went through/are going through related to the cancer experience?
    a) On the other hand, what do you wish you knew about what your partner went through/is going through related to the cancer experience?
12. As we've talked about these specific aspects of your relationship, what have you taken away about how your relationship with your partner has changed, if at all, from pre-to-post cancer?
13. What, if any, additional information about your experience would you like to share?

Conclusion: Thank you so much for your time today and for your participation in the study. We appreciate your willingness to share, and we hope that this study will contribute to a deeper understanding of how breast cancer impacts the relationships of women who are partnered with women. This interview will be transcribed, and I will email you a copy to review to ensure accuracy. Please contact me via email if you would like to expand upon or amend any comments you made today. Many thanks again, and I will be in touch with your transcript when it is prepared.

Appendix E: Definition of Terms

GLAAD is an organization founded in 1985 that seeks to accelerate acceptance for the LGBTQ community and contribute to cultural change by engendering dialogue, shaping the media narrative, and using advocacy and education to encourage the use of preferred terms relevant to the LGBTQ community. The following preferred terms are defined and described by GLAAD and have been taken directly from the Media Reference Guide-10th Edition, on the GLAAD website (GLAAD, 2020).

Sexual Orientation. The scientifically accurate term for an individual's enduring physical, romantic and/ or emotional attraction to members of the same and/or opposite sex, including lesbian, gay, bisexual, and heterosexual (straight) orientations.

Lesbian. A woman whose enduring physical, romantic, and/or emotional attraction is to other women.

Gay. The adjective used to describe people whose enduring physical, romantic, and/or emotional attractions are to people of the same sex (e.g., gay man, gay people). Sometimes lesbian is the preferred term for women. Use gay, lesbian, or when appropriate bisexual or queer to describe people attracted to members of the same sex.

Queer. An adjective used by some people, particularly younger people, whose sexual orientation is not exclusively heterosexual (e.g. queer person, queer woman). Typically, for those who identify as queer, the terms lesbian, gay, and bisexual are perceived to be too limiting and/or fraught with cultural connotations they feel don't apply to them. Some people may use queer, or more commonly genderqueer, to describe their gender identity and/or gender expression. Once considered a pejorative term, queer has been reclaimed by some LGBT people to describe themselves; however, it is not a universally accepted term even within the LGBT community. When Q is seen at the end of LGBT, it typically means queer and, less often, questioning.

Relationships. GLAAD states that as a rule, try to avoid labeling an activity, emotion, or relationship gay, lesbian, bisexual, or queer unless you would call the same activity, emotion, or relationship straight if engaged in by someone of another orientation. In most cases, readers will be able to discern people's sexes and/or orientations through the names of the parties involved, depictions of their relationships, and use of pronouns. GLAAD states that “relationship” or “couple” is preferred and, if necessary, “gay/lesbian/same-sex couple" may be used.

Gender Identity. A person's internal, deeply held sense of their gender. For transgender people, their own internal gender identity does not match the sex they were assigned at birth. Most people have a gender identity of man or woman (or boy or girl). For some people, their gender identity does not fit neatly into one of those two choices (non-binary and/or genderqueer). Unlike gender expression, gender identity is not visible to others.

Sex. The classification of a person as male or female. At birth, infants are assigned a sex, usually based on the appearance of their external anatomy. This is what is written on the birth certificate. A person's sex, however, is actually a combination of bodily characteristics including chromosomes, hormones, internal and external reproductive organs, and secondary sex characteristics.

Appendix F: Table 1 Participants' Demographics

Table 1

Participants' Demographics

Demographic characteristic	Survivor group (*N*=5)	Partner group (*N*=5)
Gender	Women (5)	Women (5)
Age	30-35 (1) 40-45 (1) 46-50 (3)	25-30 (1) 35-40 (2) 40-45 (1) 46-50 (1)
Sexual orientation	Gay (1) Lesbian (3) Undefined (1)	Bisexual (1) Female (1) Lesbian (3)
Racial/ethnic background	Hispanic (1) White (4)	Black (1) White (4)
Annual income	25-50K (2) 75-100K (2) Unknown (1)	25-50K (3) 50-75K (1) 150-175K (1)
Education completed	College degree (2) Graduate degree (3)	College degree (2) Graduate degree (3)
Time since diagnosis	<1 year (1) 1-2 years (2) 2-3 years (1) 5-6 years (1)	
Breast cancer stage	Stage 0 (1) Stage 2 (3) Stage 3 (1)	
Length of romantic relationship	1-5 years (3) 10-15 years (1) 15-20 years (1)	

Appendix G: Table 2 Scores on the MPDQ
Scores on the Mutual Psychological Development Questionnaire (MPDQ) - Form A (Genero, Baker Miller, Surrey, & Baldwin, 1992a)

Table 2

MPDQ Scores for Partners

Partner (#) from Couple (Letter)	"I am likely to…"	"My survivor is likely to…"	Partners' Total Mutuality Score for Couple
16 Q	3.42	3.64	3.53
11 P	3.5	3.27	3.39
20 R	3.5	3.36	3.43
15 T	3.67	4.09	3.88
10 S	4.75	3.36	4.06
Total	3.77	3.55	3.66

MPDQ Scores for Survivors

Survivor (#) from Couple (Letter)	"I am likely to…"	"My partner is likely to…"	Survivors' Total Mutuality Score for Couple
9 Q	4.18	3.82	4.00
18 P	3.36	3.27	3.32
17 R	3.09	3.36	3.23
12 T	3.45	4.00	3.73
19 S	3.64	3.91	3.76
Total	3.55	3.67	3.61

MPDQ Scores for Couples

Couple	Total Mutuality Score
Q	3.76
P	3.35
R	3.33
T	3.80
S	3.91
Total	3.63

The measure is scored on a scale of 0 to 6, with higher scores indicating higher levels of mutuality.

Appendix H: Table 3 Research Questions and Domains

Table 3

Research Questions and Domains

Research Questions	Survivor Group	Partner Group
Contextual Domains Described Before Answering Research Questions	• Survivor Responses to Cancer-Related Circumstances	• Partner's Role as Caregiver • Partner's Internal Experience
Research Question #1: What is the impact of breast cancer on younger survivors and their women partners with regard to authenticity, mutuality, relationship awareness, connection, and disconnection? **Research Question #4:** What lasting relational changes do the couple report due to cancer?	• Connection in the Relationship - Before, During, and After Cancer • Disconnection in the Relationship - Before, During, and After Cancer	• Connection in the Relationship - Before, During, and After Cancer • Disconnection in the Relationship - Before, During, and After Cancer
Research Question #2: What are the barriers and supports to the sense of connections between women partnered with women in the context of breast cancer?	• Interpersonal and Organizational Influences on Cancer Experience	• Community Involvement, Advocacy, and External Support Systems
Research Question #3: How does minority stress affect the couple's relationship dynamic and ability to feel connected after cancer?	• Interactions with Healthcare System and Providers	• Interactions with Healthcare System and Providers

Appendix I: Table 4 Results

Results – Domains, Categories, Sub-Categories, Frequencies, and Illustrative Quotations

Survivor Group Results

Domains, Categories & Sub-Categories	Frequency	Illustrative Quotation
Survivor responses to cancer-related circumstances (Survivor Group Domain)		
a) Cancer-related emotional reactions	General	Does this mean I'm done? They don't ever go 'you are cancer free' so I am kind of like, am I clear? I feel like I'm always gonna be this cancer patient, you know, where I'm always being checked on. I go in every six months to see my oncologist. (P9)
b) Altered view of partner or relationship	General	Her mental health has definitely declined. (P9) Before all this happened, it was pretty equal as far as both of us contributing to the relationship. I feel a little bit inadequate, I guess, in the relationship right now. (P18)
c) Lifestyle changes	Typical	We're proud of how far we've come as far as coping with daily stress and making changes in our lives so that we don't have to live stressed out all the time. Making our health and our food a priority. It's pretty cool. We're a different couple than before and the cancer was most definitely the catalyst for all that because it wakes you up. It shakes your foundation. (P17)
d) Post-traumatic growth	Typical	My body tried to kill me in slow motion and I escaped and survived a near death experience… Everything frivolous just falls away. You can see what's really important and what you want to do. (P17)

Disconnection in the relationship – before, during, and after cancer (Survivor Group Domain)		
a) Conflict due to changes in relationship dynamics and roles	Typical	She'd go in the kitchen and start cleaning and suddenly she'd be slamming cabinets and grumbling… she had to shoulder a lot of the burden and I'm sure there was some resentment. Then I would feel guilty that she was doing all the housework so I would try to do some, and she would get mad at me. (P19)
b) Lack of authenticity and communication difficulties contribute to maladaptive relational patterns	General	One stressful thing I can think of is just, you know, her not wanting to share things just because she feels like it's not important compared to what I'm going through, but I'd rather I'd rather her tell me. I want to know what's going on in her life. Yeah. I don't want to be shut out in that way. (P18)
c) Challenges of interdependence and lifestyle discontinuity	Typical	We are working on kind of like separating ourselves from each other so that we're not as entangled. I don't think we've lost ourselves in eachother, but I think that we've, like, been in lockstep together maybe long enough to where it's like, okay, well, now we have to make sure that we're taking care of ourselves. (P9)
d) Challenges with physical intimacy contributed to disconnection	Typical	When I first got diagnosed, I had a problem with my chest being touched, and that upset her. Even I didn't want to touch that area, but she took it personally. I made myself, allowed myself, to be touched in those areas. I realized that she needed to be close to me to feel close to me. (P18)
Connection in the relationship – before, during, and after cancer (Survivor Group Domain)		
a) Relationship history and the impact of cancer on closeness and	Typical	We are officially engaged. It's almost like we're marching forward, but we're marching forward into something new. I don't think there's a way to go back to whatever was pre-cancer… but I also don't think that's necessary

	commitment		or good. We learned so much through this process and we want to take that into our lives in the future. (P12) It was an extended period of time of her taking care of me in that very specific way, I think, was another form of closeness, like I have no idea how she did it. (P12)
b)	Relationship awareness: understanding and interacting through the lens of cancer	General	She obviously hasn't been getting one hundred percent from me and I can't contribute one hundred percent because of what I'm going through. I tried to put myself in her shoes and I know it can be frustrating when you're not getting what you need in a relationship. We've talked about it, and she understands. (P18)
c)	Authentic, open, and frequent communication	General	Let's take an honest question like this and be able to sit down and talk about it, no, I don't think we would have been able to do that or have been interested in even tackling something like that, because it would be too honest. If anything has happened in our relationship [since cancer], it has gotten a lot more honest. (P17)
d)	Mutual empathy and empowerment are avenues for connection	General	The biggest advantage to being with a female partner was that she really was able to understand where I was coming from and that kind of agonizing over what [surgical] decision to make. She was very quietly supportive and was able to weigh in as far as, I know what you're feeling. (P9) I trust you one hundred percent, I'm okay with it, so it was definitely a learning moment for us. (P12)
e)	Couple coping contributes to connection	General	So we both are now in recovery. She's stopped drinking and I'm a recovering co-dependent. It's been really refreshing. (P17)
f)	The downside of connection	Typical	I think we're still trying to figure out how to get back to an equal, a fully equal partnership.

		I'm thinking, like how do I reduce my reliance upon [survivor] in this moment. (P12)
Interpersonal and organizational influences on cancer experience (Survivor Group Domain)		
a) Sources of support impacting cancer experience	General	Subcategory: Support stemming from personal relationships It was crazy expensive and very quickly we went through money. Our family sent us money and it was lovely, but it was also like, this is not sustainable (P12). Subcategory: Support stemming from organizations It was so awesome. It was the best. I didn't realize I was going to be the most recently treated and everybody was like, oh, man, you guys had to go through that during COVID, that sucks. (P12)
b) Sociocultural issues contribute to difficulty navigating adjustment to cancer	General	The lesbian breast cancer support group is incredibly unsupportive of people who don't go flat! That forced me into the straight groups for advice. Very negative vibe for me. (P19)
c) Loss of support, lacking support, unhelpful support, and barriers to support	Typical	My parents are wonderful people and we're very close, but I'm constantly taking care of them. I'm ready to put it behind me emotionally and they're still hung up on it, like 'should you get second opinions, are you sure you don't need chemotherapy or radiation or tamoxifen, what's your prognosis?' It's very worrying. (P19)
Interactions with healthcare system and providers (Survivor Group Domain)		

a)	Beneficial communication content and process by providers	General	I did skin sparing and nipple sparing surgery. So, it’s really great because they’re pretty much what they were before. The doctor said that for the most part, it didn’t increase my likelihood of recurrence. She was like, I can send you all the research you want, but it doesn’t increase recurrence that much. (P12)
b)	Non-beneficial or lacking communication by providers	Typical	It would have been nice to know, to be aware beforehand and know what to expect. I was feeling, you know, kind of wimpy. I was getting dehydrated to the point where I could barely move. (P18)
c)	History of LGBT oppression, fear of discrimination, and microaggressions experienced during cancer care	General	We kind of speculated, was it because we’re gay? That’s always in the back of our minds. (P18)
d)	Perception of acceptance by providers in the context of WPW identity and partners integration in care	General	They would address her and ask her questions, specifically. She was very much a part of all my care and decision-making processes. They addressed both of us, so it felt inclusive in that sense. (P12) She wasn’t at all [integrated into care]. They literally didn’t even look directly at her. It felt like she was an extra chair. They would literally trip on her, like actually physically trip on her. I don’t know if that’s the same with straight people. Do they not trip on husbands? It got to a level that was weird sometimes, and it was with everyone. It added a level of surrealness to the experience that I wish hadn’t been there. (P19)
e)	Intersectionality of identities and	Typical	Race, I mean, there couldn’t be more data showing that my race [White] ensured a good

cancer		outcome here. (P19)
f) Healthcare structure negatively impacted care for WPW	Typical	All of the literature was very oriented toward heterosexual people. (P19)

Partner Group Results

Domains, Categories & Sub-Categories	Frequency	Illustrative Quotation
Partner's internal experience (Partner Group Domain)		
a) Common emotional responses to diagnosis and active treatment	General	The isolation was pretty profound. Those winter months were incredibly, incredibly lonely. We would just be home alone together and for the weeks she had chemo she would sleep for like 20 hours a day, for a week, and I was just there. (P15) I guess just watching her go through all the…it's like having somebody die in your family. It really is. All those emotions, there's no track. That whole thing about 'oh, you go through these stages,' well those stages come and go as they please (P10)
b) Empathy as a WPW during breast cancer	General	If a dude got his dick cut off, he sure would be upset about it, but somehow, he can't understand how it feels to have your breasts removed. I'm glad she had a female partner during her experience, because at least I could empathize. My body is more the same. (P15) Because I have breasts and know what it would feel like to lose a part of your body due to something you can't control, I certainly have more empathy for what she was going through

		emotionally. (P10)
c) Post-traumatic growth for partners	General	Meeting people that just got a three-month time limit [on life], and to see them smile and say ‘oh, I’m going to have lunch with my daughter’ and stuff like that, it really humbled me as a person and taught me how to genuinely care for what we have. (P16)
Partner’s role as caregiver (Partner Group Domain)		
a) The impact of prior exposure to cancer or caregiving experiences	Typical	I was very familiar with the treatment. I was very hands on with her recovery. So strangely, it left me oddly prepared to know what we were getting into. (P15)
b) Caregiver duties: domestic, physical, medical, managing relationships, emotional support	General	It feels almost intrusive to make her tell me everything that is going on in her head, because I’m already carrying her to the bathroom and washing her in the shower. So, to take away that layer, like I’m all up in her business. I want to respect some level of privacy. (P16)
c) Assessing survivor needs, confusion about how to meet survivor needs, and experiencing helplessness	Typical	It’s just feeling kind of helpless. Like there’s nothing you can really do except sit there with her, feeling like you don’t really know what to do. That’s the hardest part. (P11)
d) Navigating the competing demands of caregiving and work/school responsibilities	General	It almost feels like it hasn’t totally hit me yet because I just sort of went into survival mode about it. It’s just such a whirlwind. I’ve been compartmentalizing everything so that when I’m in school or work, I’m just doing school or work and when I’m seeing her, I’m just seeing her. There’s not really any overlap. (P11)

		How do I find the balance there? (P16)
e) The impact of changing roles, responsibilities, and power dynamics on caregivers	Typical	I couldn't get her to breach her silence of what she wanted to herself for anything. So, I was having to make all the decisions. (P20).
Disconnection in the relationship – before, during, and after cancer (Partner Group Domain)		
a) Emotional distress for partners causes disconnection	General	I feel like, sometimes, I feel I'm carrying this burden on my own, and I just need to deal with it. But then it gets too heavy, and it's really tied to my cycle. When I'm really irritated and agitated and it kind of comes out of my control. (P11)
b) Changes in survivor negatively impact partner and cause disconnection	Typical	Cancer just kind of put a boulder on top of my wife. We lost our loving relationship right after 'no evidence of disease' and that was I feel based mostly on the chemotherapy and she just wasn't the same person. The self-esteem was gone. Not feeling good about your body, you know, can really put a stranglehold on your relationship. (P20)
c) Problematic communication patterns: withholding, lack of communication, angry outbursts	Typical	I wish that she would have had more of an opportunity to speak up about her feelings, and how she felt while she was going through cancer, the things that were on her mind, the things that she wouldn't talk about, the things that she couldn't talk about, the things that she shouldn't talk about. I wish she would have known that all of those things are perfectly acceptable to talk about at any time. (P20) I don't share a lot of what's going on with me, as far as what stresses me out because I just don't really want her to worry about it. I don't really feel support from her, but at the same time, I don't ask for it either. (P11)

d) Disconnection related to lacking physical intimacy	Typical	Our sex life is non-existent right now. We used to have a really good sex life, and that’s just not happening. We have really good chemistry and that was a big part of our relationship. (P11)
e) New relational dynamics within couples due to survivor and caregiver role adherence disrupts connection	General	You know, she stopped seeing me as her wife, her partner, her friend. You know, because I was the caregiver. I’m so much more than that. (P20)
f) Focus on issues within the relationship prevents connection	Typical	Medical issues are what creates are biggest bonder and our biggest disconnector. Bonding in the way that we both do kind of jump in, try and tackle it. But we’re also in a sense feeling hopelessness as the caregiver. (P16)
Connection in the relationship – before, during, and after cancer (Partner Group Domain)		
a) History of connection, shifts in commitment, and longevity of relationship	General	We’ve had the luxury of having been together for a long time so we’ve also had a lot of experience before this. I don’t think there’s an overreaching arc [of change from pre to post cancer] and this could just be a produce of us having been through so much for so long, it feels like one big hurdle we are still kind of hurtling over. (P10)
b) Relationship awareness, intentionality, and accommodation during cancer	General	We’ve been able to just have our evenings together a lot more than we did in the past. It feels almost like comfortable dating again sitting on the couch and watching TV. I realized not checking my phone is not something that I’ll regret on my deathbed. (P10)
c) Mutual empathy and empowerment contributed to	General	The overlap of mental illness in our families, life experiences, growing up in a conservative place, and less wealthy, I think that creates a lot of compassion for both of us for the other one

	closeness and connection		and really helps us support each other in more fundamental ways. (P15)
d)	Authenticity and beneficial communication	Typical	We’ve kind of reached that point of you’ve seen me in a place that I’ve been my lowest and that I’ve been helpless and don’t really know what to do. Even in the short time that we’ve been with each other we’ve had conversations that I haven’t ever had with family members. It makes it feel like we’ve known each other for so much longer. (P16) We’re probably more careful with each other, maybe due to understanding each other better, we’re less likely to say the things that incite and more likely to say the things that affirm. (P15)
e)	Managing stress and healthy couple coping engenders connection	General	We were very lighthearted and very, very playful at home. So that was helpful in kind of easing up some of the seriousness of everything. (P16) There wasn’t a need for deep conversation. It could be unemotional and like, ‘oh my gosh look at that lady’s red shoes, aren’t they gorgeous’. It was very lighthearted conversation, which was way more beneficial. (P20)

f)	Connection via physical engagement and finding new avenues	General	Subcategory: Closeness via physical caregiving It did make me feel stronger as a partner, as well, and it made me feel like we did come closer and that we just kind of figured it out as we went… just trying to shower but not get this part of your body wet or making sure we put the bandages on the right way. (P16). Subcategory: Adjusting physical intimacy Since her recovery we’ve been working on, not necessarily different erogenous zones but different places to touch and touching regularly. Sometimes it’s been requesting it, holding hands or shoulders or gentle kisses or caresses. It’s not overly, you know, sexual. (P10)
g)	Developing relationship strength and resilience due to adversity	Typical	We have a great partnership and we really, we’ve been through a lot together, even beyond cancer, and I think that’s made us… it feels like it was forged in fire. (P15) It is a bit of, wow, something could happen to either of us at any given moment, so maybe we should try to enjoy what we have as much as we can. (P10)
Community involvement, advocacy, and external support systems (Partner Group Domain)			
a)	Involvement with cancer or community organizations	Typical	Her survivor is fighting for: new coding on the medical billing paperwork, to have an option that reads ‘flat’ mastectomy. (P20)
b)	Helpful support from friends and family	Typical	My parents have been really supportive of just me and my process, which I think has helped me be more present for her [survivor]. (P11)
c)	Couple connection enhanced by	General	Her [survivor’s] mom does a lot for her and stuff for me too that makes it nicer for the two of us, so we don’t really have to worry about

interactions with external sources		cleaning and taking care of the dog, and it gives us more time to connect and have quality time. (P11) It's very nice to know that it is a strong relationship and everything else that we can encounter will be much smaller than the things that we've hit already. (P16)
d) Support and challenges related to work and school systems	Typical	When I was getting fired, I looked at my boss and was like [survivor] has cancer. He agreed to cover the cost of COBRA insurance for a few months in the severance package, and I took money from retirement accounts but didn't get as much cash as we needed to. (P15)
e) Unhelpful support from friends and family	Typical	Subcategory: Family issues/dynamics exacerbated by cancer, often increasing stress for partners Survivor wasn't able to tell them, hey, can you come over and do such and such for me? Or for us? So, by not being able to do that, that did leave me with a lot to do. (P20) Subcategory: Lack of support/access to support, or burden of requesting it We only see each other because of COVID so that's intense that we only see each other, a lot. You know, I don't really have social contacts outside of the relationship right now. (P11)
Interactions with healthcare system and providers (Partner Group Domain)		
a) Affirming interactions between partner/survivor/couple and the healthcare system or providers	Typical	It was very easy to access her [surgeon], and I was really thankful for it. The day of the surgery, both surgeons called me after they were done with their part to tell me about how it went. It felt really natural and really respectful. (P15) They [surgeon, oncologist, nurses] have always

		been really friendly, and answered my questions, and just treat me as her partner even though we're not married. That's made me feel more connected to her and what she's going through. It allowed me to play a larger role [in her care]. (P11)
b) Non-affirming interactions between partner/survivor/couple and the healthcare system or providers	Typical	They didn't pointedly tell me anything. I don't know if it is different with a male partner, but I frankly don't feel… it wasn't my body, so I let survivor take the rein on all those questions. (P10)
c) Logistics, challenges, and barriers when navigating the healthcare system and accessing services	Typical	There was a lump and so we watched it, but also with the COVID lockdowns it wasn't easy to get appointments. (P15) I was just like, almost like I had this fragile bird that I was trying to get to the other side of town, and everybody was just everywhere. So, I think it just it was stressful because of that high alert. (P16)
d) Couple decision-making or responses prompted by healthcare	Typical	Getting a domestic partnership was as much about having some power over her health experience as it was to get insurance. (P15)
e) Partner/couple identities intersecting with healthcare system	Typical	I've known about the disparities in the healthcare system when it comes to treating African American people, especially African American women. When I started to bring [White] survivor to appointments, things started to change, the whole dynamic changed because then it was someone else here advocating for me. (P16)

Appendix J: Terminology

The body of psychological and medical research that this manuscript draws from uses many different terms to refer to the population of interest for this study, including sexual minority women, lesbian, gay, bisexual, queer, same-sex or same-gender couple, and female-partnered sexual minority women. The population recruited for this study may identify with some of these terms, other terms, or no terms to describe their personal sexual orientation/identity and/or their relationship identity. This study explored the relational processes occurring in a current relationship between two people who identify as women. This study does not explore in depth the labels the participants use to describe their sexual orientation or relationship, but rather focuses on their behaviors and experiences in their current relationship as two women, which is of primary relevance to the aim of this dissertation. This study aimed to use the most inclusive term to capture the population of interest, so decided on "women partnered with women" (WPW). This WPW term is not focused on sexual orientation, as there is evidence that sexual behaviors and identities are fluid for women over time or may be undefined (Sell, 2007). Participants for this study were eligible for the study based only on their gender identity, as a woman, and by the gender of their partner, also a woman, and not by their sexual orientation.

The term women partnered with women has been used sparsely in the literature but was defined by Goldberg and colleagues (2017), who referred to women partnered with women as part of their exclusion criteria. They defined the term as women who identity as nonheterosexual, bisexual, or behaviorally bisexual meaning they may have previously been partnered with males. Public health literature uses a similar term, "women who have sex with women," to explore health outcomes based on patient reported behaviors as well as intersecting identities (Ho, Sheldon, & Botelho, 2021). Like women partnered with women, this term is behaviorally focused, rather than sexual orientation focused. It is important to acknowledge that research literature regarding sexual orientation includes many dimensions such as sexual attraction, sexual behavior, sexual fantasies, emotional preference, social preference, self-identification, and hetero/gay lifestyle (Klein, 2014). Discussing all the components to sexual orientation in more detail is outside the focus of this dissertation.

The use of the word partner is widely used by heterosexual and non-heterosexual couples to describe their loved one with whom they have a romantically based relationship. Two well-known dictionaries recognize the term partner as follows: "a person with whom one shares an intimate relationship" (Merriam-Webster, 2022); "one member of a couple" (Merriam-Webster, 2022); "the person that you are married to or having a sexual relationship with" (Oxford Learner's Dictionary, 2022); or "a sexual/romantic partner" (Oxford Learner's Dictionary, 2022). These definitions reflect the common understanding of a partner as one with whom you are close with in an intimate, romantic, or sexual way.

To accurately represent the literature that is reviewed, this dissertation includes the terms used in the original research to describe the population studied. General definitions of frequently used terms in the reviewed research are included in Appendix E: Definition of Terms. Two terms not included there that are frequently used in the research described are sexual minorities (SM) and sexual minority women (SMW). Research defines sexual minorities as "a group whose sexual identity, orientation or practices differ from the majority of the surrounding society" and who may experience disparities in health care due to this identity (Math & Seshadri, 2013, p. 4). Sexual minority women (SMW) has been defined as "including, but not limited to, women who self-identify as lesbian, bisexual, or another non-heterosexual identity and/or engage in same-sex sexual behavior" (Ross et al., 2018, p. 1057).

Appendix K: Protecting the Identity of Participants

Please note that it was necessary to protect the identities of participants within the context of the couples, so that participants could not identity what their partner shared during the interview. For this reason, a specific description of each couple is not included. Additionally, the participant identification numbers, and the couple identification letters were changed for the manuscript.