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Affectionate Communication Mediates the Effects of Minority Stress on Mental Wellness for LGBTQIA+ Adults

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ABSTRACT

As a prosocial behavior, affectionate communication evidences a stress-buffering effect, ameliorating the deleterious effects of stressors on stress. Although much previous research has documented such an effect on physiological stress reactivity, the present study examines the ability of trait-level affectionate communication to mediate the effect of minority stress on mental wellness for LGBTQIA+ adults. Using a sample of U.S. American LGBTQIA+ adults ($N = 494$), this project demonstrates that psychological stress and depressive symptoms are negatively associated with trait affectionate communication and that trait affectionate communication partially mediates the effect of minority stress on these outcomes.

KEYWORDS

Affection exchange theory; affectionate communication; depression; LGBTQIA+ health; minority stress; stress

Depression and psychological stress are common impairments to mental well-being in the general population (Hammen, 2005). Major depressive disorder is the most commonly diagnosed mental health disorder in the United States (Gotlib & Hammen, 2009), with a worldwide prevalence rate of 10.8% (Lim et al., 2018). A range of impairments accompanies depression, from fatigue, feelings of worthlessness, and decreased concentration to anhedonia, unexplained weight changes, and insomnia or hypersomnia (American Psychiatric Association, 2013). Significantly, depression is also a primary predictor of attempted suicide (Nanayakkara et al., 2013). Psychological stress is the individual's reaction to perceived threat (Fink, 2010). Although it is not a diagnosable psychopathology, psychological stress can lead to a variety of physical symptoms, including headaches, immunosuppression, muscle tension, and pain, and to various psychological symptoms, such as sadness, irritability, and panic attacks (Cleveland Clinic, 2021). Tangri (2003) estimated that psychological stress costs the U.S. economy more than \$300 billion each year in the form of employee turnover, accidents, workers' compensation awards, absenteeism, lost productivity, and legal, medical, and insurance fees.

The substantial impairments that depressive symptoms and psychological stress impose on quality of life make relevant any effective means of diminishing their prevalence. Much social science research has documented a buffering effect of prosocial communication, whereby strong, supportive relational bonds protect the individual against the effects of threatening events on wellness, including depressive symptoms and psychological stress (e.g., Cohen et al., 2015). One classification of threatening events commonly predictive of impairments in wellness is the experience of minority stress. This study investigates the protective effect of one type of prosocial communication – affectionate communication – for reducing the influence of minority stress on depressive symptoms and psychological stress in lesbian, gay, bisexual, transgender, queer, intersex, asexual adults and adults with other sexual orientations and/or gender identities (LGBTQIA+), a population acutely susceptible to minority stress (see Caceres et al., 2020). Floyd and Morman (1998) conceptually defined affectionate communication as the “intentional and overt

enactment or expression of feelings of closeness, care, and fondness” from one individual to another (p. 45). Their *tripartite model* provided that affectionate feelings can be conveyed verbally (e.g., saying “I love you”), nonverbally (e.g., kissing, hugging), and via the provision of social support (e.g., helping with a project) (for extended discussion of the tripartite model, see Floyd, 2019). Although the level of affectionate communication characterizing a specific relationship can be assessed, Floyd (2002) also advocated for measuring the individual propensity both to express and to receive expressions of affection.

The study is grounded in affection exchange theory, detailed in the subsequent section. This review then introduces the effectiveness of affectionate communication as a buffer for distress and reviews minority stress as a significant stressor for the LGBTQIA+ community, before articulating hypotheses.

Affection exchange theory

Floyd (2006, 2019) proposed affection exchange theory (AET) to explain how and why humans communicate affection and with what consequences. AET assumes that survival and procreation are superordinate human motivations and that the exchange of affection is adaptive with respect to those motivations. The theory’s subpostulate 3d, in particular, links affectionate communication to survival by proposing that exchanging affection covaries with regulatory physiological pathways for stress (see Floyd, 2019). One regulatory function that has been investigated for prosocial behaviors is a stress-buffering effect, described subsequently.

Affectionate communication as a buffer against stressors

AET endorses Cohen and Wills’s (1985) *stress-buffering hypothesis* by hypothesizing that the exchange of affection buffers people against the deleterious effects of stressful events. Cohen and Wills originally postulated that social support, specifically, ameliorates the negative mental and physical effects of stressors. That is, if two individuals encounter an identical stressor, the individual who has less social support would evidence a larger increase in emotional and physiological stress arousal, whereas the same reactions would be attenuated in the individual who had greater social support. The magnitude of one’s stress reaction is relevant for health, insofar as exaggerated stress responses contribute to hypertension and associated organ damage (Manuck et al., 1990) and to the progression of cardiovascular disease (Lynch et al., 1998).

The stress-buffering benefits of social support have been well established (e.g., Moskowitz et al., 2013, Raffaelli et al., 2013). Similar research has shown that affectionate communication likewise protects against the negative effects of stressors. Grewen et al. (2003), for example, reported that handholding with and embracing a romantic partner prior to a public speaking stressor attenuated blood pressure reactivity relative to controls. A later experiment by Pauley et al. (2015) demonstrated a similar cardiovascular effect in both romantic and platonic relationships, suggesting that the stress-buffering advantage is not unique to romantic pairs (see also Cohen et al., 2015). Floyd et al. (2010) and Floyd (2022) found that even one’s trait level affectionate behavior predicted attenuated cortisol arousal to stressors, indicating that affectionate communication buffers one’s stress response even when not exchanged immediately prior to a stressful event (see also Floyd et al., 2007).

Whereas some stressors are acute, meaning they are sudden and severe in onset, others are chronic, meaning either that they are protracted (e.g., a chronic illness) or they constantly recur (e.g., repeated relational conflict). An often potent form of chronic stressor is minority stress, defined by Meyer (2003) as the “excess stress to which individuals from stigmatised social categories are exposed as a result of their social, often minority, position” (p. 675). As detailed subsequently, minority stress has multiple deleterious effects on well-being for the LGBTQIA+ community, including with respect to generalized stress and depressive symptoms.

Minority stress for LGBTQIA+ individuals

In many parts of the world, including the United States, LGBTQIA+ individuals frequently face social discrimination and prejudice not shared by heterosexual and/or cisgender individuals (see Casey et al., 2019). For instance, many LGBTQIA+ adults experience alienation or rejection from loved ones (D'Amico & Julien, 2012), as well as discrimination in employment (DeSouza et al., 2017), housing (Friedman et al., 2013), and public accommodations (Mallory & Sears, 2018). LGBTQIA+ individuals are also at greatly elevated risk of violence and hate crimes related to their sexuality and/or gender orientation (Flores et al., 2022). Such experiences often contribute to minority stress for the LGBTQIA+ population (see Saha et al., 2019). Eger (2018) found that transgender individuals even engage in “closeting communication” to manage the tension of navigating their gender identity in a workplace that is often unwelcoming.

Minority stress theory

Meyer's (1995, 2003) minority stress theory articulates three specific processes that contribute to minority stress in LGBTQIA+ individuals: (1) experiencing external, objectively stressful events, such as violence or aggression directed toward the self; (2) having expectations that such events could occur and being hypervigilant as a result; and (3) internalizing negative social attitudes regarding sexual orientation and/or gender identity (see also Meyer & Dean, 1998). To this list, later research added the stress associated with concealing one's sexual orientation and/or gender identity as an additional minority-related stressor (Cole et al., 1996).

In conceptualizing minority stress, Meyer (2003) differentiates between *distal stressors* and *proximal stressors*. The key distinction between the two is that distal stressors are stressful events an individual might face, such as experiencing harassment, discrimination, or microaggressions, whereas proximal stressors comprise the individual's subjective appraisals to such events, such as internalizing homophobia or stigma (Douglass & Conlin, 2020).

Negative health consequences of minority stress

Minority stress has been associated with a wide range of negative consequences, including substance use and abuse (Goldbach et al., 2014, Lehavot & Simoni, 2011), disordered eating (Convertino et al., 2021), HIV risk behaviors (Hatzenbuehler et al., 2008), intimate partner violence (Lewis et al., 2012), suicidality (Rogers et al., 2021), and physical health impairments such as cardiovascular disease (Case et al., 2004), respiratory disease (Steele et al., 2009), and cancer (Kavanaugh-Lynch et al., 2002, Koblin et al., 1996). Such negative outcomes are often particularly pronounced for LGBTQIA+ people who have additional minority statuses, such as LGBTQIA+ people of color (Cyrus, 2017, English et al., 2018).

Among the detriments strongly associated with minority stress are symptoms of depression and psychological stress. For transgender adults, for instance, depressive symptoms are associated with both internalized heterosexism (Hoy-Ellis & Fredriksen-Goldsen, 2017) and concealment of sexual orientation or gender identity from loved ones (Fredriksen-Goldsen et al. 2014). For transgender and gender-nonconforming adolescents and young adults, internalized transphobia even predicts diagnostic criteria for major depressive disorder (Chodzen et al., 2019; see also Baams et al., 2015). A meta-analysis reported that gender minority stress, expectations of rejection, and internalized transphobia are related to depressive symptoms as well as suicidality for transgender and gender diverse individuals (Pellicane and Ciesla, 2022).

Minority stress experiences also covary with psychological stress. Among lesbian, gay, bisexual, and other same-sex-attracted young people, Lea et al. (2014) found that perceived stigma, internalized homophobia, and experienced homophobic physical abuse were significantly associated with psychological stress and self-reported suicidal ideation (see also Lewis et al., 2009).

Kelleher (2009) found that, for LGBTQ young people in Ireland, sexual identity distress, stigma, and heterosexist experiences were all correlated with psychological stress. Carter et al. (2014) also reported a positive association between internalized homophobia and distress and further found that the association between workplace-based prejudice and psychological stress was mediated by an individual's locus of control (for additional examples, see Timmins et al., 2017, 2020).

As explicated above, AET and the stress-buffering hypothesis propose that, since affectionate communication is one method by which stress is attenuated, that differences in affectionate communication might be one pathway by which minority stress links to the outcomes of depressive symptoms and psychological stress. Specific hypotheses are articulated subsequently.

Hypotheses

Evidence confirms that minority stress functions as a stressor for LGBTQIA+ individuals. AET claims that affectionate communication can buffer individuals against the deleterious effects of stressors, and several empirical projects have demonstrated such a buffering effect with respect to acute stressors. The present study tests the prediction that a corresponding deficit in affectionate behavior is one of the reasons that LGBTQIA+ adults experience the negative effects of minority stress. As noted, this study focuses on the mental health outcomes of depressive symptoms and psychological stress. We measure minority stress as comprising two proximal stressors – perceived stigma (the extent to which one perceives that an LGBTQIA+ identity is disgraced or disapproved of) and internalized homophobia (the extent to which one turns social homophobia inward and experiences self-hatred for an LGBTQIA+ identity) – and the distal stressor of harassment/discrimination (the extent to which one has experienced events constituting harassment and/or discrimination for an LGBTQIA+ identity).

Among AET's most frequently tested hypotheses is that affectionate behavior is significantly associated with well-being. A meta-analysis by Hesse et al. (2021) demonstrated that the relationship between affectionate communication and health is moderately strong ($r = .23$), and with some infrequent exceptions (e.g., Floyd et al., 2014), the association is positive. The same prediction is proposed here as an inverse association between affectionate behavior and the various forms of distress measured herein:

H1: Affectionate communication is inversely associated with (a) depressive symptoms, and (b) psychological stress.

As noted above, multiple forms of evidence also suggest a main effect of minority stress on mental wellness. Specifically hypothesized is that minority stress – measured in its two proximal and one distal component – is directly associated with mental distress in adulthood:

H2: Perceived stigma (a), internalized homophobia (b), and harassment/discrimination (c) are directly associated with depressive symptoms.

H3: Perceived stigma (a), internalized homophobia (b), and harassment/discrimination (c) are directly associated with psychological stress.

The principal prediction, however, is that affectionate communication is one of the pathways by which minority stress affects the outcome measures. We propose a mediated model in which the minority stress of LGBTQIA+ identity inhibits the communication of affection, which in turn covaries with greater psychological stress and depression.

Research indicates that minority stress associated with sexual orientation and/or gender identity inhibits the communication of affection. Blair et al. (2023), for instance, reported that relational partners are less affectionate with each other when they perceive greater marginalization and less support for their relationships. In line with that contention, Rohleder et al. (2023) found that LGBTQ+ participants routinely curtailed public displays of affection out of fear of social disapproval, retribution, or aggression. Such reactions are common, according to research (e.g., De Oliveira et al., 2013). Similarly, Blair et al. (2022) found that partners in same-gender and gender-diverse relationships (including participants with transgender or non-binary identities) were significantly less likely to share affectionate behavior and significantly more vigilant about sharing affectionate communication, at least in public, than were partners in mixed-gender relationships (for additional examples, see Hocker et al., 2021, Kent & El-Alayli, 2011, Vaquera & Kao, 2005).

These observations lead to the final two predictions:

H4: Affectionate communication mediates the association between depressive symptoms and (a) perceived stigma, (b) internalized homophobia, and (c) harassment/discrimination.

H5: Affectionate communication mediates the association between psychological stress and (a) perceived stigma, (b) internalized homophobia, and (c) harassment/discrimination.

Method

Procedure and participants

Participants were recruited via the online participant recruitment portal Prolific. To be eligible for the study, participants had to be at least 18 years old, able to read and write in English, and self-identify as LGBTQIA+. Eligible participants completed and submitted an online questionnaire in exchange for \$2.47US, which equated to an average per-hour rate of \$21.68US based on a median completion time of 6 minutes, 50 seconds. The study was approved by the BLINDED institutional review board at BLINDED, approval number 00001804. Data were collected from late February to early March 2022.

A sample size of 500 participants was initially recruited, and every participant who returned a completed questionnaire passed embedded attention checks. Six participants were later eliminated from the data file because they endorsed only heterosexual, cisgender identities, which did not represent our sampling frame. A seventh participant who endorsed both a heterosexual and a bisexual identity was retained in the data file. A total of 494 participants therefore remained for analysis. Participants ranged in age from 18 to 84 years ($M = 32.68$ years, $SD = 11.12$). Percentages for participants' current gender identities appear in Table 1.

With respect to ethnicity, 15.4% reported identifying as Hispanic and 84.6% as non-Hispanic. Most (77.9%) identified as white, whereas 14.0% identified as Latino/a, 11.1% as Black, 5.5% as Asian, 2.6% as Native American or Aleut, 0.6% as Arab, 0.6% as Native Hawaiian/Pacific Islander, and 1.0% as having other racial identities.¹ With respect to education, 35.7% had a high school diploma or less, 4.9% had a vocational or technical school diploma, 9.3% had an associate degree, 37.5% had a baccalaureate degree, and 12.5% had a graduate or professional degree. Participants came from 45 U.S. states and the District of Columbia. At the time of the study, nearly half (49.2%) were married or in a significant long-term relationship, whereas 45.9% were unmarried, 4.7% were divorced, and 0.2% were widowed. Most of the participants (62.8%) identified as bisexual, whereas 21.1% identified as gay, 13.2% as pansexual, 10.7% as lesbian, 10.1% as queer, 2.4% as questioning, 2.2 as same-gender loving, 1.8% as asexual, 0.2% as heterosexual, and 0.6% as having another sexual orientation.

Table 1 Participants' Current Gender Identities ($N = 494$)

Identity	n	Percent
Agender	7	1.4
Cisgender man	113	22.9
Cisgender woman	184	37.2
Genderqueer	12	2.4
Man	96	19.4
Non-binary	35	7.1
Questioning	10	2.0
Transgender man	13	2.6
Transgender woman	12	2.4
Woman	89	18.0
Another gender	7	1.4

Percentages sum to > 100 because some participants endorsed multiple gender identities.

An a priori power analysis (G*Power 4; Faul et al., 2007) indicated that the target sample size of 500 provides in excess of 95% power to identify a small effect size ($f^2 = .02$), assuming a .05 probability level.²

Measures

Affectionate communication (McDonald's $\omega = .95$) was measured with the 16-item Trait Affection Scale (TAS; Floyd, 2002). TAS asks participants to report how demonstrative they generally are of their affection for others and how much affection they generally received from other people by indicating their level of agreement with statements such as "Anyone who knows me would say I'm pretty affectionate," "I am always telling my loved ones how much I love them," and "People are always telling me that they like me, love me, or care about me." Level of agreement was assessed on a 9-point scale anchored with 1 (*strongly disagree*) and 9 (*strongly agree*). TAS has been extensively validated and evidences multiple forms of psychometric adequacy (for extended discussion, see Floyd, 2019). A score for affectionate communication, and for all multi-item measures, was calculated as the mean of the items.

Depressive symptoms ($\omega = .92$) were assessed with the Iowa Short Form (Kohout et al., 1993) of the Center for Epidemiological Studies Depression (CES-D) scale (Radloff, 1977). The 11-item measure asks participants how frequently in the past week they experienced symptoms during the past week such as loss of appetite, changes in sleep patterns, or self-dislike. Specific items included, "I could not get going," and, "My sleep was restless." Level of frequency was measured on a 9-point scale from 1 (never or almost never) to 9 (always or almost always).

Psychological stress ($\omega = .94$) was measured with the 14-item Stress Scale developed by Cohen et al. (1983). Items ask participants how often, in the past month, they have experienced stress, nervousness, anger, difficulty coping with irritations, and difficulty dealing with changes, among other things. Specific items included, "Able to control irritations in your life," and "Angered because of things that happened that were outside of your control." Level of frequency was measured on a 9-point scale from 1 (never or almost never) to 9 (always or almost always).

Perceived stigma ($\omega = .93$) was measured with a five-item revised version of the perceived stigma scale developed by Puckett et al. (2017). The items were originally based on Kuhns et al. (2008). Items asked participants to indicate their level of agreement with items such as "Many people believe that LGBTQIA+ people have psychological problems" and "Many people believe that LGBTQIA+ people should not raise children." Level of agreement was assessed on a 9-point scale anchored with 1 (*strongly disagree*) and 9 (*strongly agree*).³

Internalized homophobia ($\omega = .85$) was measured with the five-item Revised Internalized Homophobia Scale (IHP-R; Herek et al., 2009). Items asked participants to indicate their level of agreement with items such as "I wish I weren't an LGBTQIA+ person" and "I have tried to change the

Table 2 Descriptive Statistics and Intercorrelations of Study Variables ($N = 494$)

	High	v Low	<i>M</i>	<i>SD</i>	1	2	3	4	5
1. Aff. Comm.	9.00	1.15	5.47	1.83	–				
2. Depression	9.00	1.00	4.55	1.90	–.32*	–			
3. Stress	8.90	1.00	4.87	1.87	–.30*	.85*	–		
4. Stigma	9.00	1.00	5.17	1.95	–.14*	.24*	.23*	–	
5. Homophobia	9.00	1.00	1.74	1.25	–.15*	.12*	.06	.20*	–
6. Harassment/discrimination	5.00	1.00	1.56	0.76	.02	.20*	.15*	.25*	.19*

Affectionate communication, depression, stress, stigma, and homophobia were measured on 9-point scales; harassment/discrimination was measured on a 6-point scale. In all cases, higher scores index greater levels of the variable. * $p < .01$ (two-tailed).

types of people to whom I am attracted.” Level of agreement was assessed on a 9-point scale anchored with 1 (*strongly disagree*) and 9 (*strongly agree*).⁴

Harassment/discrimination ($\omega = .95$) was assessed with the 14-item Heterosexist Harassment, Rejection, and Discrimination Scale (HHRD; Szymanski, 2006). Items asked participants on a six-point scale how many times they have experienced issues such as being rejected by friends, being verbally insulted, being denied a promotion at work, or being treated unfairly by strangers in the past year because of their sexual orientation and/or gender identity. Frequency of these experiences was assessed on the following: 1. The event has never happened to you; 2. The event happened once in a while (less than 10% of the time); 3. Sometimes (10–25% of the time); 4. A lot (26–49% of the time); 5. Most of the time (50–70% of the time); and, 6. Almost all the time (>70% of the time).

Descriptive statistics and intercorrelations of study variables appear in Table 2.

Data analysis

Hypothesis tests were all simultaneously run using a path model in AMOS v29, allowing us to test both the direct effects as well as the tests of mediation. In the path model, perceived stigma, internalized homophobia, and harassment were used as the IV, affectionate communication was used as the mediator, and depression and stress were used as the DV. This analysis plan was used for two main reasons – first, to control for Type I error by accounting for the number of statistical tests, and second, to account for the likely shared variance with our variables (especially with two criterion variables that point to a shared outcome of mental health).

Results

Data transformation

A normality report on the study variables revealed that affectionate communication, depressive symptoms, psychological stress, and perceived stigma were platykurtic, whereas internalized homophobia and harassment/discrimination were leptokurtic and positively skewed. A log-10 transformation was applied to the variables, which reduced both skewness and kurtosis. For ease of interpretation, raw (untransformed) values of the variables were used to compute descriptive analyses and are reported in Table 1, but transformed values were used to test the predictions.

Hypotheses

The first three hypotheses predicted a set of relationships between the study variables, whereas the final two hypotheses predicted that affectionate communication would mediate those relationships. Specifically, we predicted that affectionate communication is inversely related to depressive symptoms and stress, and that perceived stigma, internalized homophobia, and harassment/discrimination are directly related to both stress and depressive symptoms.

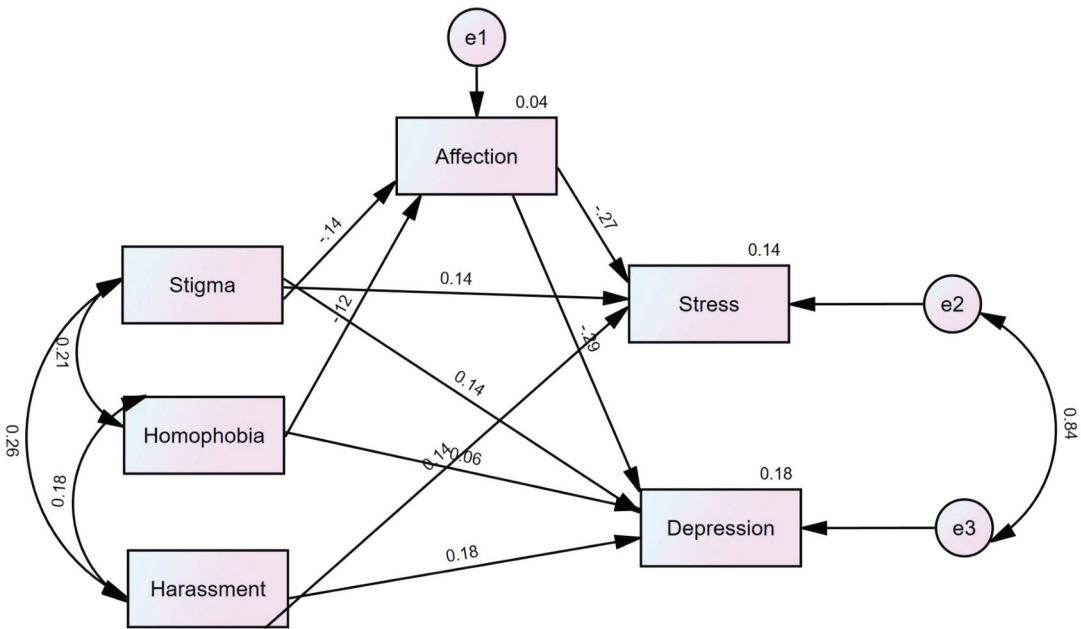


Figure 1 Final Path Model Testing Study Hypotheses The three minority stress variables were allowed to covary, and the two outcome variables were also allowed to covary. The variable label of "affection" refers to affectionate communication.

We initially included age, gender, and education as control variables in hierarchical regression models used to test the first three hypotheses. However, those variables added little variance to the models, while not significantly affecting the hypothesized relationships. Thus, in the service of parsimony, we removed those covariates and tested all five of our hypotheses in a full path model. After running our initial model containing all relevant pathways, we removed nonsignificant pathways sequentially in the model. We also ran a bootstrapping test with a 90% confidence interval to examine the indirect effects (Hayes, 2018). The final model is shown in Figure 1.

The final model showed excellent fit, $\chi^2 = 2.56$, $df = 2$, $p = .28$, CFI > .99, RMSEA = .024. With respect to H1, we found significant associations between affectionate communication and both stress ($\beta = -.27$, 95% CI = $-.40$ to $-.23$, $p < .001$) and depressive symptoms ($\beta = -.29$, 95% CI = $-.45$ to $-.28$, $p < .001$). H1 is supported. For H2, we found significant effects between depressive symptoms and perceived stigma ($\beta = .14$, 95% CI = $.10$ to $.28$, $p = .001$), harassment ($\beta = .18$, 95% CI = $.14$ to $.30$, $p < .001$), and homophobia ($\beta = .06$, 95% CI = $.05$ to $.13$, $p = .02$). H2 is supported. Finally, for H3, we found significant effects between stress and perceived stigma ($\beta = .14$, 95% CI = $.09$ to $.27$, $p = .001$), and harassment ($\beta = .14$, 95% CI = $.08$ to $.24$, $p = .002$). However, there was no significant effect between stress and homophobia. H3 is partially supported.

We tested the final two hypotheses by examining the indirect effects in the model. There were significant direct effects between affectionate communication and both stigma ($\beta = -.14$, 95% CI = $-.17$ to $-.05$, $p = .003$) and homophobia ($\beta = -.12$, 95% CI = $-.16$ to $-.04$, $p = .006$). However, there was no significant relationship between harassment and affectionate communication, and thus no indirect effects present for either stress or depressive symptoms. There were small but significant indirect effects for perceived stigma on both stress ($\beta = .04$, 95% CI = $.02$ to $.06$, $p = .003$) and depressive symptoms ($\beta = .04$, 95% CI = $.02$ to $.08$, $p = .003$). There were also significant indirect effects for homophobia on both stress ($\beta = .03$, 95% CI = $.01$ to $.06$, $p = .005$) and depressive symptoms ($\beta = .04$, 95% CI = $.02$ to $.06$, $p = .006$). H4 and H5 are both partially supported.

Discussion

Psychological stress and depression are both significant threats to public health and wellness, and both are associated with LGBTQIA+ minority stress in adulthood. Just because minority stress *may* increase susceptibility to depressive symptoms and psychological stress, however, does not imply that it *must*. Prosocial communication behaviors can buffer individuals against the negative effects of minority stress, and the present study tested AET's prediction that affectionate communication has a stress-buffering effect by serving as a pathway between minority stress, depressive symptoms, and psychological stress in LGBTQIA+ adults.

On the basis of AET, multiple previous investigations have hypothesized and found that affectionate communication is inversely related to depressive symptoms and psychological stress, and both predictions were successfully replicated here. This study also replicated the hypotheses that minority stress scores significantly predict depressive symptoms and stress on their own (outside of internalized homophobia on stress, which was nonsignificant in both the full model and the zero-order correlation).

The critical contribution of the present study was to demonstrate that affectionate communication can mediate the association of minority stress with depressive symptoms and stress. Specifically, we found evidence of partial mediation for both perceived stigma and internalized homophobia, with smaller direct effects than the zero-order correlations and significant (though small) indirect effects on both outcome measures. Thus, our argument that a dearth of affectionate communication is one of the pathways by which minority stress variables relate to both psychological stress and depressive symptoms is supported. This result also links to previous research that has shown a similar mediating effect of affectionate communication with the stresses of adverse childhood experiences (Floyd, 2022), alexithymia (Hesse et al. 2008), and affection deprivation (Hesse & Tian, 2020) with respect to variables such as depression, psychological stress, and loneliness.

Affectionate communication as a buffer for minority stress

The present findings suggest that when minority stress is high, LGBTQIA+ individuals are less inclined to exchange affectionate communication and, consequently, to share in its benefits with respect to reduced depression and psychological stress.

For what reasons would affectionate communication be associated with less mental distress? One prospect, which is consistent with interpersonal psychotherapy (Weissman et al., 2017), is that highly affectionate people are more proficient at creating and drawing on supportive relational alliances. In line with that suggestion, Floyd (2002) reported that, compared to less-affectionate adults, highly affectionate adults were more socially active and less socially isolated, and were more likely to have a significant romantic relationship. Interpersonal assets such as these have the potential to ameliorate the effects of minority stress on LGBTQIA+ adult wellness. For those LGBTQIA+ adults lacking the stress-buffering benefits of high trait affectionate communication due to the influence of increased minority stress, however, poorer mental well-being is common.

Strengths, weaknesses, and conclusions

Although not a statistically representative sample of the U.S. LGBTQIA+ adult population, the current sample did represent a good deal of demographic and geographic diversity. Participants came from 45 of 50 U.S. states plus the District of Columbia. Eleven gender identities and ten sexual orientations were represented, and participants represented a considerable age range.

How representative was the sample of the U.S. LGBTQIA+ adult population? Full and precise demographics for the U.S. LGBTQIA+ adult population are difficult to ascertain, but Goldberg et al. (2020) drew on a U.S. representative sample of adults who identified as lesbian, gay, bisexual, queer, or as another sexual-minority identity to document demographic characteristics. Crissman et al. (2017)

drew on a probability sample of U.S. transgender adults to document similar demographics. Goldberg et al. documented a mean age of 29.03 years, three years younger than the mean age of the present sample. The same analysis reported that 69.48% were assigned female at birth (compared to 56.4% in the present sample), and 30.55 were assigned male at birth (compared to 42.4% in the present sample). Both Goldberg et al. and Crissman et al. reported that ~ 60% of their samples identified as white. As is true in the broader literature on affectionate communication and health (Floyd et al., 2023), the present study oversampled white participants, at nearly 77.9%. Black and Latino/a participants were slightly undersampled, relative to the demographics identified by Goldberg et al. and Crissman et al.⁵

The present findings cannot be considered generalizable to non-U.S. cultures. There is little reason to believe that the problematic consequences of minority stress are limited to U.S. Americans; indeed, Sun et al. (2021) reported on minority stress for sexual minority men in China (see also Lea et al., 2014, for data from an Australian sample). Whether the mediating effect of affectionate communication on mental well-being generalizes to non-U.S. cultures is an empirical question. Such a question awaits attention, and the present findings offer a warrant for pursuing that question. Future studies should also add other possible variables of interest, including religiosity (both as a potential stressor for LGBTQIA+ adults or a source of potential resiliency due to the building of community) and other elements of the social/physical environment of the individual (for example, there might be more examples of minority stress occurring in specific environments in the United States known for exhibiting higher levels of homophobia and oppression).

Symptoms of depression and psychological stress can be debilitating, and experiences of minority stress can contribute to their prevalence for LGBTQIA+ adults. This is especially true for those lacking affectionate behavior. When minority stress is pronounced, affectionate communication is attenuated, as are its benefits for mental wellness. This is the first known study to identify such a finding, and as such, replication is warranted. Overall, however, these findings attest to the strength of the wellness potential of affectionate communication in human relationships.

Notes

1. These percentages sum to > 100 because participants could select multiple racial identities.
2. A post-hoc power analysis confirmed that the effective sample size of 494 still provided in excess of 95% power to identify the same effect size under the same parameters.
3. Remaining items were “Many families would be disappointed to have an LGBTQIA+ child,” “Many people do not accept same-sex couples,” and “Many people believe that LGBTQIA+ romantic partners should not hug, hold hands, or kiss in public”
4. Remaining items were “If someone offered me the chance to be completely heterosexual/straight, I would accept it,” “I feel that being LGBTQIA+ is a personal shortcoming for me,” and “I would like to get professional help to change my sexual orientation to heterosexual/straight”
5. In the current study, 11.1% of participants identified as Black, whereas 17.08% of Goldberg et al.’s participants and 15.3% of Crissman et al.’s participants similarly identified. In the current study, 14% of participants identified as Latino/a, whereas 22.23% of Goldberg et al.’s participants similarly identified.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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