Perceived Social Support for Relationships As a Predictor of Relationship Well-Being and Mental and Physical Health in Same-Sex and Mixed-Sex Relationships:
A Longitudinal Investigation

By

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Abstract

Intimate relationships function not in isolation, but within a broader social network and social environment, in which the opinions and actions of close network members can play a role in how a relationship develops. The current study investigated how perceiving support for one’s relationship (including same-sex and mixed-sex relationships) from friends and family is associated with not only relationship well-being, but also the mental and physical health of the individuals within the relationship. After establishing that social support specifically for a relationship was indeed a separate and unique construct as compared to more general social support for an individual, the study tested a hypothesized model using structural equation modeling, finding evidence for a model in which the association between support for a relationship and the health outcomes for an individual is fully mediated by relationship well-being. Relationship type (i.e., same-sex versus mixed-sex) was not a significant moderator, indicating that regardless of relationship type, individuals who perceive more support for their relationship are also more likely to report greater relationship satisfaction and better mental and physical health. Furthermore, participants provided data up to three times over a period of three years, allowing for an examination of how social support for a relationship functions as a predictor of relationship well-being and health outcomes over time. Perceived social support for a relationship at Time 1 was found to be a significant predictor of the rate of relationship dissolution over the course of the study as well as relational and health outcomes at later points in time. With respect to the source of support for the relationship, evidence was found that support from parents and friends both have associations with relationship outcomes, but these findings were inconsistent across analyses with support from parents having stronger associations in some analyses and support from friends having stronger associations in others. Reasons for these discrepancies are discussed, as well as theoretical implications concerning the role that perceived social support for relationships plays in the prediction of relationship well-being and mental and physical health.
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Just as this thesis argues that individuals and relationships do not exist within a social vacuum, it is equally true that dissertations and doctoral degrees do not manifest themselves in isolation. The final product printed on these pages is the culmination of a project that began nearly a decade ago and over the course of that decade I have had the privilege to be surrounded by an ever changing, yet wonderful and inspiring ‘social network’ of mentors, colleagues, friends, family and furkids. It would be a tome longer than this thesis if I were to adequately acknowledge and thank every person and institution that has helped along the way, but I hope that I can do justice here to at least a few of the most important figures that have made significant contributions.

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CHAPTER 1
INTRODUCTION

What happens when family and friends reject a loved one’s potential mate? Hollywood has played out the answer to this question many times over, elaborating and embellishing the common experiences of many who bring home a partner who somehow does not meet the expectations of their family and friends, or social network. A social network may reject a potential partner for any number of reasons. In Guess Who, the 2005 adaptation of the 1967 classic Guess Who’s Coming to Dinner?, the issue at hand for the parents is the race of the new partner. In My Big Fat Greek Wedding, both families are displeased with the children’s choice of partner, with the Greek family being upset that their daughter’s choice of a husband is not from the Greek community, and the White Anglo-Saxon Protestant family being disoriented by the sheer size, boisterousness and traditions of the Greek family. In The Notebook, Noah and his true love, Allie Hamilton, are deliberately pulled apart by Allie’s parents because she is from an upper class family that cannot condone her relationship with a working class boy. Meet the Parents plays out a plot where an ex-CIA agent father is generally skeptical of his daughter’s new fiancé, and goes to great lengths to try to prove that Gaylord Focker is not a suitable match for his daughter.

These movies all come to happy, amicable endings in which the differences are eventually settled and the new partner is welcomed into the family. However, life does not always run according to the same script, and many times support for a new relationship can be withheld for many months, years, or even indefinitely. Through these movies, and many others with similar plot lines, Hollywood has made a social commentary on the importance of social support for romantic relationships, in terms of predicting their well-being and long-term success. But we need not rely on Hollywood and fiction to determine the importance of social support; scientific studies have shown many times over that social support is a crucial element in the happiness and well-being of individuals within relationships (Bryant & Demian, 1994; Bryant & Conger, 1999; Felmlee, 2001; Parks & Eggert, 1991).

Although Hollywood would make it seem like common sense that social support specifically for a relationship is an important predictor of relationship well-being, much of the current research on
relationships has limited its focus to examining the impact of overall social support for an individual, rather than examining support specifically for the relationship and the choice of partner (Berscheid, 1999). Furthermore, the notion that having support for a relationship might increase the functioning and quality of that relationship appears to make logical sense. But is it also possible that having social approval of your relationship could also predict well-being in other areas of life, such as mental and physical well-being? Research has found strong associations between overall social support and health (Cassel, 1976; Cobb, 1976; House, Umberson, & Landis, 1988; Uchino, Cacioppo, & Kiecolt-Glaser, 1996), as well as health benefits associated with being in a romantic relationship (Bloom, Asher, & White, 1978; Remen & Chambless, 2001; Tolpin, Cohen, Gunthert, & Farrehi, 2006). The literature to date, however, has not addressed the question of whether or not social support specifically for a relationship can predict relationship well-being, and then, in turn, also predict the mental and physical well-being of the individuals within the relationship. Blair and Holmberg (2008) tested such a model and found that social support for relationships did indeed predict relationship well-being, and in turn, the mental and physical health of the individuals within the relationship; for individuals in mixed-sex as well as same-sex relationships. The current study will extend this research by examining the model from a longitudinal perspective, attempting to replicate these findings, and examining how the associations among social support for relationships, relationship well-being and mental and physical health function over time.

In the movie examples provided above, the social network disapproved of some aspect of the particular partner chosen (e.g., race, ethnicity, social class, personality). Would the process be any different if the social network potentially disapproved not only of the current partner, but also all partners to whom an individual is likely to be attracted? Gay and lesbian individuals potentially face such long-standing disapproval. They must negotiate social support from their friends and family not only for one particular relationship, but also for the general type of relationship to which they are drawn (i.e., to a partner of the same sex). Qualitative studies (e.g., LaSala, 1998; Rostosky et al., 2004) suggest that such network disapproval is a challenge in same-sex relationships, but quantitative studies comparing these
processes in both mixed-sex and same-sex couples are rare (c.f. Kurdek, 1997, 1998, 2004; Kurdek & Schmidt, 1987), and studies exploring the mental and physical health outcomes for both groups are nonexistent. The current study includes individuals from both types of relationships (i.e., mixed-sex and same-sex) in order to examine whether individuals in both types of relationships benefit (and suffer) equally from varying levels of social support for their relationships.

The following review of the literature will examine the existing research linking social support to mental and physical health outcomes, the association between relationships and health, as well as the association between social support and relationships. The difference between social support for a relationship provided by friends versus parents will be discussed, followed by a review of the current literature that compares mixed-sex and same-sex couples, and their relative experiences with social support. Finally, the current study’s hypothesized model and research questions will be presented.
CHAPTER 2
LITERATURE REVIEW

Social Support

At the most basic level, social support can be defined as the resources that individuals provide to each other (Cohen & Syme, 1985) “that [promote] the attainment of goals and the resolution of life tasks” (Elizur & Mintzer, 2003, p. 414). The resources provided are often categorized into four groups: emotional support, informational support, tangible support, and belonging support (Uchino, 2004). Emotional support refers to the feeling that someone will be there to provide a sense of acceptance and comfort during difficult times. Informational support involves the provision of advice and guidance, and can often easily overlap with emotional support when the advice provided comes from a sense of genuine care on the part of the provider. Tangible, or material, support refers to the actual provision of material aids, such as financial assistance or shelter (Uchino, 2004). Tangible, or material/instrumental, support can also include the giving of time, assistance or direct interventions on an individual’s behalf (House, 1981). The fourth category is belonging support, or the availability of shared social activities that contribute to a sense of social belonging. This form of support, sometimes referred to as appraisal support (House, 1981), also includes the transmission of evaluative information, such as affirmation, approval, constructive criticism (i.e., feedback) or social comparison (House, 1981).

The types of social support can be further categorized based on the source from which the support comes: spouses, friends, parents, extended family, co-workers, and even society as a whole. The individuals by whom we are surrounded throughout our lives and with whom we have day-to-day contact form what researchers call our social network, and it is this network that is most often our largest source of social support. Oftentimes social support is measured across network members in order to generate an indicator of how much total support an individual receives (Davis, Morris, & Kraus, 1998; Uchino, 2004), but researchers have also emphasized the importance of identifying the quality and quantity of support received (or perceived) from specific sources (domains) within our social network (Brock, Sarason, Sarason, & Pierce, 1996; Davis et al., 1998; Fenlason & Beehr, 1994). Research has found that
individuals who receive social support from a variety of sources (i.e., friends, family, co-workers) show greater resilience when faced by social stressors or negative interpersonal experiences (Lepore, 1992).

In addition to differentiating among the sources and purposes of social support, the study of social support can also be differentiated by asking participants about the actual amount of support they receive (e.g., measuring day-to-day supportive interactions or asking network members about the support they provide) or inquiring about how much social support an individual perceives to be available (Uchino, 2004). While one may assume that perceived and received support would be quite similar, if not equal, researchers have found that individual perceptions of available support differ significantly from measures of actual received support (Uchino, 2004). Furthermore, measures of perceived support seem to be most relevant with respect to predicting health outcomes. One exception to this finding is that measures of perceived social support for relationships have been found to correlate highly with reports of offered/actual social support from social network members (Sprecher, 2011).

Social support can also be distinguished by the variety of purposes for which it may be offered, a concept referred to as domain specificity (Davis et al., 1998; Goldsmith, 2004). The definitions provided earlier are perhaps best considered as descriptors of general social support, or, in other words, the general resources (emotional, tangible, informational, belonging) provided to an individual from a variety of sources and for a variety of reasons. Social support can, however, have a much more narrow focus and be directed at a specific behaviour, identity, or quality that an individual displays. For example, an individual may experience social support for bereavement, educational challenges, physical or mental illness (Uchino, 2004), or sexual identity. Bearman and La Greca (2002) studied family support for individuals with diabetes and found evidence that this kind of social support was unique as compared to more general social support. Several researchers have also established that content-specific measures of social support are more accurate in predicting related outcomes than are general measures of social support (Davis et al., 1998; Fenlason & Beehr, 1994; Goldsmith, 2004; Uchino, 2004). Researchers who have examined general social support in conjunction with a more specific form of social support have found that the inclusion of specific domains of support and support from various sources improves the extent to which
variability in outcome measures (such as health) can be explained (Bearman and La Greca, 2002; Davis et al., 1998).

**Social Support and Health**

Perhaps one of the most robust findings in the social support literature is the strong link between general social support and health outcomes. Social support has consistently been found to be an important predictor of mental and physical health across a wide variety of populations. An overall sense of social support from our family and friends has been linked to lower levels of depression and anxiety (Bertera, 2005; Chi Kuan Mak, Bond, Simpson, & Rholes, 2010; Dean, Kolody, & Wood, 1990; Dew & Bromet, 1991; Reisen & Poppen, 1999; Ross, Lutz, & Lakey, 1999; Simpson, Collins, Tran, & Haydon, 2007); higher self-esteem (Pierce, Sarason, & Sarason, 1992); better sleep quality (Bertera, 2005; Chi Kuan Mak et al., 2010; Ross et al., 1999; Simpson et al., 2007); more robust immunological functioning; fewer physical symptoms (Uchino et al., 1996); and increased longevity (Aneshensel & Frerichs, 1982; Billings & Moos, 1982; Blazer, 1982; Henderson, Byrne, & Duncan-Jones, 1981; Holahan & Moos, 1981; Nordin, Knutsson, Sundbom, & Stegmayr, 2005; Turner, 1981; Williams, Ware, & Donald, 1981).

Research in this area has not only established strong correlational evidence linking social support to better health outcomes, but it has also provided consistent longitudinal evidence which many researchers believe demonstrates a causal link between social support and health outcomes (Cohen & Syme, 1985; House, 1987; Uchino, 2004). Berkman and Syme’s (1979) study of over 6000 residents of Alameda county was one of the first population based longitudinal studies to strongly suggest a causal link between social support and mortality through rigorous treatment of potential confounding variables such as prior health status. The results of the nine-year study found that individuals reporting low levels of social support were between 2.3 and 2.8 times more likely to die during the course of the study (Berkman & Syme, 1979). More recent research controlling for a variety of alternative explanations, including age, health behaviours, socio-economic status, prior health status and gender have provided additional evidence supporting a causal interpretation of the link between social support and health outcomes (Dalgard & Haheim, 1998; Kaplan et al., 1994; Roy, FitzGibbon & Haug, 1996; Uchino, 2004).
The availability of social support has been associated with lower coronary heart disease, decreased stress hormones, better cardiovascular regulation, lower blood pressure (Billings & Moos, 1982; Cassel, 1976; Cobb, 1976; House et al., 1988; Sarason, Sarason, & Gurung, 2001; Uchino et al., 1996), as well as improved functioning of the endocrine and immune systems (S. Cohen & Wills, 1985). A number of more recent studies have emphasized the importance of examining social support in a multidimensional way that identifies the potential interactions among sources of support, various outcome measures and the purpose or content of the support offered (Bearman & La Greca, 2002; Fingerhut, Peplau, & Ghavami, 2005; Keleher, Wei, & Liao, 2010; Walen & Lachman, 2000; Moak & Agrawal, 2010; Teasdale & Bradley-Engen, 2010). For example, Walen and Lachman (2000) examined the relative contributions of social support and social strain to mental and physical health across different relationship types (i.e., family, friends and partner). They found that social strain was more strongly linked to physical health outcomes, while social support was more strongly linked to mental health outcomes. Furthermore, only support from friends was predictive of subjective health status, and the extent to which social support played a buffering role in the association between strain and physical health varied both by the gender of the participant and the source of support (Walen & Lachman, 2000).

Results such as those found by Walen and Lachman (2000) highlight the importance of domain specificity in the study of social support. For example, emotional support is the best predictor of emotional well-being, as compared to instrumental or informational support (Uchino, 2004). Thus, different types of support (emotional, instrumental/material, informational, belonging/appraisal) appear most beneficial when matched with corresponding needs. Furthermore, matching certain types of providers with certain types of support can further enhance benefit. For example, cancer patients have been found to prefer emotional support over informational support when offered from friends and family, but they appreciate informational support when it is provided by doctors and other cancer patients, individuals from whom emotional support may not be appropriate (Goldsmith, 2004).

Theoretical Perspectives on Social Support

There are two main theories, which seek to explain the relationship between social support and
health outcomes, both of which have received substantial empirical support (S. Cohen & Wills, 1985). The first theory, the buffering model (or stress-buffering model), suggests that social support acts as a buffer against the aversive effects of stress. In other words, although stress occurs on a regular basis for a variety of reasons, social support helps an individual to cope successfully with stressful experiences, and thereby reduces the negative impact of stress on the individual’s mental and physical health (S. Cohen & Wills, 1985). Evidence for the buffering model is demonstrated when social support proves most beneficial in the context of existing stressors. The matching hypothesis of social support is particularly relevant to the buffering model, given that buffering effects are most likely to be demonstrated when the type of social support offered matches the need presented by the occurring stressor(s) (Cohen & McKay, 1984; Cutrona & Russell, 1990).

The second theory, the direct effects model, suggests that the presence of social support actually prevents stressful events from occurring, and thus provides an individual with an overall sense of positive affect, predictability, and stability. This model suggests that regardless of any buffering role support may play after a stressor has been experienced, social support also has a direct and ongoing impact on physical and mental well-being, independent of specific and discrete experiences of stress (S. Cohen & Wills, 1985). Evidence for this model is demonstrated when social support benefits all individuals, regardless of varied stress levels, or when stress levels have been controlled. In the case of preventing stressful events altogether, the model suggests that being embedded within a social network, which brings with it a sense of social support and belonging, helps to prevent negative experiences (e.g., loneliness, financial or legal problems) from ever occurring (S. Cohen & Wills, 1985). The direct effects model also helps to explain the general positive health benefits associated with social support, because it posits that social support providers in an individual’s social network provide ongoing encouragement and monitoring of healthy behaviour, such as smoking cessation, alcohol abuse intervention, or regular health care check-ups (Krantz, Grunberg, & Baum, 1985; Wills, 1983). These processes should promote mental and physical well-being regardless of an individual’s exposure to specific stressors.
Both the direct effects model and the buffering model seek to explain how social support influences health outcomes. Two other theories are important for understanding the distribution and manipulation of social support and stress. Social stress theory (Aneshensel, 1992; Pearlin, 1989) takes a sociological approach to understanding the unequal distribution of stressors across different social stratifications. Instead of assuming stress differs at an individual level, social stress theory examines the various social structures that create and maintain differing levels of stress throughout segments of the population (Pearlin, 1989). This theory has emphasized the importance of examining group differences in the experience of stress, rather than controlling for group differences in establishing the link between stress and health. In the context of the present study, social stress theory explains the existence of minority stress, a term coined by Meyer (2003) to describe the chronic stress associated with managing a stigmatized sexual identity.

The second relevant theory is the social control theory of social support (Vincke & Bolton, 1994), which posits that the offering and withholding of social support is a mechanism through which social networks act to exert social control over the behaviour and identities of others. In other words, social support is offered to others to the extent that they conform to the social norms and expectations that are valued by their social network. When individuals deviate from the norm, they may place themselves at risk of losing the social support provided by their network, as the network members seek to manipulate their behaviour. For example, in the current study, individuals in same-sex relationships may be deviating from the heteronormative values of their social network, and may, therefore, receive less support from their social networks.

Together, these four theories help to explain not only how social support can influence mental and physical health, but also how social forces can influence the quantity and quality of stressors experienced by different groups of people, and how these same groups may also experience fluctuating levels of social support.
Given the demonstrated link between social support and health, it is not surprising that participation in romantic relationships is also closely linked to both mental and physical well-being. Research has consistently shown that individuals with stable, satisfying, low-conflict romantic relationships have significantly lower levels of depression (Horowitz, White & Howell-White, 1996; Remen & Chambless, 2001; Tolpin et al., 2006), anxiety (Campbell, Simpson, Boldry, & Kashy, 2005) and stress (Berkman & Syme, 1979; Bloom et al., 1978; Brown & Harris, 1978; Cassel, 1976; Cobb, 1976; Gove, 1972; Horowitz, McLaughlin & White, 1998; Kurdek & Schmidt, 1987; Ross, Mirowsky & Goldsteent, 1990; Tolpin et al., 2006; Waite, 1995). The link between positive relationship dynamics and mental/physical health appears to be bidirectional: Studies have found that individuals higher in depression and anxiety are more reactive to negative relationship events, perceive greater levels of conflict in their romantic relationships and deal with conflict less effectively (Campbell et al., 2005; Tolpin et al., 2006).

Cassel (1976) and Cobb (1976) have argued that marriage acts as a buffer against stress, by providing the social support necessary to prevent stressful events from occurring and by facilitating effective coping with stress (Herek, 2006). Such processes may explain the mental and physical health benefits of marriage. For example, studies have found associations between marital status and lower depression (Horowitz et al., 1996; Kim & McKenry, 2002), lower levels of overall psychological distress (Strohschein et al., 2005; Williams, Sassler & Nicholson, 2008), and greater psychological and financial well-being (Stack & Eshleman, 1998). Married people also have lower levels of morbidity, mortality, substance abuse and distress than unmarried people (Berkman & Syme, 1979; Bloom et al., 1978; Brown & Harris, 1978; Burman & Margolin, 1992; Cassel, 1976; Cobb, 1976; Gove, 1972; Horowitz et al., 1998; Hu & Goldman, 1990; Johnson et al., 2000; Julien et al., 2003; Kiecolt-Glaser & Newton, 2001; Ross et al., 1990; Laros, Guay & Boivin, 2002; Umberson, 1987; Waite, 1995). In addition, marital discord and low levels of support within the relationship (i.e., between spouses) have been associated with...
poorer mental and physical health more generally, and compromised immunological functioning more specifically (see Kiecolt-Glaser & Newton, 2001, for a review).

When spouses, or significant others, are viewed as buffers against stress (Berkman & Syme, 1979; Bloom et al., 1978; Cassel, 1976; Cobb, 1976; Kurdek & Schmidt, 1987), it is also possible to see the potential for a link between relationship quality and the prevention of physical health ailments, (e.g., immune dysfunction, the common cold, wound healing, cancer, and infection) as stress has been repeatedly shown to be a significant predictor of these physical health problems (see Witek-Janusek & Matthews, 2000, for a review). The impact of a romantic relationship on health outcomes can also be more direct, as spouses have been found to be one of the most significant sources of social control, especially in relation to health-related behaviours (Lewis & Butterfield, 2007). Not only do married individuals simply report better health outcomes, they also report better health practices and fewer health risks; something that is at least partially attributable to the social control or influence exerted by one spouse over the other (Lewis & Butterfield, 2007). In a study of social control and health, Umberson (1992) found that a single-item measure of spousal social control was capable of predicting improved health practices among married individuals over a 2-year period. In Lewis and Butterfield’s study (2007), 73% of participants indicated that their spouse was a source of social control and couples reported that social control attempts were made at least once per week. Furthermore, the relational aspect of social control and health behaviours within romantic relationships leads health improvements to be experienced not only by the spouse being “controlled” but also by the spouse attempting to exert health-related social control (Lewis & Butterfield, 2007). In other words, when we motivate or help our partner to achieve a health goal, we vicariously improve our own health at the same time. Furthermore, researchers have established that self-selection alone is not responsible for the differences in well-being experienced by married and unmarried individuals, or in other words, the association between marriage and health is not simply due to the fact that happier and healthier individuals are more likely to get married (Horowitz et al., 1998; Johnson & Wu, 2002).
Research using same-sex couples has also found a link between relationships and mental health, such that sexual-minority individuals with romantic partners report a greater sense of overall well-being and less personal conflict over their sexual orientation than individuals without romantic partners (Lewis, Derlega, Berndt, Morris & Rose, 2001). In addition, single gay men and lesbians report higher levels of distress than individuals in relationships (Lewis et al., 2001). Despite the generally positive correlates of same-sex relationship participation, such relationship participation may also confer health risks due to the increases in stress that may be associated with disapproving family reactions, societal misunderstanding, social stigma, and general minority stress (Lewis et al., 2001). Participation in the gay and lesbian community and having a strong sexual-minority friendship network can act as a buffer against these forms of stress, and has been found to be associated with lower levels of distress, and less visibility stress (i.e., stress related to being identifiable as a sexual minority) among friends, family and the general public (Lewis et al., 2001). With respect to the links between relationship dynamics (i.e., quality, stability, commitment, and satisfaction) and mental well-being, researchers have reported similar correlations for same-sex couples as have been found for heterosexual couples, such that greater relationship well-being predicts greater mental health in both populations (Julien et al., 2003; Kurdek, 1993, 1997, 1998; Kurdek & Schmidt, 1987; Rostosky et al., 2004).

**Social Support and Relationships**

Just as social networks can provide support to an individual, they can also provide support for that individual’s romantic relationship. As noted earlier, research has investigated four main types of social support, and each of these types is relevant for social support offered to a specific relationship. For example, informational support can be provided to a relationship in the form of relationship advice, or tips for “best practice.” Hence, an example of informational support offered for a relationship might be a friend lending a relationship self-help book (i.e., informational/material support). An example of tangible support for a relationship would be relatives showering a newlywed couple with gifts and/or money; an example of emotional support offered for a relationship might be when friends or family listen to a couple talk about their problems, or mediate between them during a conflict. An example of belonging/appraisal
support for a relationship would be including a couple in invitations to social events. Whether the support is offered to one individual within the relationship or to both individuals, these forms of support can be construed as social support specifically for relationships because they are specifically offered in the context of the romantic dyad.

Although a number of studies have indicated that individuals report varying amounts of support or approval for their romantic relationships from social network members (Blair & Holmberg, 2008; Felmlee, 2001; Jin & Oh, 2010; Johnson & Milardo, 1984; Julien, Chartrand, & Bennett, 1999; Kline & Shuangyue, 2009; Sprecher & Felmlee, 1992, 2000), no studies have empirically tested the unique relational and mental/physical health benefits of social support for relationships (SS4R), independent of the benefits of general social support. Yet the aforementioned research on the importance of domain specificity to support effectiveness (e.g., Bearman & LaGreca, 2002) lends credence to the notion that social support for relationships should represent a distinct and uniquely beneficial form of social support.

Research suggests that individuals perceive and experience support differently when it is offered for a relationship versus other domains. For example, Frost (2011) examined the challenges and difficulties faced by participants in mixed-sex and same-sex relationships when attempting to complete two different types of projects: a work related project and an intimacy (relationship oriented) project. Frost (2011) found that while mixed-sex couples experienced similar challenges and supports for both types of projects, individuals in same-sex couples experienced more challenges (from others) associated with their intimacy projects. Thus, the results of this study conceptually imply that social network members react differently to relationship projects than to work-related projects, providing differing degrees of help and/or hindrance (Frost, 2011). The following review of the literature examines how the construct of social support for relationships has been measured and identified, and what influence it has been found to have on relationship well-being and functioning.

**Theoretical Perspectives on Social Support for Relationships**

To borrow from Felmlee (2001), “No couple is an island” (p. 1259). All intimate relationships function within the larger context of families, friends, in-laws, and society. When a new relationship is
created, each partner brings with him/her his or her own social network; members of these networks will each have their own opinions and feelings about the new partner joining their network and about the new relationship in general. Based on these opinions and feelings, network members may then impose “social sanctions . . . [which are] . . . signals sent to partners . . . to express approval or disapproval for the romantic relationship” (Bryant & Conger, 1999, p. 438). These social sanctions serve as a means through which social networks are able to enforce their norms and values (Bryant & Conger, 1999), functioning as a form of social control (Vincke & Bolton, 1994).

Three main theories support the notion that social network support and approval are important predictors of relationship well-being. Lewis (1973) suggested that symbolic interactionist theory, which posits that individuals gain a sense of their personal identity through social interactions with important others, explains why the social reactions of network members can influence the development of intimate relationships. Lewis stated that “significant others play key roles in initiating, perpetuating and crystallizing premarital dyadic commitments” (Lewis, 1973, p. 218), helping the couple to develop its own dyadic identity. Thus, negative interactions between a dyad and its network members may have detrimental effects on the couple’s ability to develop a stable identity as a couple, rather than as two separate individuals.

A second theory, Berger’s (1979) uncertainty reduction theory, suggests that relationships will be impacted by social network support via the “positive reactions from family and friends [decreasing] uncertainty because they reinforce the notion that members of a couple are right for each other” (Sprecher & Felmlee, 2000, p. 326). In other words, the social network, by either approving or disapproving of a romantic relationship, can create a sense of certainty or uncertainty within either or both individuals concerning their choice of partner. These feelings of certainty, in turn, can influence partners’ commitment to one another, potentially influencing the stability of the relationship.

The third theory of relevance comes from Heider’s (1958) theory of cognitive balance and the concept of transitivity (Parks, Stan, & Eggert, 1983; Sprecher, 2011; Sprecher & Felmlee, 1992). Transitivity refers to the notion that if A likes B, and B likes C, then A will also like C. Research has
found that transitive relationships -- in which A, B and C all like and approve of one another -- are more stable and satisfying than intransitive relationships, in which there are discrepancies among A, B, and C regarding mutual liking and approval (Parks et al., 1983). According to this theory, perceived social support for a relationship may increase relationship well-being as a result of the cognitive balance it creates for the individuals within the relationship. In other words, when a relationship receives social support, balance is achieved among the individual, the dyad, and the social network. Relationships that do not receive social support may threaten cognitive balance, such that distress may be experienced in one or more of these relationships (i.e., between the individual and their network, within the dyad, or between the dyad and the network). Additionally, the theory suggests that if the network likes an individual’s partner, then this will increase the individual’s liking for their partner, thereby further enhancing increased relationship quality, commitment, and stability (Sprecher, 2011).

In summary, whether the opinions of important network members shape our views of our romantic relationships, help us to feel more comfortable and certain about our choice of partner, or create balance between ourselves, our social networks and our relationships, it makes logical sense to expect that levels of perceived social support/approval for a romantic relationship are related to the relational well-being of the partners involved. Indeed, a number of researchers have demonstrated the importance of social support as a predictor of relationship quality, stability, and satisfaction (Berger, 1990; Blair & Holmberg, 2008; Bryant & Demian, 1994; Caron & Ulin, 1997; Haas, 2002; Oswald, 2002; Parks & Eggert, 1991; Rostosky et al., 2004; Smith & Brown, 1997; Sprecher & Felmlee, 1992). While early research focused on overall perceived social support for the individual, more recently research has emphasized the importance of examining perceived social support specifically for the romantic relationship (Blair & Holmberg, 2008; Bryant & Conger, 1999; Felmlee, 2001; LaSala, 1998; Leslie, Huston & Johnson, 1992; Sprecher & Felmlee, 2000). According to Sprecher (2011), social support (or approval/disapproval) of relationships is the most frequently studied social network characteristic concerning relationships. High levels of perceived social support for a romantic relationship are associated with increased relationship quality, increased relationship stability, and increased levels of
love, satisfaction, and commitment (Blair & Holmberg, 2008; Bryant & Conger, 1999; Felmlee, Sprecher & Bassin, 1990; Sprecher & Felmlee, 1992; Sprecher & Felmlee, 2000). In addition, fluctuations in social support for a relationship have been found to predict fluctuations in relationship quality over time (Sprecher & Felmlee, 1992). Bryant and Conger (1999) found that the impact of social network approval for a relationship continues well beyond the initial developmental stages of a romantic relationship, with social support remaining a significant predictor of marital success and satisfaction after two decades or more of marriage. Although approval of a relationship has been shown to predict increases in relationship commitment, quality, and stability, disapproval of a relationship has been associated with the demise of a relationship (Johnson & Milardo, 1984; Sprecher & Felmlee, 1992).

Measurement of Social Support for Relationships

Perceived social support for a relationship has been measured by examining the extent to which members of an individual’s social network approve or disapprove of that individual’s relationship and the extent to which they offer support to both partners (Felmlee, 2001). Approval or support for a relationship can be manifested in either direct or indirect ways, such as commenting that partners were “made for each other” (direct support), or including the partner of a loved one in invitations to family and social events, thereby treating the two individuals as “a couple” (indirect support: Felmlee, 2001). Social networks may disapprove of a specific romantic relationship for a variety of reasons, including those related to the specific partner choice (personality), the type of partner (race, gender, religion, class), or beliefs about their loved one (i.e., not yet ready for a relationship: Felmlee, 2001). Furthermore, some research has addressed the accuracy of individuals’ perceptions of social support for their relationship by examining whether these perceptions correspond with reports of actual support provided by social network members, and have found high correlations across reports (Etcheverry, Le & Charania, 2008; Sprecher, 2011). Hence, variability in individuals’ perceptions of support for their relationships appears to tap actual variation in support that social networks report providing.

The composition of social networks has been shown to change over the course of a relationship (Johnson & Leslie, 1982), thereby adjusting the sources and qualities of support available to a particular
dyad. The withdrawal hypothesis, first suggested by Johnson and Leslie (1982), states that as a couple’s romantic involvement increases, their friendship networks begin to shrink as the couple withdraws socially and become more important sources of social support for one another. It is possible that the isolation a couple creates through withdrawing from other social relationships acts, in part, as a buffer against the possible negative effects of any perceived lack of support, but it is also possible that this isolation contributes to a lack of support, as friends become unhappy that the couple has withdrawn. This possibility is supported by research that demonstrates that the highest levels of interference from network members and the lowest levels of perceived social support for the relationship occur when couples move from a more casual stage of dating to being in a more serious, committed relationship (Johnson & Milardo, 1984; Knobloch & Donovan-Kicken, 2006; Sprecher, 2011).

**Question of Parents Versus Friends**

Does the source of support for relationships matter? Researchers, to date, predominantly agree that support offered by peers for a romantic relationship is significantly related to the dynamics of the relationship, with increased peer support predicting increased relationship quality, satisfaction, commitment, and stability (Felmlee, 2001; Sprecher & Felmlee, 1992, 2000). The question of whether or not support from parents is also a strong predictor of relationship success is more ambiguous. While some research has found that support and approval for a relationship from parents is related to relationship well-being (Felmlee, 2001; LaSala, 1998; Lewis, 1973; Smock, Cohen & Manning, 2010; Parks et al., 1983; Sprecher & Felmlee, 1992, 2000), others have found parental support to be a poor predictor of relationship stability and well-being (Blair & Holmberg, 2008; Driscoll, Davis & Lipetz, 1972; Felmlee, 2001; Leslie et al., 1986). Driscoll et al. (1972) found that romantic love within a relationship did not increase with parental support, but instead was more likely to increase with parental interference. The researchers termed this phenomenon the “Romeo and Juliet Effect,” whereby disapproval of a relationship by one or both sets of parents had the opposite of the parents’ intended effect, actually bringing the couple closer together. This result, however, has not been successfully replicated (Felmlee, 2001). Some researchers have argued that the Romeo and Juliet effect is, in fact, observed (in the form of higher levels
of commitment) when the disapproved relationship is a nonnormative relationship (age-discrepant, mixed-race, or same-sex; Lehmiller & Agnew, 2006; 2008), although parental support was not specifically isolated in these studies. Leslie et al. (1986) found that perceived approval and disapproval from mothers and fathers for a relationship was a poor predictor of relationship stability and duration. Finally, Sprecher and Felmlee (2000) reported that high parental support in fact boded poorly for relationships, predicting higher levels of breakup. Support from friends was a much stronger predictor of relationship well-being than support from parents (Sprecher & Felmlee, 2000). However, Sprecher and Felmlee (2000) also found that perceptions of low support from one’s own family and friends, and a dislike of a partner’s family, were both significant predictors of breakup.

Research by Baxter and Widenmann (1993) reported that parents were much more likely than peers to react negatively to information about their children’s romantic relationships (of any kind), but they did not examine the associations of these reactions with relationship well-being. Individuals are also more likely to hide information about their relationship from their parents than from their friends (Baxter & Widenmann, 1993), and Leslie et al. (1986) reported that young adults made significantly more attempts to influence the opinions of their parents with respect to their relationships than the opinions of their friends. Both of these findings may suggest that due to increased attempts to alter the perceptions of our relationships held by our parents, we may then discount their opinions or offerings of social support, knowing that they are operating on reduced or inaccurate information. In contrast to these findings, Smock et al. (2010) reported that parental advice and opinions had a significant impact on decisions concerning cohabitation among young adults. The authors suggested that one reason for this finding may be that young adults are most in need of the emotional and financial support provided by parents and thus cannot afford (emotionally or financially) to risk losing their parents’ approval (Smock et al., 2010). Notably, research has found that married couples consistently perceive and receive more social support from parents than unmarried adults, potentially indicating that regardless of parental support directly for a specific relationship, parents might offer more support to children participating in socially-approved relationships, such as marriage (Arnett, 2004; Cooney & Uhlenberg, 1992; Eggebeen, 2005; Hao, 1996;
Herek, 2006; Marks & McLanahan, 1993; Nock, 1995; Sprecher, 1988; Umberson, 1992). Thus, the importance of parental approval or disapproval of a relationship remains unclear. The lack of consensus in this field provides further evidence for the need of research on domain specificity in the context of social support for romantic relationships.

**Same-Sex Relationships**

Heterogeneous definitions of sexual identity and orientation plague research on same-sex relationships and as such, the following review of the literature concerning same-sex relationships and sexual minority health will not necessarily be reflective of the current study’s sample. Throughout the review, the terms used (for example, “heterosexuals,” “nonheterosexuals,” “gay couples,” “opposite-sex couples”) will reflect those that were used in the research being described.

Overall, research on same-sex couples has found that there are very few differences between same-sex couples and mixed-sex couples in terms of relational processes, level of satisfaction, levels of intimacy, and relationship quality (Frost, 2011; Gottman et al., 2003; Herek, 2006; Julien, Chartrand & Bennett, 1999; Julien et al., 2003; Kurdek, 1993, 1997, 1998; Patterson, 2000). Same-sex couples are similar to heterosexual couples in terms of desire to engage in long-term relationships, relationship quality, relationship conflict, sources of conflict (Julien et al., 2003), relationship satisfaction and sexual functioning (Patterson, 2000), although some research has reported that same-sex couples experience greater relationship quality, compatibility, intimacy and less conflict than heterosexual married couples (Balsam, Beauchaine, Rothblum & Solomon, 2008). Additionally, the impact of relationship dissolution is similar for same-sex couples and heterosexual couples, in terms of levels of distress experienced (Kurdek, 1997).

Despite these similarities, there are some differences between same-sex and heterosexual couples. Researchers have found that same-sex couples tend to report higher levels of flexibility and egalitarianism (Kurdek, 1993), greater levels of autonomy, more frequent rates of relationship dissolution (Gottman et al., 2003), fewer perceived barriers to leaving a relationship (Kurdek, 1998; Lannutti, 2007), more relationship problems arising from functioning within a heteronormative social environment (Frost, 2011;
Julien et al., 2003; Lannutti, 2007, 2008), and weaker perceived and actual support from social networks (Buffie, 2011; Eisenberg & Resnick, 2006; Julien et al., 1999; Needham & Austin, 2010; Russell, Franz & Driscoll, 2001; Saewyc et al., 2009; Ueno, 2005). Despite these differences in mean levels of relationship experiences, research has not found any differences in the strength of associations between these experiences and relationship quality measures (Julien et al., 2003).

Some research shows that same-sex couples report lower levels of perceived and actual support from their social networks, (Buffie, 2011; Eisenberg & Resnick, 2006; Julien et al., 1999; Needham & Austin, 2010; Russel et al., 2001; Saewyc et al., 2009; Ueno, 2005), although the majority of research examining links between perceived social support and relationship well-being has used exclusively heterosexual samples. Furthermore, while some studies have examined overall social support as a predictor of relationship well-being in same-sex couples (Julien et al., 1999; Julien et al., 2003), very few have examined perceived social support specifically for same-sex relationships (Kurdek, 2004, 2006), and nearly all such studies have methodological problems (notably, small sample sizes and no direct comparisons to individuals in mixed-sex couples). The following sections provide a review of the literature concerning social support and same-sex relationships.

Kurdek’s (2004) extensive review of the similarities and differences between heterosexual and nonheterosexual couples found that one of the only dimensions on which significant differences were found between same-sex and mixed-sex couples concerned perceived support for the relationship (Kurdek, 2004, 2006). Gay men and lesbians perceived less support for their relationship, from both their own family and their partner’s family, than did heterosexuals. The measures of social support used in these studies, however, did not directly assess social support specifically for the relationship. Participants were asked to indicate the extent to which they felt accepted by their own parents and by their partner’s parents, but they were not specifically asked about the extent to which they felt their relationship was accepted by parents. Another indicator of “support for the relationship” in these studies was the ratio of contact between friends and family, with the assumption that if the ratio leaned more toward friends than family, that this could be taken as an indication of lower social support for the relationship from family
(Kurdek, 2006). This measure, too, is obviously not a direct measure of social support for the relationship. Nonetheless, these findings provide indirect evidence that individuals in same-sex relationships may perceive less support for their relationships from their family and their partner’s family than do individuals in mixed-sex couples.

**Social Support for Same-Sex Relationships**

The majority of the research concerning parental support and sexual minorities has focused on the role of general social support or acceptance of sexual identity among adolescents and young adults (see Russell et al., 2001 for a review). Needham and Austin (2010) found that a lack of support from parents in lesbian, gay and bisexual (LGB) young adults was associated with increases in negative health outcomes, such that parental support was associated with reduced odds of negative health outcomes ranging from 8% (for marijuana use) to 16% (for depression). Research has also consistently found that same-sex attracted youth and LGB young adults perceive less support from their parents than do their heterosexual peers (Eisenberg & Resnick, 2006; Russel et al., 2001; Saewyc et al., 2009; Ueno, 2005). Based on this, it is not surprising to find that the research that has examined social support for same-sex relationships has often reported low levels of perceived parental support (Blair & Holmberg, 2008; LaSala, 1998, 2000; Lannutti 2007, 2006; Lehmiller & Agnew, 2007). A 7-month longitudinal study of marginalized (same-sex, age-gap, mixed-race) and nonmarginalized (mixed-sex, same-age, same-race) relationships reported that individuals in same-sex relationships perceived greater social network disapproval and that Time 1 perceptions of disapproval were predictive of relationship dissolution at Time 2 (Lehmiller & Agnew, 2007). Research in a similar area by the same authors found that greater perceived disapproval of the relationship was associated with lower levels of relationship commitment in same-sex couples (Lehmiller & Agnew, 2006). In earlier research, Kurdek (1988; Kurdek & Schmitt, 1987) examined the association between general network support and relationship well-being in same-sex relationships and found a small but significant association between these domains in lesbian couples, such that lower levels of general support predicted lower relationship quality.
Support from Parents Versus Friends

The majority of other quantitative studies have focused on overall support for the individuals within the relationship, as opposed to support specifically for the romantic relationship itself. One of the most consistent findings with respect to social support and same-sex relationships is that gay men and lesbians receive more social support from their peers than from their families of origin (Bryant & Demian, 1994; Cohen & Savin-Williams, 1996; Croasbourg-Burnett & Helmbrecht, 1993; D’Augelli, Grossman & Starks, 2005; Kurdek, 1988, 2004; Kurdek & Schmidt, 1987; Laird & Green, 1996; Lasala, 1998; Oswald, 2002; Smith & Brown, 1997). Smith and Brown (1997) refer to this phenomenon as one of “chosen families,” in which gay men and lesbians, in the face of disapproval from their families based on their sexual orientation, develop close-knit “family-like” bonds with friends and members of their community. More recent research has provided additional evidence for this idea of chosen families, demonstrating that despite the ever-changing social attitudes concerning sexuality and same-sex relationships, sexual minorities still tend to seek out support from their friends more so than from their families of origin (Dewaele, Cox, Van den Berghe & Vincke, 2011; Herek, 2006).

Despite these compensatory strategies, the opinions of families of origin have still been shown to be associated with perceived relationship quality in same-sex couples (Berger, 1990; Bryant & Demian, 1994; Cohen & Savin-Williams, 1996; Lannutti, 2007, 2008; Lasala, 1998; Smith & Brown, 1997; Solomon, Rothblum & Balsam, 2004). Smith and Brown (1997) even found that support from families for individuals in same-sex relationships was correlated with relationship well-being at a rate that was disproportionate to the support’s actual occurrence; support from family and peers each accounted for equal amounts of variance in relationship quality, yet 75% of the actual support came from peers, with only 25% of actual support originating from families. A qualitative study examining the impact of parental support (or lack thereof) on relationship well-being in same-sex couples found that a lack of perceived support for the relationship from family members led to the experience of negative emotional reactions, such as hurt and anger, and also negatively impacted the ability of partners to commit to the relationship (Rostosky et al., 2004). When positive support was received, members of same-sex couples
reported that this support had a strengthening effect on the relationship. Additionally, Murphy (1989) found that 45% of a lesbian sample reported that a lack of social support from family had a negative impact on their relationship well-being. In a similar vein, 34% of sexual minority participants in one study reported that at least one family member had refused to accept them based on their sexual orientation (Herek, 2006). These studies suggest that parental support may be an important predictor of personal and relationship well-being for individuals in same-sex relationships.

Other studies, however, have found that support from friends is more important and more salient than support from family. For example, Kurdek and Schmidt (1987) found that high levels of emotional support from friends were correlated with fewer psychopathology symptoms. Although these couples did perceive less overall support from their families than from their friends, only support from friends predicted psychological adjustment (Kurdek & Schmidt, 1987). Given that a significant amount of social change has occurred between 1987 and the present, one may question whether findings such as these still hold any value or truth (given that the gradual increases in social acceptance of same-sex couples may render contemporary same-sex couples more sensitive to parental disapproval versus support than previous cohorts of same-sex couples). Research conducted throughout the 1990s and 2000s has continued to find that sexual minorities appear to rely more heavily on their friends and peers than family when looking for sources of social support (Herek, 2006; Oetjen & Rothblum, 2000). Oetjen and Rothblum (2000) found that support from friends was the most potent predictor of depression in a sample of lesbians and concluded “lesbians clearly do not see their families as being their main source of support” (p. 69). More recent research conducted in Flanders (a very LGBTQ-friendly area of Belgium with legalized same-sex marriage) found that gay men, lesbians and bisexuals turned to their friends for support in order to compensate for unsupportive or poor family relationships (Dewaele et al., 2011). The study reported that the social networks of LGB individuals in Flanders differed significantly from non-LGB Flemish individuals in that their networks were much more heavily weighted to friends than family, and that their networks, overall, were smaller (Dewaele et al., 2011).

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1 LGBTQ: Lesbian, gay, bisexual, transgendered and queer
Same-sex couples also seem to adopt strategies to allow them to deal relatively effectively with parental disapproval. For example, Rostosky et al. (2004) report that same-sex couples developed a variety of strategies to deal with a lack of support from family members, the most common of which were to accept the situation and personally reaffirm the couple relationship, or to simply deceive the family about the relationship (Rostosky et al., 2004). Lannutti’s (2008) study of 263 same-sex couples who were either married or engaged in the state of Massachusetts examined the many obstacles the couples faced in their decision to get married. The main obstacle reported was disapproval from parents, and participants had a variety of means for coping with this obstacle, similar to those reported by Rostosky et al. (2004). Lannutti (2008) categorized the coping behaviours as either direct (confronting a social network member about their disapproval or engaging in political activism) or indirect (ignoring the problem or talking about it with their partner). Although 41% of Lannutti’s sample reported that parental disapproval was an obstacle to getting married, participants who did receive the support of their parents and family felt that this support made a positive impact on their relationship, well-being, and family relationship.

In another qualitative study, LaSala (1998) found that gay men reported very little impact on their relationship well-being as a result of negative reactions and a lack of social support from their families of origin. The author posited that repeated exposure to negativity related to the men’s sexual orientation, whether from their families of origin, school experiences or society in general, has contributed to a “need for thick skin” (LaSala, 1998) which serves as a “psychological [immunization against] . . . their parents’ and society’s negativity” (LaSala, 1998, p. 590). Specific coping skills reported included open communication about parental rejection as a method of offsetting the potential damage incurred from parental negativity, and taking rejection of the relationship as a method of strengthening the couple bond (i.e., the “common enemy” concept). Despite the reported ability of many gay men to insulate themselves from the potential negative impact of social disapproval of their relationships, these same men did report that social support did have a positive effect on their relationships when it was offered (LaSala, 1998; Smith & Brown, 1997), similar to the results discussed by Lannutti (2008). Thus, while it may be possible to find adaptive coping mechanisms to deal with a lack of social support, this does not seem to negate the
importance of social support as a positive contributor to relational well-being when it is provided by families and friends (LaSala, 1998).

Social control theory, discussed earlier, may offer some useful explanations as to why individuals in same-sex relationships receive and perceive lower levels of social support (either for their relationship, or as individuals). In a 1994 study by Vincke and Bolton, perceptions of social support among gay men in Belgium were tied to the process of sexual identity disclosure and psychological well-being. The authors speculated that the manipulation of social support, or in other words, the offering or withholding of social support, served as a process of social control, in which societies (and social networks) seek to influence the behaviours, choices and identities of nonconforming individuals. The paper suggested that in order to elicit socially acceptable or approved behaviour, members of social networks (consciously or unconsciously) “provide or withdraw respect, positive evaluative appraisal, emotional assistance, and the assurance that someone will be available when things go wrong” (p. 1051). Same-sex relationships stand in the face of the heteronormative values that are upheld in most Western societies, and thus, the manipulation of support for these relationships can be seen as a process of social control, through which social networks and societies as a whole attempt to deter individuals from participating in same-sex relationships (or, in fact, any behaviour or identity deemed deviant), thereby at least partially explaining the lower levels of perceived social support often reported by LGBTQ individuals and same-sex couples.

**Theoretical Perspectives**

According to social stress theory (Pearlin, 1989), stress is both “a consequence of location in the social system and [a] determinant of . . . psychological distress” (Aneshensel, 1992, p. 19). Social stress theory posits that stressors do not vary solely based on individual characteristics, but that they also vary based on group characteristics, such that certain groups of individuals, or individuals who jointly occupy certain social positions and identities, are more likely to encounter stress (Aneshensel, 1992; Pearlin, 1989). In Aneshensel’s words, “Location in the social system influences the probability of encountering stressors, which in turn increases the probability of…” (p. 19) encountering the consequent mental health outcomes of psychological distress. According to the theory’s originator, the process of seeking out the
sources of stress “may begin fruitfully by scrutinizing the social arrangements of society and the structuring of experience within these arrangements” (Pearlin, 1989, p. 242). The application of social stress theory to the lives of sexual minorities is quite simple, and translates directly into what Meyer (1995, 2003) has termed “minority stress” or the chronic stress that results from day-to-day management of a stigmatized social status (Rostosky, Riggle, Horne, Denton, & Huellemeir, 2010). With respect to sexual minorities, Herek et al. (2007) have defined the source of stigma as coming from sexual minorities’ sexual orientation, as a result of “society’s shared belief system through which homosexuality is denigrated, discredited, and constructed as invalid relative to heterosexuality” (p. 171).

Research on the impact of minority stress on the mental and physical well-being of sexual minorities has concluded that minority stress operates independently of life stress, and is composed of constant, daily stressors experienced within family settings, the workplace, school, and even within an intimate relationship (Lewis, Derlega, Clarke, Kuang, Jacobs, & McElligott, 2005). Individuals do not need to experience overt discrimination in order to suffer from the effects of minority stress. In fact, research has highlighted that it is the more subtle, inadvertent or insensitive aspects of daily rejection and discrimination that have very strong links to psychological distress among sexual minorities (Buffie, 2011; Fingerhut, Peplau, & Ghavami, 2005; Russell et al., 2011; Szymanski, 2006). Furthermore, research has shown that individuals need not actually experience any form of discrimination and that the anticipation of discrimination and prejudice alone are sufficient to generate the experience of minority stress (Rostosky et al., 2010; Szymanski, 2006). Minority stress in LGBTQ individuals is not in any way related to inherent mental health differences or differences in the susceptibility to stressors, but rather is a result of societal structures that place sexual minorities within a second-class status relative to heterosexuals which carries with it the “message that one is less worthy than others . . . ultimately . . . [creating] a sense of negative self-worth, and . . . depression” (Kaplan, 2006, p. 1).

Mental health research with LGBTQ individuals consistently finds links between the experiences of minority stress and psychological distress, including increased depression (Lewis, Derlega, Griffin, & Krowinski, 2003), anxiety (Mays & Cochran, 2001; Potoczniaik, Aldea, & DeBlare, 2007) and substance
abuse (Gillespie & Blackwell, 2009). Needham and Austin (2010) recently reported that LGBTQ young adults report more symptoms of depression, more suicide attempts and greater drug and alcohol use than heterosexual young adults. Other studies have reported linear increases in depression as a function of increased heterosexism and discrimination among lesbian and bisexual women (Szymanski, 2006; Szymanski & Owens, 2009). One of the most consistent mediators of the link between minority stress and mental health is perceived social support. To the extent that individuals perceive greater levels of social support, the association between minority stress and negative mental health outcomes is weakened (Beals, Pelau & Gable, 2009; Fingerhut et al., 2005; Oetjen & Rothblum, 2000; Szymanski & Kashubek-West, 2008; Teasdale & Bradley-Engen, 2010; Vineke & Bolton, 1994). One instance that sexual minorities face on a day-to-day basis that brings with it the potential of minority stress experiences is the process of disclosing their sexual identity. Although one may think of the "coming out" process as something that happens once in an individual’s life, it is actually an event that occurs daily, every time an individual is put in a position where another individual is unaware of their sexual identity (e.g., being asked about weekend plans, being asked about having a partner, filling out a hospital form and being asked for next of kin or emergency contact information; Beals et al., 2009). As such, disclosure stress can become a form of minority stress. Research by Beals et al. (2009) found that perceived social support fully mediated the relationship between disclosure of sexual identity and psychological well-being. The conclusion of the study was that disclosure of one’s sexual identity was predictive of improved psychological well-being due to disclosure’s association with greater perceived social support and understanding (Beals et al., 2009). Additionally, concealing one’s sexual identity, or failing to disclose, was associated with lower levels of perceived support, higher levels of depression and lower levels of self-esteem and life satisfaction (Beals et al., 2009).

**The Blair-Holmberg Model**

According to a 2011 review of the literature by Lau and Strohm, there has only been one study to date that has examined social support for a relationship, relational well-being, and physical and mental health within a single model. Blair and Holmberg (2008) tested a theoretical model (shown in Figure 1) in
which perceived social support for relationships contributed to relational well-being and, in turn, positively predicted mental and physical health using a sample of over 400 participants in either same-sex or mixed-sex relationships. The study was unique in a number of ways, including its lack of dependence upon a student sample, the geographic diversity of the sample, its use of well-validated measures, its statistical rigor, and the use of an online methodology that increased participant anonymity (which may be of particular importance when studying marginalized groups). The study reported strong support for the hypothesized model and found no notable differences between same-sex and mixed-sex couples; with the exception of same-sex couples showing a stronger link between relationship well-being and mental health than did the mixed-sex couples (Blair & Holmberg, 2008). The study also concluded that, for the sample on hand, social support for the relationship from parents was not a significant contributor to the model, and thus, support from friends remained the only significant source of social support for the relationship (Blair & Holmberg, 2008).

Figure 1. The Blair-Holmberg model.

Although the study contributed to the literature by outlining the structural associations between social support for relationships, relational well-being and health, the study did have a number of limitations. The cross-sectional nature of the analysis precluded any determination of directionality or causality within the model and also made it difficult to decipher between competing alternative models (i.e., a fully reversed model, a reversed mediation model, or a direct effects model), all of which had equivalent fit indices to the hypothesized structural model. This is, of course, a limitation common to
structural equation modeling (SEM), in which any model that matches the pattern of correlations seen in the data set is likely to produce a good fit (Byrne, 2010). Additionally, it was unclear whether the failure of the variable indicating support for the relationship from parents failed to contribute to the model because of truly not impacting relationship well-being or due to measurement error (i.e., it is possible that the measure used did not adequately capture the concept of parental support for relationships). The authors noted, however, that an identical measure for support from friends did operate as expected, so it is unlikely that the result was entirely due to measurement error unless the construct of social support for relationships from parents is meaningfully different than social support for relationships from friends (Blair & Holmberg, 2008). Finally, the study did not include a direct measure of general social support, and was only able to estimate this construct from other measures. While the study did find evidence of discriminant validity between social support for relationships and general social support, the failure to use a validated measure of general social support leaves the question of construct validity without a definitive answer. In terms of the study’s sample, after missing data and data from single individuals were removed, the sample size was reduced to fewer than 500 participants who were predominantly female.

As with all theoretical models, the model proposed by Blair and Holmberg (2008) requires replication on distinct data sets and a more nuanced examination of directionality and causality. The current study was designed to replicate the Blair-Holmberg model, definitively establish social support for relationships as a unique construct implicated in the prediction of relational well-being, and extend the Blair-Holmberg model longitudinally in an attempt to eliminate alternative models and to clarify the issue of relative sources of support for the relationship (i.e., parents versus friends).

**Current Study**

**Gaps in the Current Literature**

Although previous studies have examined the various links between social support, relationship well-being, and physical/mental health in a piecemeal fashion, the Blair and Holmberg (2008) study is the only one to date to link all of these concepts under the framework of one model using both same-sex and mixed-sex couples. Studies that have investigated these concepts separately have generally limited their
recruitment to heterosexual convenience samples made up of university students in one location (Bryant & Conger, 1999; Leslie et al., 1986; Sprecher & Felmlee, 1992), which may or may not yield findings that are generalizable to the greater public. Most studies investigating social support in same-sex relationships have used a qualitative approach (LaSala, 1998, 2000; Lannutti, 2007, 2008; Rostosky et al., 2004), have failed to look at support specifically for the relationship, and have used small, geographically limited samples (Julien et al., 2003; Lannutti, 2007; LaSala, 1998, 2000; Rostosky et al., 2004). Finally, although Kurdek (1988, 1993, 1998) has investigated issues of support and relationship well-being in both heterosexual and nonheterosexual relationships with large samples, he has not incorporated mental and physical health as important outcomes of social support for romantic relationships, nor have his measures of social support for relationships been adequate.

Additionally, while previous research has provided clear support for some of these associations (e.g., predictive value of social support and relationships on physical and mental well-being; the association between social support for a relationship and relationship well-being), it has provided less consistent support for others, including the relative value of support from parents and peers, and the potential differences in these associations as a function of relationship type (i.e., same-sex versus mixed-sex). The current study is unique in its attempt to determine whether support specifically for a relationship can predict not only relationship well-being, but in turn, can also predict the mental and physical health of the individuals within the relationship, using a large longitudinal sample of individuals in same-sex and mixed-sex relationships. The study is also unique in its use of a large, geographically diverse sample recruited outside of the university community.

**Study Objectives**

The objectives of the current study can be divided into four areas, each with its own specific research questions and hypotheses. The first objective is to empirically establish social support for relationships as a unique construct as compared to other forms of social support. The second objective entails replicating the results published by Blair and Holmberg (2008). The third objective seeks to clarify the relative importance of different sources of support for relationships, by examining whether support
from parents versus friends has a greater association with relationship and health outcomes. Finally, the fourth objective involves extending the hypothesized structural model within a longitudinal framework, testing the model’s predictive power over time and exploring the nuances of how the model operates longitudinally. The specific hypotheses and research questions associated with each objective are detailed below.

**Objective 1. Social support for relationships as a unique construct.**

_Hypothesis 1.1:_ Social support for relationships (from all sources) will have a low to moderate correlation with general social support.

Although it is believed that social support for relationships is a unique construct with the ability to uniquely explain variance in associated outcome measures (e.g., relationship well-being), it is still likely that social support for the relationship will correlate with general social support to some extent, as they are both measuring social support processes. Despite this, the correlation is hypothesized to be only small to moderate, providing ample support for the notion that social support for relationships is indeed a unique construct. Evidence from research on other forms of domain specificity with respect to the sources and purposes of social support lend credence to this hypothesis (Cutrona & Russel, 1987; Davis et al., 1998; Fenlason & Beehr, 1994; LaGreca & Bearman, 2002; Russel, Altmaier & Van Velszen, 1987) as do research results that show that social network members (and society) view relationship and individual issues separately (Frost, 2011). Thus, while a social network may be supportive of a particular individual with respect to their personal goals and identity, this support may not automatically translate into support for the individual’s relationship.

_Hypothesis 1.2:_ Social support for relationships and general social support (from all sources) will each account for a unique portion of the variance in related outcome measures (i.e., indicators of relationship well-being).

Although both social support constructs are expected to be associated with the relevant outcome variables (relationship well-being, mental and physical health), it is hypothesized that divergent validity will be established for these two constructs through their ability to uniquely predict these outcome
variables. In other words, social support for relationships will account for a portion of the variance in outcome measures over and above that accounted for by general social support, and vice versa.

**Objective 2: Test hypothesized model.**

**Hypothesis 2.1:** The model tested by Blair and Holmberg (2008) will fit the data collected in the current study.

**The hypothesized model.** The current study views the constructs of social support for a relationship, relationship well-being, mental and physical health as all fitting within one hypothesized model, as shown in Figure 1. The model, which received previous support in a study conducted by Blair and Holmberg (2008), posits that social support for a relationship (offered by both friends and parents) will predict relationship well-being. Furthermore, relationship well-being, will, in turn, serve as a mediating variable, predicting mental and physical health for the individuals within the relationship. Based on previous research (Cobb, 1976), it is assumed that self-reported mental and physical health ratings will be correlated. It is expected that the model fit will be invariant across the data collected by Blair and Holmberg (2008) and the data collected in the current study. This precise model was tested by Blair and Holmberg (2008) on a smaller sample of individuals in same-sex and mixed-sex couples and the model fit the data very well (CFI = .970, RMSEA = .068: see Method section for more detailed information on the meaning of structural equation fit indices, but in general, CFIs above .90 and RMSEAs below .08 indicate good fit).

![Figure 2. The hypothesized model.](image-url)
Hypothesis 2.2: It is hypothesized that the model depicted in Figure 2 will fit the data in the current study.

It is expected that the model will continue to fit the data well when an additional latent variable for general social support is added, thereby demonstrating that social support for relationships makes a unique contribution to the outcome variables in the model. Table 1 lists the indicator measures for each of the constructs (latent variables) depicted in the model.

Table 1

Proposed Factor Structure

<table>
<thead>
<tr>
<th>Social support for relationship</th>
<th>General social support</th>
<th>Relationship well-being</th>
<th>Mental health</th>
<th>Physical health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceived social support for relationship</td>
<td>Social support from family</td>
<td>Hendrick’s Relationship Assessment</td>
<td>CES-D</td>
<td>CHIPS</td>
</tr>
<tr>
<td>Friend approval</td>
<td>Social support from friends</td>
<td>Rempel’s trust scale</td>
<td>STAI</td>
<td>SF12 physical health questionnaire</td>
</tr>
<tr>
<td>Parent approval</td>
<td>Dyadic adjustment scale</td>
<td>Perceived stress scale</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. CES-D (Centre for Epidemiological Studies Depression Scale), STAI (State Trait Anxiety Inventory), CHIPS (Cohen-Hoberman Inventory of Physical Symptoms).

This hypothesis is strongly supported by previous research, which has found that perceived social support for relationships is associated with relationship well-being and additional research that has established the strong link between relationship well-being and mental and physical health outcomes. The current study uses slightly different indicator variables and includes the construct of general social support, but it is expected that the data will still fit the model very well. Furthermore, while the association between perceived social support for relationships and mental/physical health is expected to be fully mediated by relationship well-being, it is hypothesized that the association between general social support and health outcomes will not be fully mediated by relationship well-being, thereby retaining significant direct effects to mental and physical health.
**Hypothesis 2.2a:** The hypothesized model will fit the data for individuals in same-sex couples.

**Hypothesis 2.2b:** The hypothesized model will fit the data for individuals in mixed-sex couples.

**Research Question 2.1:** Is the hypothesized model invariant across relationship types?

When Blair and Holmberg (2008) tested the hypothesized model depicted in Figure 1, it was found to fit the data from individuals in same-sex and mixed-sex relationships equally well, with the exception of the path between relationship well-being and mental health being significantly stronger for individuals in same-sex relationships. Blair and Holmberg (2008) suggested that perhaps intimate relationships are especially salient for sexual minorities, providing a source of intimate support in a heteronormative society. Additionally, given the simple fact that sexual minorities, by virtue of definition, face a smaller pool of potential dating partners, finding a successful and satisfying same-sex relationship may then have an even stronger impact on mental health than it does for those inclined to have mixed-sex relationships, who may potentially have a sense that there are “other fish in the sea” (Blair & Holmberg, 2008). Given the relatively few documented differences between same-sex and mixed-sex couples (Herek, 2006), it is expected that the model will fit the data well for individuals in both types of relationships. It is, however, still possible that the model may fit the data for each group differently, despite fitting the data well in both groups. Thus, it is left open as a research question to determine whether the model is invariant between the two groups.

It is quite possible that there will be no significant differences in any of the paths within the model as a function of relationship type. This possibility is supported by previous research that has tended to find relatively few differences between same-sex and mixed-sex relationships. Although same-sex couples may perceive lower levels of familial and societal approval for their relationships than individuals in mixed-sex relationships (Crosbie-Burnett & Helmbrecht, 2007; Julien et al., 1999; Julien et al., 2003; Kurdek, 2003; Kurdek, 2004; Oswald, 2002), it does not seem to impact them in an unduly negative
manner (e.g., LaSala, 1998; Rostosky et al., 2004; Lannutti, 2008), as they are able to develop coping mechanisms to insulate themselves from the worst effects.

It is, however, possible that there will be differences in how the model fits the data as a function of relationship type. If individuals in same-sex relationships develop particularly good coping strategies, it may be possible that perceived social support could actually have a weaker impact on outcome variables, as compared to individuals in mixed-sex relationships. Individuals in same-sex relationships may be able to discount any negative reactions from their network quite effectively (e.g., “It is nothing about my partner or this relationship; it is probably just homonegativity”). However, research has found that even when individuals demonstrate the ability to cope with low levels of perceived support, they continue to report benefits associated from any support that they do perceive or receive (LaSala, 1998). Finally, given that social support for same-sex relationships may be a very salient factor, especially given the current political and cultural context of changing laws with respect to marriage, it may even be possible that a stronger relationship between perceived social support, relationship well-being and health will be found for individuals in same-sex relationships as compared to those in mixed-sex relationships (e.g., “You’re not just rejecting this one relationship; you may be rejecting who I am as a person”).

Thus, while hypotheses 2.2a and 2.2b indicate that the model will fit the data well for each group, (i.e., social support for relationships will be associated with relationship well-being, which will, in turn, be associated with mental and physical health), it is possible that the individual paths between variables within the model may vary as a function of relationship type, and thus, the invariance of the model between groups is left as an open research question.

**Research Question 2.2:** Do any alternative models fit the data better than the hypothesized model?

Due to the nature of SEM, any model that allows the latent variables to correlate as they do in the correlation matrix will have good fit indices. Determination of the best model is partly dependent upon theory, such that the model proposed and tested should have a strong theoretical basis. Three alternative models will be tested in the current study, all of which have some theoretical basis, but it is believed that
none are equal in theoretical strength to the hypothesized model. It is, however, quite possible that some, or all of these alternative models will fit the data well.

The first alternative model to be tested is a full reversal of the model, depicted in Figure 3, suggesting that mentally and physically healthy individuals have better relationships, which, in turn, are associated with greater perceptions of social support for the relationship. While it is certainly possible that improved health can help a relationship to function better, it seems less likely that the direction of effects goes from health to relationship well-being than vice versa. Similarly, it is also plausible that social network members provide more social support to couples who seem happy and healthy, taking such health and happiness as an indication that the relationship is good for their loved one. Greater provided support could then easily translate into greater perceive social support for the relationship on behalf of the individuals within the relationship.

![Diagram](image)

**Figure 3.** First alternative model.

The second alternative model to be tested is a direct effects model, depicted in Figure 4, in which social support for relationships directly predicts greater relationship well-being, mental and physical health, but where relationship well-being does not mediate the relationship between social support for the relationship and health. Within this model, physical health and mental health will continue to be set free to correlate with one another, but the path between relationship well-being and the health outcome variables will be fixed to zero. It is highly likely that this model will receive support, as it is hypothesized that social support will be associated with all three of these outcome variables; however, it is believed that the meditational model makes more theoretical sense and will still present a better fit to the data.
Figure 4. Second alternative model.

The third, and final, alternative model, to be tested is a reverse mediation model, depicted in Figure 5, in which perceived social support for the relationship mediates the association between relationship well-being and mental and physical health. In other words, relationship well-being is associated with mental and physical health because relationship well-being is associated with perceptions of social support for the relationship. Again, it is very likely that this model may fit the data well, but given the well-established link between relationship well-being and health outcomes, it seems unlikely that social support for relationships would fully mediate this association. Partial mediation, however, may still be a realistic possibility.

Figure 5. Third alternative model.
Objective 3: Parents versus friends.

Hypothesis 3.1: Social support for the relationship from parents will fail to predict outcome variables within the hypothesized model.

In the model tested by Blair and Holmberg (2008), support from parents did not correlate highly with the other measures of support, and thus was tested as a separate construct, compared to support from friends. Support from parents continued to reduce the model fit and after the construct was removed, model fit improved significantly. Because support from parents was dropped during the confirmatory factor analysis stage, the study did little to clarify the questions surrounding the relative contributions of support from parents versus friends (Blair & Holmberg, 2008). Even after restricting the age sample to participants between the ages of 18 and 25, Blair and Holmberg (2008) still failed to find any correlation between parental support and relationship well-being, mental or physical health.

Based on the low correlations between parental support and outcome measures reported by Blair and Holmberg (2008), and based on the numerous studies that have reported support for relationships from friends being more predictive of relationship well-being and stability than support for relationships from parents, it is hypothesized that in the current study, support from parents will not be a significant predictor of outcome variables in the model. It is expected that this finding will be even more pronounced for individuals in same-sex relationships, who consistently report perceiving lower levels of social support from their families, but who have also been found to report successful coping mechanisms for dealing with low levels of social support (LaSala, 1998).

Objective 4: Longitudinal analysis.

Hypothesis 4.1: Higher levels of support at Time 1 will be associated with stability (remaining together) at Time 2 and Time 3.

It is expected that higher levels of perceived social support for the relationship reported at Time 1 will be predictive of couples remaining together longer. Sprecher and Felmlee (2000), tested a very similar model, in which they collected data on perceived social support for the relationship and then followed participants for a period of 2 years. The results indicated that social support for the relationship
was indeed predicative of relationship stability, as well as the rate of dissolution, in other words, the less social support a relationship received, the earlier the relationship was likely to end (Sprecher & Felmlee, 2000).

**Hypothesis 4.2:** The hypothesized model will be supported by the longitudinal data.

The hypothesized model is expected to fit the data well across all three phases of data collection, independently, or in other words, will demonstrate a good fit with the data from Time 1, Time 2, and Time 3.

**Hypothesis 4.3:** Social support for relationships at Time 1 will be a significant predictor of outcome variables at Time 2 and Time 3.

Based on the hypothesized model, social support is expected to be associated with relationship well-being, and then, in turn, with mental and physical health. Thus, it is expected that social support for the relationship at Time 1 will be predictive of relationship well-being, mental and physical health at the two later time points as shown in Figure 5.

![Figure 6. Proposed longitudinal model: Time 1 to Time 3.](image)

**Research Question 4.1:** Does support for the relationship from friends predict relationship and health outcomes over time better than support for the relationship from parents (or vice versa)?

In order to continue decoding the relative associations between parental and friend support for relationships and the outcome variables, exploratory analyses will be conducted with the longitudinal data.
to determine when, if ever, parental support has the strongest predictive power with respect to the outcome measures in this study. For example, does support for the relationship from parents matter more as relationships progress (i.e., does the correlation between parental support and outcome measures become successively stronger over time?). Similarly, do individuals who perceive changes in the support for their relationship offered by their parents report stronger or weaker associations between these perceptions and the outcome variables? Perhaps when parental support remains stable (whether it be high or low) it is less salient to the individuals within the relationship, but when it fluctuates over time, the individuals become more cognizant of the support, and thereby experience greater susceptibility to the support (or lack thereof) from their parents.
CHAPTER 3

METHOD

Participants

The initial sample collected for this study consisted of 3597 registered participants. Participants were recruited for the study using a variety of methods, including online ads, Google ads, Facebook ads, listserv announcements, appeals sent to electronic mailing lists, ads in relevant periodicals such as *The Advocate, OUT, Curve,* and *LOTL,* as well as through posters sent to university student groups, conferences, and special events, such as Pride in Toronto, Ontario (Appendix A shows copies of advertisement and recruitment material). In addition, snowballing methods were used and participants were encouraged to invite their friends and partners to participate in the study.

Data from some participants were excluded from the analysis for a variety of reasons. First, 399 participants only completed the user registration process and did not continue to complete the study questionnaires. Next, of the remaining 3198 participants, participants, 214 were eliminated because they were not currently in a romantic relationship. After removing participants who were not in relationships, the sample consisted of 2984 participants. Missing data analysis revealed that another 1566 participants had substantial missing data, (i.e., lacking a score on one or more entire factor) and the data from these participants were deleted. Participants with substantial missing data had been in their relationships for a shorter period of time ($t = 3.157, p = .002$), had dated more people in the past ($t = -3.520, p = .000$), were in less serious relationships ($X^2(9) = 23.911, p = .004$), reported lower levels of relationship satisfaction ($t = 2.074, p = .038$), were less likely to be white ($X^2(8) = 18.01, p = .021$), were less educated ($X^2(7) = 44.22, p = .000$), more likely to report being exclusively heterosexual ($X^2(6) = 16.85, p = .010$), and more likely to report being Catholic, Christian, Muslim or Hindu and less likely to report being Atheist or Agnostic ($X^2(12) = 31.72, p = .002$). There were no significant differences in age, perceived support for the relationship or whether the participant was living with their partner. Participants who were missing data on one or more indicator variables, but were not missing an entire factor, had their missing data imputed. Expectancy Maximization imputation in AMOS was used to estimate values for these missing
data points (Byrne, 2006). This process takes into consideration the overall distribution of scores for the missing variable, as well as the target participant’s individual scores on other variables within the same factor, in order to generate the most likely score to replace the missing value (Byrne, 2006). For example, the latent variable of mental health had three indicator variables: depression, anxiety, and stress. If a participant was missing the Stress score, AMOS would predict that individual’s most likely score for stress, based on his or her provided Depression and Anxiety scores relative to others in the sample, as well as the overall distribution of the stress scores.

Because of participants being encouraged to invite their partners to participate in the study, it was necessary to identify the number of couples within the sample. During the User Registration process, participants were asked to provide information that would allow their data to be linked to that of their partner’s, should their partner decide to participate in the study. This code was designed to be unique enough to identify members of a couple, but cryptic enough to not provide any identifying information. To this end, participants were asked to provide the last three digits of their phone number, the first three letters of their mother’s maiden name, and month and day of their birth. Participants then entered this information for their partner as well, resulting in the generation of two codes (e.g., 442TAP1007 / 274GRA0915), which were then later used to identify couples and provide each couple with a couple identification code (i.e., Couple001). In the end, 208 couples participated in the study, with 137 of these providing complete data for both partners. Individuals within a participating couple were randomly assigned to be labeled as either Partner A or Partner B (using a random number generator) and the couples sample was then divided for the current analysis, with Partner B being excluded from the sample so as to avoid issues of data independence.

The remaining sample of 1281 participants was predominantly female (732 (58.4%) Women, 487 (38.9%) Men—including 14 (1.1%) MtF, 19 (1.5%) FtM) and 1 (.1%) Genderqueer, but more evenly split between individuals in mixed-sex and same-sex relationships, with 669 (52.2%) in same-sex relationships.

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2 MtF – An individual who has transitioned from male to female; a trans woman.
3 FtM – An individual who has transitioned from female to male; a trans man.
4 Genderqueer – An individual who does not subscribe to gender sex binaries.
relationships and 609 (47.5%) in mixed-sex relationships. With respect to sexual orientations, the sample included 533 (41.9%) heterosexuals and 740 (58.1%) nonheterosexuals (gay men, lesbians, bisexuals, queer-identifying). A more detailed breakdown of distributions of sexual orientations across relationship types can be found in Table 2. As the current study was interested in relationship type (same-sex or mixed-sex), the gender composition of the relationship was used to determine which group a participant would be placed in. As Table 2 demonstrates, using sexual orientation as an indicator of the gender composition of an individual’s current relationship can be inaccurate, with heterosexuals being found in same-sex relationships and nonheterosexuals being found in mixed-sex relationships.

The mean age of the overall sample was 29.9, ranging from 18 to 79, and participants had been with their current romantic partner, on average, for 50.89 months, ranging from .25 months to 459.25 months. As shown in Table 3, the samples do differ on a variety of demographic variables. The same-sex sample was, on average, six years older than the mixed-sex couple ($t(1276) = 13.71, p < .001$), which likely influenced other demographic variable differences, such as same-sex couples being more likely to live together ($\chi^2(2) = 52.88, p = .000$), having been in their relationships, on average, for nearly 2 years longer than the individuals in mixed-sex relationships ($t(1135) = 5.55, p < .001$) and reporting higher household incomes ($\chi^2(7) = 19.83, p = .006$). Individuals in same-sex couples reported having been in more serious relationships than individuals in the mixed-sex sample ($t(1275) = 6.03, p < .001$). Perhaps the most noticeable difference between the samples lies in their geographic locations, with the majority of individuals in the same-sex sample residing in the United States, while the majority of individuals in mixed-sex couples resided in Canada ($\chi^2(24) = 593.81, p < .001$). Furthermore, a greater proportion of mixed-sex couples resided somewhere outside of Canada and the United States (nearly one quarter of the mixed-sex sample compared to less than 10% of the same-sex sample). Finally, mixed-sex couples were more likely to be married, while same-sex couples were more likely to report being in a common-law relationship or having a domestic partnership or civil union (likely an artifact of the same-sex couples predominantly residing in the United States where same-sex marriage remains constitutionally banned in a majority of states and at the federal level; $\chi^2(9) = 137.79, p = .000$). With respect to ethnicity,
education, and general relationship stage, the samples were much more similar. The gender split between the samples is also similar, although men in mixed-sex relationships represent the smallest relationship by gender group, which is not inconsistent with previous relationship research (Blair & Holmberg, 2008).

Table 2

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Mixed-sex n (%)</th>
<th>Same-sex n (%)</th>
<th>Full sample n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sexual orientation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heterosexual</td>
<td>528 (86.7)</td>
<td>5 (.7)</td>
<td>553 (41.8)</td>
</tr>
<tr>
<td>Homosexual</td>
<td>11 (1.8)</td>
<td>552 (82.6)</td>
<td>563 (44.1)</td>
</tr>
<tr>
<td>Bisexual</td>
<td>42 (6.9)</td>
<td>60 (9)</td>
<td>105 (8.2)</td>
</tr>
<tr>
<td>Queer</td>
<td>14 (2.3)</td>
<td>40 (6)</td>
<td>54 (4.2)</td>
</tr>
<tr>
<td>Pansexual</td>
<td>10 (1.6)</td>
<td>11 (1.6)</td>
<td>21 (1.6)</td>
</tr>
<tr>
<td><strong>Sexual identity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gay</td>
<td>3 (.5)</td>
<td>332 (50.8)</td>
<td>335 (26.8)</td>
</tr>
<tr>
<td>Lesbian</td>
<td>4 (.7)</td>
<td>262 (40.1)</td>
<td>266 (21.3)</td>
</tr>
<tr>
<td>Bisexual</td>
<td>42 (7.1)</td>
<td>42 (6.4)</td>
<td>87 (7)</td>
</tr>
<tr>
<td>Straight</td>
<td>523 (88)</td>
<td>2 (.3)</td>
<td>525 (42)</td>
</tr>
<tr>
<td>Unlabelled</td>
<td>22 (3.7)</td>
<td>15 (2.3)</td>
<td>37 (3)</td>
</tr>
<tr>
<td><strong>Kinsey scale</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 (heterosexual)</td>
<td>385 (64.1)</td>
<td>5 (.7)</td>
<td>390 (30.7)</td>
</tr>
<tr>
<td>1</td>
<td>134 (22.3)</td>
<td>3 (.4)</td>
<td>137 (10.8)</td>
</tr>
<tr>
<td>2</td>
<td>46 (7.7)</td>
<td>10 (1.5)</td>
<td>58 (4.6)</td>
</tr>
<tr>
<td>3</td>
<td>25 (4.2)</td>
<td>30 (4.5)</td>
<td>56 (4.4)</td>
</tr>
<tr>
<td>4</td>
<td>4 (.7)</td>
<td>30 (4.5)</td>
<td>34 (2.7)</td>
</tr>
<tr>
<td>5</td>
<td>4 (.7)</td>
<td>136 (20.4)</td>
<td>140 (1.1)</td>
</tr>
<tr>
<td>6</td>
<td>3 (.5)</td>
<td>454 (68.0)</td>
<td>457 (35.9)</td>
</tr>
</tbody>
</table>
Table 3

*Time 1 Sample Demographics*

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Mixed-sex</th>
<th>Same-sex</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>n</strong></td>
<td>609</td>
<td>669</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
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<td></td>
</tr>
<tr>
<td>Female</td>
<td>411</td>
<td>325</td>
</tr>
<tr>
<td>Male</td>
<td>169</td>
<td>316</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>26.12</td>
<td>33.32</td>
</tr>
<tr>
<td>Range</td>
<td>18–58</td>
<td>18–79</td>
</tr>
<tr>
<td><strong>Relationship Demographics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean years together</td>
<td>39.9 months</td>
<td>61 months</td>
</tr>
<tr>
<td>Living together</td>
<td>54%</td>
<td>73%</td>
</tr>
<tr>
<td><strong>Relationship stage</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Casually dating</td>
<td>3.5%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Seriously dating</td>
<td>18.9%</td>
<td>18%</td>
</tr>
<tr>
<td>Thought about marriage, but not discussed</td>
<td>4.8%</td>
<td>3.9%</td>
</tr>
<tr>
<td>Discussed marriage, but no formal plans</td>
<td>34.5%</td>
<td>27.8%</td>
</tr>
<tr>
<td>Engaged</td>
<td>12.3%</td>
<td>10.2%</td>
</tr>
<tr>
<td>Married</td>
<td>18.1%</td>
<td>10.7%</td>
</tr>
<tr>
<td>Common-law</td>
<td>6.4%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Domestic partnership</td>
<td>1.3%</td>
<td>20.7%</td>
</tr>
<tr>
<td>Civil union</td>
<td>.2%</td>
<td>1.8%</td>
</tr>
<tr>
<td><strong>Average number of serious relationships</strong></td>
<td>2.61</td>
<td>3.28</td>
</tr>
<tr>
<td><strong>Hours per week spent with partner</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0–12</td>
<td>17.9%</td>
<td>6.2%</td>
</tr>
<tr>
<td>13–24</td>
<td>10.4%</td>
<td>5.9%</td>
</tr>
<tr>
<td>25–36</td>
<td>8.1%</td>
<td>8%</td>
</tr>
<tr>
<td>37–48</td>
<td>7.6%</td>
<td>6%</td>
</tr>
<tr>
<td>49–64</td>
<td>6.8%</td>
<td>9.5%</td>
</tr>
<tr>
<td>65–72</td>
<td>5.8%</td>
<td>9.1%</td>
</tr>
<tr>
<td>73–84</td>
<td>11.6%</td>
<td>13.9%</td>
</tr>
<tr>
<td>85–168</td>
<td>31.8%</td>
<td>41.4%</td>
</tr>
<tr>
<td><strong>Personal demographics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethnicity</td>
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<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>88.4%</td>
<td>88.7%</td>
</tr>
<tr>
<td>Mixed-race</td>
<td>3.3%</td>
<td>5.3%</td>
</tr>
<tr>
<td>African American</td>
<td>1.2%</td>
<td>3.1%</td>
</tr>
<tr>
<td>Asian</td>
<td>5.5%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Native American</td>
<td>1%</td>
<td>.8%</td>
</tr>
<tr>
<td>Geographic location</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canada</td>
<td>61.7%</td>
<td>10.9%</td>
</tr>
<tr>
<td>USA</td>
<td>14.8%</td>
<td>79.5%</td>
</tr>
</tbody>
</table>

*(table continues)*
Descriptive Sample Information for Time 2 and 3

Time 2 Demographics

A total of 583 participants returned to the survey for Time 2. On average, participants began Time 2 nine months after they participated in Time 1, with total time between phases ranging from 3 months to 2.3 years. Of the 583 participants who began Time 2, 442 provided sufficient data to be kept in the sample. There were no significant differences between participants who provided sufficient data to remain in the sample and those who were removed due to insufficient data. Of the 583 participants who returned to the study, 502 were still with the same partner they had been with in Time 1, and 64 reported that their relationship had terminated. Of those whose relationships had terminated, the most common reason cited for termination was “life goal differences.”

Using age information from Time 1, participants who provided data during Time 2 had an average age of 31 at the beginning of the study, ranging from 18 to 70, and had been with their partners at the beginning of the study for an average of 55.5 months, ranging from 1 week to 36.75 years. The sample consisted of 152 men and 241 women (including 4 MtF and 4 FtM), and 57.4% were in same-sex relationships. Compared to those who did not participate in Time 2 (participation defined as at least completing the update questionnaire), participants were very similar across demographic variables. Complete demographics for the Time 2 sample can be found in Table 4.
**Time 3 Demographics**

A total of 488 participants returned to the survey for Time 3. On average, participants began Time 3 16 months after they participated in Time 1, with total time between phases ranging from two months to 2.4 years. Of the 488 participants who began Time 3, 428 provided sufficient data to be kept in the sample (i.e., they completed, at a minimum, the update questionnaire). Participants kept in the data set were significantly older ($t[444] = 2.42, p = .016$) and had been in their relationships significantly longer ($t[395] = 2.02, p = .044$) than individuals who did not provide sufficient data to be kept in the data set. The participants did not differ on any other demographic or measured variables, including the Time 1 measured variables relating to the main constructs in the study. Of the participants kept in the data set, 314 were still with the same partner they had been with in Time 1, and 49 reported that their relationship had terminated.

Using age information from Time 1, participants who provided data during Time 3 had an average age of 32, ranging from 18 to 79, and had been with their partners at the beginning of the study for an average of 61.8 months, ranging from 2 weeks to 46.80 years. The sample consisted of 128 men and 235 women (including 3 MtF and 5 FtM), and 47.4% were in same-sex relationships. Compared to those who did not participate in Time 3 (participation defined as at least completing the update questionnaire), participants had very similar demographics, but had been in their relationships longer and were in more serious relationships. For complete demographics for the Time 3 sample, see Table 4.

**Table 4**

*Time 2 and 3 Demographics*

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Time 2</th>
<th>Time 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>n</strong></td>
<td>442</td>
<td>428</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>241</td>
<td>235</td>
</tr>
<tr>
<td>Male</td>
<td>152</td>
<td>128</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>31.03</td>
<td>31.63</td>
</tr>
<tr>
<td>Range</td>
<td>18-70</td>
<td>18-79</td>
</tr>
<tr>
<td><strong>Relationship Demographics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean years together</td>
<td>55.5 months</td>
<td>61.8 months</td>
</tr>
<tr>
<td>Living together</td>
<td>66%</td>
<td>63.6%</td>
</tr>
</tbody>
</table>

*(table continues)*
<table>
<thead>
<tr>
<th>Demographic</th>
<th>Time 2</th>
<th>Time 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Relationship Demographics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship stage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Casually dating</td>
<td>3.8%</td>
<td>3%</td>
</tr>
<tr>
<td>Seriously dating</td>
<td>10.4%</td>
<td>13.6%</td>
</tr>
<tr>
<td>Thought about marriage, but not discussed</td>
<td>1.9%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Discussed marriage, but no formal plans</td>
<td>27.4%</td>
<td>21.2%</td>
</tr>
<tr>
<td>Engaged</td>
<td>5.7%</td>
<td>6.1%</td>
</tr>
<tr>
<td>Married</td>
<td>24.5%</td>
<td>26.5%</td>
</tr>
<tr>
<td>Common-law</td>
<td>4.7%</td>
<td>7.6%</td>
</tr>
<tr>
<td>Domestic partnership</td>
<td>17.9%</td>
<td>15.2%</td>
</tr>
<tr>
<td>Civil Union</td>
<td>3.8%</td>
<td>.8%</td>
</tr>
<tr>
<td>Hours per week spent with partner</td>
<td></td>
<td></td>
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<tr>
<td>0–12</td>
<td>8.2%</td>
<td>11.6%</td>
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<td>13–24</td>
<td>7.9%</td>
<td>6.9%</td>
</tr>
<tr>
<td>25–36</td>
<td>8.7%</td>
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<td>37–48</td>
<td>6.1%</td>
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<td>49–64</td>
<td>6.6%</td>
<td>6.9%</td>
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<td>65–72</td>
<td>8.4%</td>
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<td>73–84</td>
<td>15.3%</td>
<td>11.9%</td>
</tr>
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<td>85–168</td>
<td>37.8%</td>
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<tr>
<td><strong>Relationship Type</strong></td>
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<tr>
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</tr>
<tr>
<td>Same Sex</td>
<td>57.4%</td>
<td>47.4%</td>
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<td><strong>Personal Demographics</strong></td>
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<tr>
<td>Ethnicity</td>
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<tr>
<td>Caucasian</td>
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<td>90.1%</td>
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<tr>
<td>Mixed-Race</td>
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<td>.3%</td>
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<tr>
<td>African American—Race</td>
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</tr>
<tr>
<td>Asian</td>
<td>3%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Native American</td>
<td>1.4%</td>
<td>.9%</td>
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<tr>
<td>Geographic Location</td>
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<td>Canada</td>
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<td>USA</td>
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<td>$20,000—$35,999</td>
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</tr>
<tr>
<td>$36,000—$55,999</td>
<td>17.8%</td>
<td>15%</td>
</tr>
<tr>
<td>$56,000—$75,999</td>
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<td>10.9%</td>
</tr>
<tr>
<td>$100,000—$150,999</td>
<td>16.7%</td>
<td>15%</td>
</tr>
<tr>
<td>$151,000—$200,999</td>
<td>5.6%</td>
<td>5.9%</td>
</tr>
<tr>
<td>&gt; $201,000</td>
<td>5.6%</td>
<td>5.9%</td>
</tr>
<tr>
<td><strong>Education</strong></td>
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<td></td>
</tr>
<tr>
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<td>0</td>
</tr>
<tr>
<td>High school</td>
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<td>9.9%</td>
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<tr>
<td>Post-doc</td>
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Measures

The measures used in this study can be divided according to the study’s major constructs of interest. As outlined in Table 1, the constructs include perceptions of social network support for the relationship, relationship well-being, mental health, and physical health. Measures were selected specifically to provide insight into these four constructs, as well as demographic information. General information on each measure is reported here, including Time 1 alphas; descriptive information for each measure in the current study is reported in the Results section.

Perceived Support From Social Network

The major predictor in this study is the perception of social support for a particular relationship. In order to measure perceived social support for the relationship, four measures were used (presented in Appendix B). In addition, a measure of general perceived social support for the individual was also included.

Social network support. Sprecher and Felmlee (1992) developed a six-item measure of perceived social support for relationships. Participants were asked to rate the level of approval/disapproval displayed by their parents and friends for their relationship on a seven-point scale, ranging from 1 (very much disapproves) to 7 (very much approves). For example, participants were asked, “to what degree do you think your family disapproves/approves of your current relationship?” The mean on these six items provides a score for the Network Support Index, which has been reported to have good overall internal consistency (.83), as well as good test-retest reliability (.67; Sprecher & Felmlee, 1992). Based on the results from a pilot study and comments from participants, the current study modified two items of this scale in order to distinguish more clearly between perceived support from parents and perceived support from siblings (as opposed to a single item to assess support from family). Additionally, subscales were created to represent perceived support for the relationship from various sources, namely family and friends. The alpha for the overall measure of perceived social support for the relationship in the current study was .86, and the subscale alphas were .78 for friends and .74 for family.
Behaviours of parents and friends. Leslie, Huston, and Johnson (1986) asked students to indicate the types of behaviours that their friends and parents engaged in which indicated either approval or disapproval of the students’ relationships. Leslie et al. (1986) summarized their findings into the ten most frequent approving behaviours, and ten most frequent disapproving behaviours. These lists were used to create a measure for the current study, designed to tap into the level of support offered for participants’ relationships, individually from their friends, up to four of their own parental figures, and up to four of their partner’s parental figures. Once again, results from the pilot study indicated that asking about four parental figures as opposed to two was an option frequently requested by participants.

The adapted list consisted of 18 approving and disapproving behaviours for each of the parents and 14 items for friends. Not all items provided by Leslie and colleagues (1986) were appropriate for the current study’s purposes, with some being more geared towards adolescent relationships and some being geared specifically to parent-child relationships, and thus two items were dropped from the list for parents and six items were dropped from the friends’ list of behaviours. Participants were asked to indicate the frequency with which each individual displayed each of the behaviours listed on a scale ranging from 0 (never), to 4 (frequently). The resulting measures each had good internal consistency in the current sample, with alphas ranging from .82 to .98. The majority of participants completed the measure for two of their own parents and two of their partner’s parents; 126 participants did not provide data on any parents, and thus their data for this measure were not used. Scores on support from participant’s own parents (up to four) were significantly correlated with each other (r = .42 to r = .70, p < .001), as were the scores for the partner’s parents (r = .48 to r = .66, p < .001). Support from the participant’s parents and support from the partner’s parents had a lower correlation (r = .29, p < .001), and as such, three separate measures of support from parents were created: support from participant’s parents (averaging across all four), support from partner’s parents (averaging across all four) and support from all parents (averaging across all eight potential parental figures). A further analysis comparing the approving and disapproving items on the scale demonstrated that the mean of each of these groups did not have a perfect inverse correlation, indicating that disapproving behaviours are not necessarily the direct opposite of approving
behaviours, nor are each of these types of behaviours mutually exclusive. As a result, eight additional subscales were created, breaking the approval and disapproval items into separate scales.

**Multidimensional scale of perceived social support (MSPSS).** The MSPSS is a 12-item scale that measures perceptions of perceived social support from three sources: family, friends, and a significant other. A scale score that represents general perceived social support was obtained by taking the mean across all 12 items. Additionally, three subscales were created. The developers of the scale have reported an alpha of .88 (Zimet, Dahlem, Zimet, & Farley, 1988) and also provided validity evidence for the scale through demonstrated negative associations with mental health scores among college students (Zimet et al., 1988). Participants responded using a 5-point Likert type scale, ranging from 1 (strongly disagree) to 5 (strongly agree). Sample items include: “I can talk about my problems with my family,” and “I have friends with whom I can share my joys and sorrows.” Cronbach’s alpha in the current sample was .90 for the full scale, and .85, .86, and .93 for each of the subscales: family, friends, and significant other, respectively.

**Relationship Measures**

**Hendrick’s Relationship Assessment Scale.** Hendrick’s Relationship Assessment Scale (Hendrick, 1988) is a seven-item scale that measures general relationship satisfaction (Appendix C). Participants respond to items that indicate the extent to which their partner meets their needs, how their relationship compares to the relationships of others, their regrets about the relationship, how well their expectations have been met, their general relationship satisfaction, how much they love their partner, and the extent of problems in their relationship. Responses are rated on a 5-point scale, ranging from 1 (poor/unsatisfied) to 7 (excellent/extremely satisfied), where higher numbers are indicative of greater satisfaction. Hendrick and colleagues (1998) report a mean interitem correlation of .49, Cronbach’s alpha of .86, and a test-retest reliability of .85 over a six- to seven-week period. The alpha in the present study was .86.

**Rubin Love Scale.** The Rubin Love Scale (Rubin, 1970) is a 13-item measure used to assess the extent to which participants love their partners (Appendix C). Participants rate each of the 13 items using
a 9-point scale, ranging from *Not at All True; Disagree Completely* to *Definitely True; Agree Completely*. Previous research has found Rubin’s love scale to have high internal consistency, reporting a coefficient alpha of .84 (Rubin, 1970). In the current study, participants responded using a 7-point scale, as the result of a programming error at the time of survey creation. Given that a mean score is used for this measure, the scale was not discarded. The internal consistency within this sample remained high, with a coefficient alpha of .87.

**Trust.** The Trust Scale developed by Rempel, Holmes and Zanna (1985) was used to assess the level of trust within participants’ relationships (Appendix C). The measure includes 17 items, which can, if desired, be broken down further into three subscales: predictability (e.g., “My partner behaves in a very consistent manner”), dependability (e.g., “I can depend on my partner to keep the promises he or she makes to me”) and faith (e.g., “Though times may change and the future is uncertain, I know my partner will always be ready and willing to offer me strength and support”). Each item is rated on a 7-point scale, ranging from 1 (strongly disagree) to 7 (strongly agree), with higher scores indicative of greater levels of trust. Rempel and colleagues (1985) reported individual coefficient alphas of .55, .69, and .81 for each of the subscales, respectively. In this study, one overall measure of trust was used, incorporating all 17 items, and the calculated alpha was .91.

**Dyadic Adjustment Scale (DAS).** The Dyadic Adjustment Scale is a 32-item measure that is designed to tap into relationship satisfaction, cohesion, affectional expression, and consensus. Research has shown the measure to be reliable and well-validated (Whisman & Jacobson, 1992), with the original developer reporting a Cronbach’s alpha of .96 (Spanier, 1976). Due to an error in programming, the response scale for item 23 of the DAS was incorrect, and thus the item was dropped, resulting in a sum score across 31 items. The items are rated on various scales, with higher scores indicating greater levels of relationship satisfaction. In the present study, Cronbach’s alpha was .89 for the scale and subscales were not used.

**Commitment.** To measure relationship commitment, a 9-item subscale from the Investment Model Scale was used (Rusbult, Martz & Agnew, 1998). All items were rated on a 9-point scale ranging
from 1 (do not agree at all) to 9 (agree completely). Example items include “I am committed to maintaining my relationship with my partner,” and “I feel very attached to our relationship.” The Cronbach’s alpha for the commitment subscale in the present study was .88.

**Health Measures**

The outcome constructs in this study include measures of mental and physical health. The next two sections describe the various measures used to provide an overall picture of participants’ mental and physical functioning (measures are presented in Appendices D and E, respectively).

**Mental health. CES-D.** The Centre for Epidemiological Studies Depression Scale (Radloff, 1977) is a 20-item, self-report scale designed for assessing depressive symptomatology in the general population. The items on the scale consist of characteristic and noncharacteristic statements concerning depression, (e.g., I felt lonely, I had crying spells, I was happy). Participants respond by indicating the frequency of occurrence within the last week for each item on a 4-point scale ranging from Rarely Or None of the Time to Most Or All of the Time, with higher numbers indicating greater depression. The literature reports a range for Cronbach’s alpha between .87 (Hann, Winter & Jacobsen, 1999) and .93 (Verdier-Taillefer, Gourlet, Fuhrer & Alperovitch, 2001), and for the present study, it was .93.

**STAI.** The State-Trait Anxiety Inventory (STAI; Spielberger, 1983) is a self-report measure that examines feelings related to anxiety from a transitory (state) perspective as well as a more stable (trait) perspective. The inventory has 40 items; 20 that assess state anxiety and 20 items that assess trait anxiety. For this study, participants completed the 20 items associated with state anxiety (e.g., I feel calm, I feel jittery, I am relaxed). Participants were asked to rate how they felt right now on a 4-point scale, ranging from 1 (not at all) to 4 (very much so), with higher numbers indicating greater anxiety. The median alpha coefficient for state anxiety subscales in normative samples (i.e., nonclinical) is .92 (Spielberger, 1983), and in the present study it was .94.

**Perceived Stress Scale.** Participants completed the 10-item Perceived Stress Scale, which provides an overall rating of a participant’s perceived level of stress over the past month. Participants responded on a 5-point scale (0 = never, 4 = very often) to items such as “In the last month, how often
have you been upset because of something that happened unexpectedly?” (Cohen, Kamarck, & Mermelstein, 1983). Higher scores on this scale are indicative of greater stress. Cohen and colleagues (1983) reported coefficient alpha reliability as ranging from .84 to .86 and a test-retest reliability of .85 over a two-day period. In the present study, Cronbach’s alpha was .90.

Physical health. CHIPS. The Cohen-Hoberman Inventory of Physical Symptoms (CHIPS; Cohen & Hoberman, 1983) measures the occurrence of 33 relatively minor physical symptoms (e.g., nausea, headache, cold, or cough) over the past month by using a 5-point rating scale to indicate the extent to which each symptom has been a bother or distress in the past month. Higher numbers are indicative of more minor health problems. Researchers have reported high reliability, with a Cronbach’s alpha of .89 (Aspinwall & Taylor, 1992). For the current study, the scale was reverse scored, so that higher scores would indicate fewer minor health problems. This was done so that the overall physical health factor would be indicative of better health. Cronbach’s alpha in the present sample was .93.

SF-12. The RAND SF-12 Health Survey (Ware, Kosinski, & Keller, 1996) is a measure produced by RAND which measures a variety of health-related issues, including an individual’s general health status, ability to perform various tasks, and some more specific mental and physical health symptoms. The measure includes 12 items and is designed to be a short form of the 36-item RAND Health Outcomes Survey. Summing the individual items after reverse scoring negatively worded items generated a total score on this measure, in which higher scores indicate better health. Due to the summed nature of this score, and the fact that each item had a different response scale, thereby omitting many options for the replacement of missing data (i.e., mean replacement), only participants with complete data on all 12 items had a total score for this measure calculated. Cronbach’s alpha in the present sample was .84.

Demographics

Personal demographics. Demographics were collected from all participants detailing their age, gender, nationality, ethnicity, level of education, sexual orientation, and sexual identity (Appendix F).

Relationship demographics. The second set of demographic questionnaires concerned participants’ current and past relationship experiences, including the nature of the relationship (same-sex,
mixed-sex), duration of the relationship, average amount of time spent together per week, and the seriousness or stage of the relationship (e.g., dating, engaged, married) and location of their partner (i.e., same household, same city, different city, different state/province, etc.; see Appendix F).

**Time 2 and Time 3 Measures**

The measures described above were all included in Time 1 of the study and the same measures, with a few exceptions noted below, were also included in the subsequent phases of the study (Time 2 and Time 3). The alphas for each scale across each study phase are presented in Table 5 along with notes on any differences in the scales between time points.

In Time 2 and 3, basic personal and relationship demographics were not repeated, but participants were asked to complete the Time 2/3 Update Questionnaire (see Appendices G and H), in which they provided information about the current status of their relationship and confirmed details about their relationship status that they had provided in the previous phase of data collection (i.e., nature of relationship, gender, sexual orientation). If discrepancies existed, participants were able to provide new demographic information. Participants who indicated that the relationship they had been in during Time 1 had ended were forwarded to the Time 2/3 Break Up Questionnaire (see Appendices I and J). This questionnaire asked participants to indicate the cause of their relationship termination, the total length of the relationship, whether or not they were in a new relationship, and an open ended question about how support for the relationship had influenced their relationship. Participants in new relationships were given the opportunity to indicate whether or not they would like to be contacted to continue their participation in the study based on their new relationship. Finally, the programming errors from Time 1 were corrected and Time 2 included the validated version of the Rubin Scale (a 9-point response scale instead of a 7-point response scale) and item number 23 of the DAS was corrected.
Table 5
Cronbach’s Alpha for Each Scale at Time 1, 2 and 3

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<th>Time 1</th>
<th>Time 2</th>
<th>Time 3</th>
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</tr>
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<td>Friends</td>
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<td>SF-12</td>
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Procedures

Time 1

All recruitment material directed potential participants to the study’s website (http://www.klbresearch.com), where they read a description of the study (Appendix K) and were provided with a link to the screening survey (Appendix L). Participants who met the study’s criteria (being 18 years of age or over, and capable of reading and writing in English) were then re-directed to the study’s secure survey portal, where they completed the official registration for the study (see below). The questionnaires for this study were programmed and disseminated using a software program called Checkbox (http://www.checkbox.com) that was housed on a secure Queen’s University server in the Psychology Department. For more information on Checkbox and the security of the data in this study, please see Appendix M.
Prior to viewing the registration questionnaire, participants read the informed consent, in which they were made aware that their participation in the study was voluntary and confidential (See Appendix N). Participants were also informed that they would be offered incentives in the form of participation points, which they could later use to enter draws for various prizes, including cash, gift certificates, and Apple™ products (see Appendix O). Participants were able to indicate their consent by clicking on a button that said, “I agree and wish to continue.” Any participants who did not wish to provide their consent would click a button that said “I do not agree and do not wish to continue,” which would then redirect them to a page outside of the survey that thanked them for their time (Appendix P).

The registration process involved selecting a username and password and then completing the user registration questionnaire (see Appendix Q). This questionnaire collected basic demographic information, as well as details of their current relationship status and the nature of their relationship. Participants were also given the chance to provide contact information to assist in the longitudinal nature of the study, but they were informed that providing this information was voluntary and that it would be stored separately from their questionnaire data. Finally, partnered participants were asked if they would like to invite their partner to participate in the study and were able to send an e-mail directly to their partner that included an invitation to the survey (see Appendix R). It was also at this stage that participants could choose to provide their consent to link their data with that of their partner’s, should their partner decide to participate, and if they provided their consent, they then provided the information necessary to generate the unique identification code discussed earlier (see Appendix S). After completing the user registration questionnaire, participants were re-directed to the first section of the study and they received an e-mail that contained their self-selected username and password as well as instructions on how to continue their participation in the study (see Appendix T). The Time 1 questionnaires were divided into five sections (Parts 1a, 1b, 2, 3, and 4). The division created clear and logical places for participants to return to the survey and separated the questionnaires required for continued participation from those that were considered auxiliary. The division was also a matter of functionality, as the survey itself loaded much more quickly when divided into separate sections, thus making the survey more user
friendly, especially for participants with slower internet connections. Appendix U details the questionnaires that were included in each of the separate parts of Time 1.

The answers provided to the initial demographic questionnaires during the registration process were used to automatically determine the appropriate set of questionnaires to be completed during the rest of the study for each participant. Each individual participant’s survey portal was personalized based on the answers they provided during the initial demographic questionnaires, so participants completed only relevant questionnaires. For example, heterosexual participants were not presented with the questionnaires specifically designed for nonheterosexual participants; those not currently in a relationship were not asked about their relational well-being.

Once a user has created a username and password within the Checkboxes program, they are able to access available surveys and complete the questionnaires at their own pace. Participants had the opportunity to select “save and exit” at any time, which would send them an e-mail with a link to where they left off in the survey. Conversely, if a participant simply closed their browser, their answers would be saved and if they re-accessed the initial link for the survey, they would be redirected to the last page they visited by entering their username and password. If participants got lost in the process of finding the different segments of the survey, they were able to access a website specifically designed for study participants which provided useful instructions and links back into various portions of the survey. Participants were not, however, able to go backwards within a survey and change their answers.

The data collected from the participants were encrypted and downloaded from the website and stored on the primary researcher’s external, password-protected hard drive. All identifying information, such as participants’ e-mail addresses, phone numbers, and physical addresses were stored in a separate password-protected file from the actual survey data. Contact information was necessary if participants wished to be eligible for some of the prizes offered in exchange for participation, but participants could choose to participate without providing their contact information. In fact, most prizes offered required only an e-mail address, not a name or physical address. An e-mail address was required in order to
participate, but participants were given instructions on how to create an anonymous e-mail account specifically for the study in the event that they wanted to remain entirely anonymous.

At the completion of all surveys offered through the survey portal, participants were given a brief debriefing form to read that explained their participation in the research (see Appendix V). Participants were also given opportunities to participate in additional studies, both during the current study and after its completion. In particular, participants were made aware that future phases of the current study would be conducted, using the same survey portal.

**Time 2 and 3**

As part of the Checkbox program, each participant who created a username and password has a user profile generated. This profile has properties that can be automatically updated while a participant completes a questionnaire. The properties can be set by the programmer, and in this study, the profile was set to record whether or not a user had completed each section of the survey. For example, if a participant completed Time 1, Part 1, the corresponding property field would contain a value. This feature allowed a list of users to be downloaded from the program that contained information on which portions of the survey had been completed, without actually linking usernames directly to the data or determining which individuals had completed which parts of the survey. As a result, it was possible to track the progress of participants and to determine who was eligible to be invited to participate in successive phases of data collection.

In order to be eligible to participate in Time 2 of the study, a participant needed to have completed a minimum of the User Registration Questionnaire, Time 1 Part 1a, Time 1 Part 1b, and Time 1 Part 2. If a participant’s user profile showed that all of these properties contained values, they were then invited (via email) to participate in Time 2 six months after their study registration date (see Appendix W). This e-mail directed the participant to the first portion of Time 2, which re-displayed the consent form and then presented the Time 2 questionnaires. Participants were then sent reminders on a monthly basis for 3 months. Participants were first directed to an update questionnaire, which asked them to confirm their profile’s demographic variables (those used to dictate the questionnaires presented) and to
provide some basic information on the status of their relationship (see Appendix G). Participants who indicated that they were no longer in the same relationship that they had been the last time they participated were re-directed to the break-up questionnaire (see Appendix I). Participants who indicated that they were still with the same partner were directed into the main questionnaire for Time 2. The Time 2 questionnaires were divided into sections, similar to those presented in Time 1. Appendix X details the questionnaires that were included in each section.

In order to be eligible to participate in Time 3 of the study, a participant needed to have first been eligible for Time 2, and in addition, needed to have completed Time 2 Part 1. If these criteria were met, then participants were invited to Time 3 using the same procedures detailed above for Time 2 invitations. Invitations were sent beginning 6 months after beginning Time 2. Again, participants were first directed to an update questionnaire (see Appendix H) and those who were no longer with the same partner were directed to the break-up questionnaire (see Appendix I). Nearing the end of data collection it was decided to invite all participants who had completed Time 1 at least 6 months earlier to Time 3, regardless of whether or not they had completed Time 2. This was done in an attempt to increase the longitudinal sample size. Thus, for some participants, Time 3 serves as Time 2, and for others it serves as a third wave of data collection. To deal with the discrepancy in times between participation points, a variable was generated within the data set that calculates the duration of time between each phase for each participant. Participants who indicated that they were still with the same partner were directed into the main questionnaire for Time 3, which was also divided into sections (see Appendix Y).
CHAPTER 4

RESULTS

A variety of data analysis methods were employed in order to assess each of the hypotheses and research questions associated with the study’s four objectives. The following description of the results follows the order of hypotheses and research questions laid out earlier. Objective one, establishing social support for relationships as a unique construct, was assessed using correlation and multiple regression procedures. Objective two, testing the hypothesized structural model, was assessed using confirmatory factor analysis and structural equation modeling, including the use of invariance testing procedures for group comparisons. Objective three, comparing the relative contributions of social support for the relationship from parents versus friends was also assessed using structural equation modeling. Objective four, the predictive power of social support for relationships over time and the functioning of the hypothesized model at different points in time, was assessed using a combination of structural equation modeling and survival (hazard) analyses. Descriptive scale and demographic statistics were examined prior to conducting any further analyses related to the study’s specific objectives. The relationship type samples differed on a variety of demographic variables, but only relationship length and hours spent together per week proved to be significant covariates with respect to the outcome variables in question, and thus the following analyses controlled for these two variables.

Social Support for Relationships As a Unique Construct

In order to determine whether social support for relationships represents, and operates as, a unique dimension of social support as compared to general social support, two analyses were conducted; interscale correlations and regressions.

Hypothesis 1.1 : Social Support for Relationships will have a low to moderate correlation with General Social Support.

The data support this hypothesis. Table 6 shows the interscale correlations between the social support for relationship variables and measure of general social support split by relationship type, with significant correlations ranging from -.09 to .46. The measure of general social support includes a
subscale for social support from significant other, and thus it was expected that this subscale would correlate more highly with the social support for relationship measures than the other two general social support subscales (friends and family). As shown in Table 6, only three significant correlations are above .4, with the majority being .2 or lower. Furthermore, a considerable number of the correlations are not significant. With respect to group differences, the overall pattern of results held regardless of relationship type, such that general social support variables and social support specifically for the relationship were had low to moderate correlations. There were, however, two statistically significant differences between participants in same-sex versus mixed-sex relationships. Specifically, perceived social support for the relationship from the participant’s own parents ($z = -2.75, p < .01$) and approval of the relationship from the participant’s own parents ($z = -2.21, p < .05$) had a statistically stronger correlation with general social support from family than it did in the mixed-sex sample.
Table 6
Social Support Interscale Correlations

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<th>All parent approval</th>
<th>All own parent approval</th>
<th>All partner parent approval</th>
<th>All parent disapproval</th>
<th>All own parent disapproval</th>
<th>All partner parent disapproval</th>
<th>Friend Approval</th>
<th>Friend Disapproval</th>
<th>Overall support for relationship</th>
<th>Own Family Support for relationship</th>
<th>Partner Family Support for relationship</th>
<th>Friend Support for relationship</th>
<th>General support: Significant other</th>
<th>General Support: Family</th>
<th>General Support: Friends</th>
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</thead>
<tbody>
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<td>.06</td>
<td>.05</td>
<td>-.11*</td>
<td>-.08</td>
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<td>.056</td>
<td>.04</td>
<td>.18**</td>
<td>1</td>
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<td>.34**</td>
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<tr>
<td>Significant other</td>
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</tr>
<tr>
<td>Family</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>**</td>
</tr>
<tr>
<td>Friends</td>
<td></td>
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<td></td>
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<td></td>
<td>**</td>
<td>**</td>
</tr>
</tbody>
</table>

* significant at p < .05
** significant at p < .001
**Hypothesis 1.2:** Social Support for Relationships and General Social Support will each account for a unique portion of the variance in related outcome measures (i.e., indicators of relationship well-being).

The second analysis conducted to help establish the discriminant validity of social support for relationships was a regression on the relationship outcome variables within the study. The relationship well-being variables were regressed on the social support variables; first, with general social support entered at the first step, followed by social support for relationships, and second, the reverse. Table 7 shows the pattern of associations between each of the predictor variables and each of the dependent variables split by relationship type. As shown in Table 8 (displaying a full sample regression analysis predicting dyadic adjustment), social support for relationship variables remained significant predictors of relationship well-being even when general social support variables were included in the model, thereby demonstrating that general social support and social support for relationships uniquely contribute to relationship well-being. Overall perceived social support for the relationship was a significant predictor across all models, as was general social support from a significant other. Approval of the relationship by friends was a significant predictor of all outcome measures except for relationship satisfaction, and general social support from friends was a significant predictor of love. The pattern of associations was consistent across both mixed-sex and same-sex relationships, and results did not differ when the regression was run on the full sample using relationship type as a moderating variable. As a moderator, relationship type was not a significant predictor within the model (e.g., for satisfaction, $\beta = -0.037, p = 0.334$). Furthermore, the pattern of coefficients and significance levels holds regardless of which set of variables is entered into the model first (SS4R or GSS), or whether the other set of predictors is present. In other words, social support for relationships does not cancel the effects of general social support, and vice versa, further demonstrating the divergent validity of these two constructs.

---

5 Social support for relationship(s)
6 General social support (not specifically for a relationship)
Table 7
Regression Summary Table

<table>
<thead>
<tr>
<th>Predictor variables</th>
<th>Love</th>
<th>Dyadic adjustment</th>
<th>Trust</th>
<th>Relationship satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall perceived social support for the relationship</td>
<td>.18**</td>
<td>.38***</td>
<td>.20***</td>
<td>.28***</td>
</tr>
<tr>
<td>Approval of the relationship from own parents</td>
<td>ns</td>
<td>ns</td>
<td>ns</td>
<td>ns</td>
</tr>
<tr>
<td>Approval of the relationship from Friends</td>
<td>.21***</td>
<td>.16**</td>
<td>.21***</td>
<td>.24***</td>
</tr>
<tr>
<td>Relationship Marginalization</td>
<td>ns</td>
<td>ns</td>
<td>ns</td>
<td>ns</td>
</tr>
<tr>
<td>General social support from significant other</td>
<td>.28***</td>
<td>.14*</td>
<td>.20***</td>
<td>.11*</td>
</tr>
<tr>
<td>General social support from family</td>
<td>ns</td>
<td>ns</td>
<td>ns</td>
<td>ns</td>
</tr>
<tr>
<td>General social support from friends</td>
<td>-.17**</td>
<td>-.13*</td>
<td>ns</td>
<td>ns</td>
</tr>
</tbody>
</table>

F (4,441) = 10.84 ***  
R^2 = .21

F (4,401) = 15.92 ***  
R^2 = .25

F (4,441) = 14.97 ***  
R^2 = .28

F (4,401) = 21.91 ***  
R^2 = .30

F (4,441) = 23.92 ***  
R^2 = .31

F (4,401) = 37.53 ***  
R^2 = .40

F (4,441) = 23.00 ***  
R^2 = .30

F (4,401) = 14.97 ***  
R^2 = .21

* p < .05, ** p < .01, *** p < .001
* Values reported are betas
Table 8
Sample Regression: Multiple Regression Analyses for Dyadic Adjustment

<table>
<thead>
<tr>
<th></th>
<th>Same-Sex</th>
<th>ΔR²</th>
<th>Mixed-Sex</th>
<th>ΔR²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>**.08</td>
<td>**.05</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Relationship length</td>
<td>-.15**</td>
<td>-.16**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship stage</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Hours per week together</td>
<td>.17***</td>
<td>--</td>
<td></td>
<td>--</td>
</tr>
<tr>
<td>Religion</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Education</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
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<tr>
<td>Household income</td>
<td>--</td>
<td>--</td>
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<td>--</td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>**.04</td>
<td></td>
<td>**.06</td>
<td></td>
</tr>
<tr>
<td>General support: significant other</td>
<td>.20***</td>
<td>.11*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General support: family</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>General support: friends</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall perceived support for relationship</td>
<td>.20***</td>
<td>.28***</td>
<td>.17</td>
<td></td>
</tr>
<tr>
<td>Approval from own parents</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Approval from friends</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Final test statistic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>F(4,431)=14.97***</td>
<td>F(4,389)=23</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>R²=.23</td>
<td>.28</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. Entries are standardized regression coefficients. Step 1 variables were entered as a block and assessed before entering Step 2 variables, Step 2 variables assessed after statistically controlling for Step 1 variables, and Step 3 variables were assessed after statistically controlling for all prior step variables. Results remained constant when sample was split by relationship type (as displayed above) and when relationship type was included as a moderating variable (entered at Step 1). * p < .05, ** p < .01, *** p < .001

Data Analysis Strategy

Objective two analyses were conducted using Structural Equation Modeling (SEM).

Confirmatory factor analysis (CFA) was used to ensure that the variables fit with the proposed factor structure. After establishing a proper factor structure, a series of structural equation analyses were performed to evaluate the fit of (a) the proposed model, broken up according to specific research questions and objectives; (b) of the proposed model across groups, testing for invariance; (c) alternative models; (d) models assessing the relative contributions of support for the relationship from parents versus friends.
All analyses were performed using AMOS 19.0 and 20.0 software. For all models, the first item of each factor was fixed to establish the factor’s scale. Results below report the chi-square, the Comparative Fit Index (CFI), the Root Mean-Square of Approximation (RMSEA), and the Standardized-Root Mean Square Residual (SRMR) for each model. In general, better fitting models have lower chi-square values, higher CFI (with values above .90 indicating good fit and values above .95 indicating very good fit), low RMSEA values (with scores below .10 indicating acceptable fit and below .05 indicating excellent fit; Bryne, 2006), and low SRMR values (values less than .08 indicate good model fit; Hu & Bentler, 1998). All factor loadings were evaluated at the .05 level.

When conducting factor analyses, one occasionally has to adjust the original hypothesized factor structure or structural model. There is a danger that such adjustments might “overfit” the observed data, fitting well in one particular sample, but not in others. To guard against such an occurrence, a random half of the sample is first used to generate an appropriate model. The second random half of the sample is held in reserve, and used to test the final model once it has been formulated. If the model fits the second sample well, then it suggests that the initial model derived has some generalizability, and does not fit only a single sample (Bryne, 2006; Mohr & Fassinger, 2003). This procedure was followed, both in the confirmatory factor analyses and in the initial structural model.

**Preliminary Screening Procedures**

Descriptive statistics for the variables used in Time 1 are presented in Table 9. After removing data from participants who had substantial missing data, a variety of methods were used to screen the data for potential problems, including problematic cases, missing data patterns, univariate normality, outliers, and multivariate normality, linearity and homoscedasticity. The procedures followed for each type of case is outlined below. Table 10 displays the correlation matrix for Time 1 scale variables.
Table 9
*Descriptive Statistics for Time 1 Scales*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Possible Range</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Same-Sex (n = 669)</td>
<td></td>
<td>Mixed-Sex (n = 609)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Social network variables</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perceived SS4R: Own Family</td>
<td>1-7</td>
<td>5.27</td>
<td>1.63</td>
<td>5.97</td>
<td>1.29</td>
</tr>
<tr>
<td>Perceived SS4R: Partner Family</td>
<td>1-7</td>
<td>5.05</td>
<td>1.74</td>
<td>5.99</td>
<td>1.25</td>
</tr>
<tr>
<td>Perceived SS4R: Overall</td>
<td>1-7</td>
<td>5.66</td>
<td>0.96</td>
<td>5.89</td>
<td>1.03</td>
</tr>
<tr>
<td>Perceived SS4R: Friends</td>
<td>1-7</td>
<td>6.25</td>
<td>0.98</td>
<td>6.13</td>
<td>1.08</td>
</tr>
<tr>
<td>General social support</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>General social support</td>
<td>1-5</td>
<td>4.05</td>
<td>0.73</td>
<td>4.10</td>
<td>0.77</td>
</tr>
<tr>
<td>Relationship well-being</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Love</td>
<td>1-7</td>
<td>5.71</td>
<td>0.88</td>
<td>5.64</td>
<td>0.92</td>
</tr>
<tr>
<td>Dyadic adjustment</td>
<td>31-147</td>
<td>90.01</td>
<td>9.69</td>
<td>89.56</td>
<td>9.86</td>
</tr>
<tr>
<td>Trust</td>
<td>1-7</td>
<td>5.77</td>
<td>0.91</td>
<td>5.78</td>
<td>0.86</td>
</tr>
<tr>
<td>Satisfaction</td>
<td>1-7</td>
<td>5.94</td>
<td>0.94</td>
<td>5.93</td>
<td>1.00</td>
</tr>
<tr>
<td>Commitment</td>
<td>0-9</td>
<td>7.20</td>
<td>1.25</td>
<td>7.20</td>
<td>1.26</td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>1-4</td>
<td>3.09</td>
<td>0.58</td>
<td>3.02</td>
<td>0.60</td>
</tr>
<tr>
<td>Perceived stress</td>
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<td>0.75</td>
<td>2.27</td>
<td>0.73</td>
</tr>
<tr>
<td>Depression</td>
<td>1-4</td>
<td>3.25</td>
<td>0.60</td>
<td>3.22</td>
<td>0.61</td>
</tr>
<tr>
<td>Approval for Relationship</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>From Friends</td>
<td>1-5</td>
<td>4.02</td>
<td>0.68</td>
<td>3.83</td>
<td>0.68</td>
</tr>
<tr>
<td>All parents</td>
<td>1-5</td>
<td>3.38</td>
<td>0.90</td>
<td>3.69</td>
<td>0.76</td>
</tr>
<tr>
<td>All own parents</td>
<td>1-5</td>
<td>3.39</td>
<td>1.09</td>
<td>3.67</td>
<td>0.87</td>
</tr>
<tr>
<td>All partner parents</td>
<td>1-5</td>
<td>3.41</td>
<td>1.10</td>
<td>3.74</td>
<td>0.89</td>
</tr>
<tr>
<td>Physical Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHIPS (physical symptoms)</td>
<td>0-4</td>
<td>3.37</td>
<td>0.54</td>
<td>3.36</td>
<td>0.58</td>
</tr>
<tr>
<td>SF12: Physical health</td>
<td>0-42</td>
<td>36</td>
<td>6.18</td>
<td>36.53</td>
<td>5.94</td>
</tr>
</tbody>
</table>

*aMental and physical health measures are scored so that higher scores indicate better health.*
### Table 10
**Correlations Matrix for Time 1 Variables**

<table>
<thead>
<tr>
<th>Overall support for relationship</th>
<th>Approval from all partner’s parents</th>
<th>Approval from own parents</th>
<th>Approval from Friends</th>
<th>General Social Support</th>
<th>Relationship Satisfaction</th>
<th>Trust</th>
<th>Dyadic Adjustment</th>
<th>Anxiety</th>
<th>Depression</th>
<th>Stress</th>
<th>SF12 Physical Health</th>
<th>CHIPS (physical symptoms)</th>
</tr>
</thead>
<tbody>
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<td>Overall support for relationship</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Approval from all partner’s</td>
<td>.41**</td>
<td>.29**</td>
<td></td>
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<td>parents</td>
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</tr>
<tr>
<td>Approval from own parents</td>
<td>.44**</td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Approval from friends</td>
<td>.41**</td>
<td>.32**</td>
<td>.31**</td>
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<td>General social support</td>
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<td>.14**</td>
<td>.26**</td>
<td>.23**</td>
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<td>Relationship satisfaction</td>
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<td>.27**</td>
<td>.28**</td>
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</tr>
<tr>
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<td>.23**</td>
<td>.22**</td>
<td>.30**</td>
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<tr>
<td>Dyadic adjustment</td>
<td>.37**</td>
<td>.24**</td>
<td>.20**</td>
<td>.32**</td>
<td>.20**</td>
<td>.55**</td>
<td>.57**</td>
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</tr>
<tr>
<td>Anxiety</td>
<td>.30**</td>
<td>.19**</td>
<td>.21**</td>
<td>.20**</td>
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<td>.38**</td>
<td>.40**</td>
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<tr>
<td>Depression</td>
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<td>.19**</td>
<td>.18**</td>
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<td>.40**</td>
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<td>Stress</td>
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<td>.20**</td>
<td>.17**</td>
<td>.25**</td>
<td>.37**</td>
<td>.39**</td>
<td>.29**</td>
<td>.79**</td>
<td>.77**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SF12 physical health</td>
<td>.26**</td>
<td>.22**</td>
<td>.19**</td>
<td>.12**</td>
<td>.26**</td>
<td>.31**</td>
<td>.29**</td>
<td>.22**</td>
<td>.71**</td>
<td>.71**</td>
<td>.63**</td>
<td></td>
</tr>
<tr>
<td>CHIPS (physical symptoms)</td>
<td>.16**</td>
<td>.10*</td>
<td>.12**</td>
<td>.01</td>
<td>.19**</td>
<td>.20**</td>
<td>.23**</td>
<td>.13**</td>
<td>.57**</td>
<td>.59**</td>
<td>.47**</td>
<td>.67**</td>
</tr>
</tbody>
</table>

** significant at p < .001
* significant at p < .05

Mental and Physical Health measures are scored such that higher scores represent better health.
Respondents Without Parents

One hundred and twenty-six respondents reported that either they, or their partner did not have any living parents, and thus did not provide data on the parent-related support measures (e.g., Parent approval). The data from these respondents were therefore deleted from the dataset. Appendix Z presents a structural model comparing the sample with and without parents; no significant differences in model fit were found.

Missing Values Analysis

Participants with substantial missing data (N=1566) (defined as missing all of the indicators of at least one factor) were deleted prior to forming the final sample for Time 1 analyses. Of the remaining 1281 participants, 20% (N=271) had missing values on one or more indicator variables. The pattern of missing values was therefore assessed using the SPSS Missing Values program. Little’s MCAR (Missing Completely at Random; 1988) test results indicated that the missing value pattern within this sample was not MCAR, $\chi^2(438) = 614.41, p = .001$. Further analyses (separate variance t-tests) indicated that the missing value pattern was missing at random (MAR), or in other words, the variables with missing values were not significantly related to the dependent variables (Tabachnick & Fidell, 2007). When data is MAR, it is acceptable to impute the missing data, and thus, an expectancy maximization procedure was used to impute the missing data (Tabachnick & Fidell, 2007).

Checking for Univariate Normality

Structural Equation Modeling can be significantly impacted by univariate nonnormality, as indicated by skewness and kurtosis (Kline, 2005). The mean composites in the dataset were assessed for skewness and kurtosis. Skew indices (skewness/SE) above three and kurtosis indices between 10 and 20 are indicative of nonnormality (Kline, 2005).

The findings in Table 11 indicate that all of the variables, with the exception of the Perceived Stress Scale, were highly skewed. A natural log function was used to transform the positively skewed variable and the negatively skewed variables were transformed using a three-step procedure (per
Tabachnick & Fidell, 2007): the variables were reverse-coded; then the reverse-coded scores were transformed using a natural log function; thereafter, the transformed scores were coded back to preserve their original directionality. The skewness of the transformed DAS (dyadic adjustment scale) variable was worse than the nontransformed version of the variable, and thus the original variable was used. All other transformed variables had acceptable levels of skewness and thus were used in subsequent Time 1 SEM analyses.

Table 11
(SKEW) Skewness and Kurtosis Statistics for the Study Variables (N = 1155)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Skewness</th>
<th>Kurtosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social network measures</td>
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<td></td>
</tr>
<tr>
<td>Overall perceived support</td>
<td>-.56</td>
<td>1.27</td>
</tr>
<tr>
<td>Own family support</td>
<td>-.12</td>
<td>.44</td>
</tr>
<tr>
<td>Partner family support</td>
<td>-.13</td>
<td>.20</td>
</tr>
<tr>
<td>Friend support</td>
<td>-.63</td>
<td>2.61</td>
</tr>
<tr>
<td>Approval for the relationship</td>
<td>-.61</td>
<td>-.14</td>
</tr>
<tr>
<td>All own parent approval</td>
<td>-.60</td>
<td>-.18</td>
</tr>
<tr>
<td>All partner parent approval</td>
<td>-.48</td>
<td>.46</td>
</tr>
<tr>
<td>Relationship well-being</td>
<td>-.56</td>
<td>1.27</td>
</tr>
<tr>
<td>Trust</td>
<td>-1.21</td>
<td>1.69</td>
</tr>
<tr>
<td>RAS</td>
<td>-1.38</td>
<td>1.99</td>
</tr>
<tr>
<td>Physical health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SF12</td>
<td>-1.70</td>
<td>3.70</td>
</tr>
<tr>
<td>CHIPS</td>
<td>-1.70</td>
<td>3.70</td>
</tr>
<tr>
<td>Mental health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety (STAI)</td>
<td>-.64</td>
<td>-.21</td>
</tr>
<tr>
<td>Depression (CESD)</td>
<td>-1.00</td>
<td>.38</td>
</tr>
<tr>
<td>Perceived stress (PSS)</td>
<td>-.31</td>
<td>-.30</td>
</tr>
</tbody>
</table>

Note. SE for skewness statistic = .07. SE for kurtosis statistic = .14.

**Screening for Outliers**

In order to detect univariate outliers, the mean scores for each scale were standardized and cases whose standardized values exceeded the absolute value of 3.29 were considered as outliers (Tabachnick & Fidell, 2007). This resulted in the removal of seven cases based on the DAS variable, one based on the SF12 (physical health measure), and three based on the CHIPS (physical symptoms).

Multivariate outliers were detected using five linear regression procedures. The five outcome measures (depression, anxiety, stress, physical symptoms, overall health) were regressed on the social
support for relationship, general social support, and relationship well-being composites. Cook’s Distance was used to detect outliers on the x- and y- spaces. Cases whose Cook’s D values were above two standard deviations of the Cook’s D mean were considered as possible multivariate outliers (Norusis, 1991). Cases found to be outliers on all five regressions were deemed multivariate outliers, and were subsequently deleted from the data set. Only one case fulfilled this criterion.

**Checking the Assumptions of Multivariate Normality, Linearity, and Homoscedasticity**

After removing the univariate and multivariate outliers, five linear regressions procedures were conducted to determine whether the assumptions of multivariate normality, linearity, and homoscedasticity were fulfilled. Multivariate normality was assessed via normal probability plots, such that when the plots are seen to fall towards the diagonal line, multivariate normality is fulfilled. The regressions for physical health (SF12), anxiety (STAI) and perceived stress (PSS) indicated that these variables met the assumption of multivariate normality, but the normal probability plots of the regressions for physical symptoms (CHIPS) and depression (CESD), did not have points falling close to the diagonal line, and thus the assumption of multivariate normality was not completely fulfilled. Given the large sample size for the study, and the fact that variables had already been transformed, no other adjustments were made to the data.

Linearity and homoscedasticity were assessed via the plot of the standardized residuals by the standardized predicted values. The assumptions of linearity and homoscedasticity are considered fulfilled when the plot results in a random scatter (as opposed to a U or funnel-shaped pattern). Random scatter plots were observed for all variables, and thus the assumptions of linearity and homoscedasticity were fulfilled.

**Confirmatory Factor Analysis Results**

Two measurement models were initially tested, one which specified a single social support for relationship factor (Figure 7), indicated by social support for the relationship from all sources (parents and friends), and one which split the social support for the relationship into two separate constructs (Figure 8),
one for parents and one for friends. The results for both models, and their subsequently revised versions, are shown in Table 12.

**Results for the Measurement Model with Single Social Support for Relationship Construct**

As shown in Table 12, the measurement model with a single Support for Relationship construct did not fit the data well. Thus, the model was revised based on two criteria: items with standardized coefficients below .50 were deleted (per Hair, Black, Babin & Anderson, 2010), and items loading onto several items or constructs (as reflected by their high modification indices) were deleted (per Byrne, 2001). This process resulted in the love and commitment scales not being included as indicators of relationship well-being.

Three of the General Social Support items had standardized factor loadings below .50. Thus, General social support items 3, 8, and 11 (Family subscale) were deleted. In addition, because General Support item 4 (“I get the emotional help and support I need”) was loading highly on to several items and constructs (e.g., the modification index indicating that it was loading highly on to All Own Parent Approval was 88.94; the modification index indicating that it was loading highly on to RAS was 67.03; the modification index indicating that it was loading highly on to Trust was 49.14) and thus was not demonstrating discriminant validity, General Support item 4 was deleted from the model.

The indicator for approval of relationship from a participant’s own parents (All Own Parent Approval) had a standardized loading below .50, and was thus removed from the model. When this was deleted, however, the standardized factor loading for approval of the relationship from the participant’s partner’s parents also dropped below .50. In order to retain a parental approval variable in the model, approval collapsed across all parents (participant’s parents and their partner’s parents) was used instead.

The revised model (Model 1 Revised in Table 14) fit the data well; the CFI was above .97 and the RMSEA and SRMR values were below their respective criterion. Additionally, all indicator variables

---

7 Item 4 of the Multidimensional Scale of Perceived Social Support (MDSPSS) is supposed to read: “I get the emotional help and support I need from my family,” but in this study, the “from my family” portion of the item was omitted by error. Thus, this item was not a good indicator of the MDSPSS Family Subscale and could easily have been related to the MDSPSS Significant Other Subscale.
loaded significantly onto their respective constructs (as shown in Table 15), and all correlations were statistically significant and in the predicted directions (as shown in Table 16).
Figure 7. Confirmatory factor analysis with a single social support for relationships factor.
Table 12
**CFA Model Results: Chi-Square Statistics and Fit Indices for the Measurement Models**

<table>
<thead>
<tr>
<th>Index</th>
<th>Model 1 proposed</th>
<th>Model 1 revised</th>
<th>Model 2 proposed</th>
<th>Model 2 revised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chi-square</td>
<td>1521.55</td>
<td>253.80</td>
<td>869.24</td>
<td>246.66</td>
</tr>
<tr>
<td>Degrees of freedom</td>
<td>160.00</td>
<td>80.00</td>
<td>137.00</td>
<td>89.00</td>
</tr>
<tr>
<td>Sig.</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
</tr>
<tr>
<td>Comparative fit index (CFI)</td>
<td>.81</td>
<td>.97</td>
<td>.90</td>
<td>.97</td>
</tr>
<tr>
<td>Root mean squared error (RMSEA)</td>
<td>.12</td>
<td>.06</td>
<td>.10</td>
<td>.06</td>
</tr>
<tr>
<td>Lower bound of 90 percent confidence interval</td>
<td>.12</td>
<td>.05</td>
<td>.09</td>
<td>.05</td>
</tr>
<tr>
<td>Upper bound of 90 percent confidence interval</td>
<td>.13</td>
<td>.07</td>
<td>.10</td>
<td>.06</td>
</tr>
<tr>
<td>Standardized root mean square residual (SRMR)</td>
<td>.11</td>
<td>.04</td>
<td>.08</td>
<td>.03</td>
</tr>
</tbody>
</table>

1 Error variance for Partner Parent Approval was negative. Therefore, the solution was not admissible.

Table 13
**Model 1 Factor Loadings: Factor Loadings for the Revised Single Support Construct Measurement Model**

<table>
<thead>
<tr>
<th>Path</th>
<th>B</th>
<th>SE</th>
<th>β</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>General support to</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SS 6</td>
<td>1.08</td>
<td>.04</td>
<td>.92</td>
<td>29.15</td>
</tr>
<tr>
<td>SS 7</td>
<td>1.11</td>
<td>.04</td>
<td>.92</td>
<td>29.12</td>
</tr>
<tr>
<td>SS 9</td>
<td>1.03</td>
<td>.04</td>
<td>.87</td>
<td>26.50</td>
</tr>
<tr>
<td>SS 12</td>
<td>1.00</td>
<td>.84</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support for the relationship to</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Network support</td>
<td>2.41</td>
<td>.22</td>
<td>.84</td>
<td>11.11</td>
</tr>
<tr>
<td>All parent approval</td>
<td>1.36</td>
<td>.13</td>
<td>.63</td>
<td>10.32</td>
</tr>
<tr>
<td>Friends approval</td>
<td>1.00</td>
<td>.53</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship well-being to</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust</td>
<td>.95</td>
<td>.05</td>
<td>.86</td>
<td>20.77</td>
</tr>
<tr>
<td>DAS</td>
<td>1.94</td>
<td>.11</td>
<td>.70</td>
<td>17.13</td>
</tr>
<tr>
<td>RAS</td>
<td>1.00</td>
<td>.82</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical health to</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SF12</td>
<td>1.00</td>
<td>.95</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHIPS</td>
<td>.43</td>
<td>.02</td>
<td>.72</td>
<td>19.16</td>
</tr>
<tr>
<td>Mental health to</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perceived stress</td>
<td>1.00</td>
<td>.84</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>1.71</td>
<td>.06</td>
<td>.90</td>
<td>27.60</td>
</tr>
<tr>
<td>Anxiety</td>
<td>1.60</td>
<td>.91</td>
<td></td>
<td>28.02</td>
</tr>
</tbody>
</table>

* p < .05. ** p < .01. *** p < .001.
Table 14  
*Model 1 Correlations: Correlations between the Constructs in the Revised Single Support Construct Measurement Model*

<table>
<thead>
<tr>
<th>Construct</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Support for the relationship</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Relationship well-being</td>
<td>.69***</td>
<td>.39***</td>
<td>.85***</td>
<td>.27***</td>
</tr>
<tr>
<td>3 Physical health</td>
<td>.30***</td>
<td>.53***</td>
<td>.22***</td>
<td></td>
</tr>
<tr>
<td>4 Mental health</td>
<td>.38***</td>
<td>.19***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 General support</td>
<td>.30***</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p < .05. ** p < .01. *** p < .001.

Results for the Measurement Model with Two Social Support for Relationship Constructs

As shown in Table 12, the measurement model with two social support for relationship constructs (one for parents and one for friends) did not fit the data well. Thus, the model was revised, following the same procedures outlined above. Support for the relationship from parents, own parent approval of the relationship, and support for the relationship from friends all had factor loadings less than .50 and were deleted from the model. Subsequently, the error variance for partner parent approval of the relationship became negative and the solution was not admissible. Because of this and because the other two parental indicator variables had been dropped, the revised version of the first measurement model, with only a single support for relationship construct was selected for all subsequent analyses.
Figure 8. Confirmatory factor analysis with two social support for relationships factors.
Results for the Generalizability of the Revised Model With a Single Support Construct

After establishing the revised measurement model, this model was tested on the second random half of the sample, and is depicted in Figure 9. As shown in Table 15, the model fit the data well: the CFI was above .95, the RMSEA and SRMR values were below their respective criteria. Further, all indicator variables loaded significantly onto their respective constructs and all correlations were statistically significant and in the predicted directions.

Table 15

*CFA 2nd Half: Chi-Square Statistic and Fit Indices for the Revised Measurement Model With a Single Support Construct Within Sample 2*

<table>
<thead>
<tr>
<th>Index</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chi-square</td>
<td>239.00</td>
</tr>
<tr>
<td>Degrees of freedom</td>
<td>80.00</td>
</tr>
<tr>
<td>Sig.</td>
<td>.00</td>
</tr>
<tr>
<td>Comparative fit index (CFI)</td>
<td>.97</td>
</tr>
<tr>
<td>Root mean squared error (RMSEA)</td>
<td>.06</td>
</tr>
<tr>
<td>Lower bound of 90 percent confidence interval</td>
<td>.05</td>
</tr>
<tr>
<td>Upper bound of 90 percent confidence interval</td>
<td>.07</td>
</tr>
<tr>
<td>Standardized root mean square residual (SRMR)</td>
<td>.03</td>
</tr>
</tbody>
</table>
Figure 9. Confirmatory factor analysis with the single social support construct (tested within the second subsample).
Results of the Structural Model Tests

**Hypothesis 2.1:** It is hypothesized that the model depicted in Figure 1 will fit the data collected in the first phase of the current study.

**Results for the Structural Model: Split Random Halves**

Consistent with the Confirmatory Factor Analysis procedures, the proposed structural model was tested first on one random half of the sample and then repeated on the second random half of the sample. The proposed model, depicted in Figure 10, fit the data well. The fit indices are reported in Table 16. All coefficients of the hypothesized paths were statistically significant and in the predicted direction. The model was then tested on the second random half of the sample. This model is depicted in Figure 11 and also fit the data well, with statistically significant coefficients for the hypothesized paths in the predicted directions.

A simultaneous group analysis was conducted to determine whether the path coefficients in the proposed structural model were invariant across the two subsamples. The following steps were taken to establish invariance:

1. The model was tested simultaneously in both groups, allowing all path coefficients to vary freely; this was the unconstrained model and served as a baseline.
2. The model was then tested simultaneously with all path coefficients specified to be equal across groups; this was the fully constrained model.
3. To determine invariance between the two groups, it is necessary to observe the change in chi-square between the unconstrained and the constrained models. If the change in chi-square is statistically significant, then further single degree of freedom comparisons are made, where a single path is set to free to vary. The change in chi-square is then observed as each successive path is set free to vary. Any significant changes in the chi-square value indicate that the path coefficient set free in that particular comparison is *not* invariant, or in other words, is significantly different across the groups being compared.
The change in chi-square between the unconstrained and constrained models was not significant ($\Delta \chi^2 (6) = 2.99, NS$), indicating that the proposed structural model fit both random halves of the sample equally well.

Figure 10. Standardized coefficients for the proposed structural model (first subsample).
Figure 11. Standardized coefficients for the proposed structural model (second subsample).

<table>
<thead>
<tr>
<th>Index</th>
<th>Subsample 1</th>
<th>Subsample 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chi-square</td>
<td>254.64</td>
<td>242.18</td>
</tr>
<tr>
<td>Degrees of freedom</td>
<td>82.00</td>
<td>82.00</td>
</tr>
<tr>
<td>Sig.</td>
<td>.00</td>
<td>.00</td>
</tr>
<tr>
<td>Comparative fit index (CFI)</td>
<td>.97</td>
<td>.97</td>
</tr>
<tr>
<td>Root mean squared error (RMSEA)</td>
<td>.06</td>
<td>.06</td>
</tr>
<tr>
<td>Lower bound of 90 percent confidence interval</td>
<td>.05</td>
<td>.05</td>
</tr>
<tr>
<td>Upper bound of 90 percent confidence interval</td>
<td>.07</td>
<td>.07</td>
</tr>
<tr>
<td>Standardized root mean square residual (SRMR)</td>
<td>.04</td>
<td>.04</td>
</tr>
</tbody>
</table>
Results for the Structural Model With the Whole Sample

As shown in Table 16, the proposed structural model fit both random halves of the sample equally well and thus the samples were combined. The model was then tested on the whole sample, and is depicted in Figure 11. The fit indices of the model are summarized in Table 17 and, as expected, the model fit the data well; the coefficients of the hypothesized paths were statistically significant and in the predicted directions.

Figure 12. Standardized coefficients for the proposed structural model without the control variables.
The proposed structural model was then tested while controlling for two variables significantly related to relationship well-being: the amount of time a couple spent together each week (hours per week) and the length of the relationship. As shown in Table 17, the model with the control variables had adequate fit. Note that (as depicted in Table 12 and presented in Table 18 and
Table 19), the magnitude of the standardized path coefficient between Support for the Relationship and Relationship Well-Being increased from .67 to .70 when the control variables were included in the model. Table 20 provides a summary of the fit indices for all Time 1 CFA and SEM models.

Table 17

*Chi-Square Statistics and Fit Indices for the Proposed Structural Models*

<table>
<thead>
<tr>
<th>Index</th>
<th>Without controls</th>
<th>With controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chi-square</td>
<td>401.59</td>
<td>495.68</td>
</tr>
<tr>
<td>Degrees of freedom</td>
<td>82.00</td>
<td>106.00</td>
</tr>
<tr>
<td>Sig.</td>
<td>.00</td>
<td>.00</td>
</tr>
<tr>
<td>Comparative fit index (CFI)</td>
<td>.97</td>
<td>.97</td>
</tr>
<tr>
<td>Root mean squared error (RMSEA)</td>
<td>.06</td>
<td>.06</td>
</tr>
<tr>
<td>Lower bound of 90 percent confidence interval</td>
<td>.05</td>
<td>.05</td>
</tr>
<tr>
<td>Upper bound of 90 percent confidence interval</td>
<td>.06</td>
<td>.06</td>
</tr>
<tr>
<td>Standardized root mean square residual (SRMR)</td>
<td>.04</td>
<td>.04</td>
</tr>
</tbody>
</table>

*Note.* Control variables: Relationship length in months and hours spent together per week.

Table 18

*Path Coefficients for the Proposed Structural Model Without the Control Variables*

<table>
<thead>
<tr>
<th>Path</th>
<th>B</th>
<th>SE</th>
<th>β</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support for relationship to relationship well-being</td>
<td>.69</td>
<td>.05</td>
<td>.67</td>
<td>13.61***</td>
</tr>
<tr>
<td>General support to relationship well-being</td>
<td>.01</td>
<td>.01</td>
<td>.02</td>
<td>.56</td>
</tr>
<tr>
<td>Relationship well-being to physical health</td>
<td>.49</td>
<td>.05</td>
<td>.35</td>
<td>10.53***</td>
</tr>
<tr>
<td>Relationship well-being to mental health</td>
<td>.23</td>
<td>.02</td>
<td>.49</td>
<td>15.03***</td>
</tr>
<tr>
<td>General support to physical health</td>
<td>.09</td>
<td>.02</td>
<td>.16</td>
<td>5.00  ***</td>
</tr>
<tr>
<td>General support to mental health</td>
<td>.03</td>
<td>.01</td>
<td>.18</td>
<td>6.27  ***</td>
</tr>
</tbody>
</table>

* * p < .05. ** p < .01. *** p < .001.
Table 19

*Path Coefficients for the Proposed Structural Model with the Control Variables*

<table>
<thead>
<tr>
<th>Path</th>
<th>B</th>
<th>SE</th>
<th>β</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support for relationship to relationship well-being</td>
<td>.69</td>
<td>.05</td>
<td>.70</td>
<td>13.78</td>
</tr>
<tr>
<td>General support to relationship well-being</td>
<td>-.00</td>
<td>.01</td>
<td>-.00</td>
<td>-.11</td>
</tr>
<tr>
<td>Hours per week to relationship well-being</td>
<td>.01</td>
<td>.00</td>
<td>.04</td>
<td>1.50</td>
</tr>
<tr>
<td>Relationship length to relationship well-being</td>
<td>-.02</td>
<td>.00</td>
<td>-.19</td>
<td>-6.60</td>
</tr>
<tr>
<td>Relationship well-being to physical health</td>
<td>.49</td>
<td>.05</td>
<td>.35</td>
<td>10.50</td>
</tr>
<tr>
<td>Relationship well-being to mental health</td>
<td>.23</td>
<td>.02</td>
<td>.49</td>
<td>14.98</td>
</tr>
<tr>
<td>General support to physical health</td>
<td>.09</td>
<td>.02</td>
<td>.16</td>
<td>5.00</td>
</tr>
<tr>
<td>General support to mental health</td>
<td>.03</td>
<td>.01</td>
<td>.18</td>
<td>6.27</td>
</tr>
</tbody>
</table>

* p < .05. ** p < .01. *** p < .001.

1 Control variable

Table 20

*Time 1 Summary: Summary Table of Final CFA and Structural Models Chi-Square, CFI, RMSEA, and SRMR*

<table>
<thead>
<tr>
<th>CFA</th>
<th>χ² (df)</th>
<th>CFI</th>
<th>RMSEA</th>
<th>SRMR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st half</td>
<td>253.8 (80)</td>
<td>.97</td>
<td>.06</td>
<td>.04</td>
</tr>
<tr>
<td>2nd half</td>
<td>239.0 (80)</td>
<td>.97</td>
<td>.06</td>
<td>.03</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Structural</th>
<th>χ² (df)</th>
<th>CFI</th>
<th>RMSEA</th>
<th>SRMR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st half</td>
<td>245.64 (82)</td>
<td>.97</td>
<td>.06</td>
<td>.04</td>
</tr>
<tr>
<td>2nd half</td>
<td>242.18 (82)</td>
<td>.97</td>
<td>.06</td>
<td>.04</td>
</tr>
</tbody>
</table>

| Full sample structural model w/o controls                          | 401.59 (82) | .97 | .06   | .04  |
| Full sample structural model w/ controls                           | 495.68 (106)| .97 | .06   | .04  |
Figure 13. Standardized coefficients for the proposed structural model with the control variables.
Testing the Proposed Structural Model With the Data from Blair and Holmberg (2008)

In order to test the proposed structural model from the current study against the model tested by Blair and Holmberg (2008), the structural model had to be slightly revised due to discrepancies in the variables used by each study. In the Blair and Holmberg (2008) model, relationship well-being was indicated by love, trust, and relationship satisfaction. In the current study, relationship well-being is indicated by trust, relationship satisfaction, and dyadic adjustment. Although data on love using the same scale (Rubin, 1970) was used in the current study, this variable correlated too highly with the other variables in the model to be included. Thus, in the comparison model, relationship well-being was indicated by the two overlapping variables: trust and relationship satisfaction. Social support for the relationship was indicated by overall perceived social support, own parent support and friend support (Behavior of Friends and Family approval and disapproval subscales collapsed).

After revising the model based on available measures in each study, the model was tested first using the current study’s data set and then with the Blair and Holmberg (2008) data set. As described below, the model fit both the current data and the Blair-Holmberg data well, and thus a simultaneous group analysis was conducted to determine whether the path coefficients were invariant across groups, or in other words, whether or not the associations between factors were similar in both data sets.

Results for the Simultaneous Group Analysis With the Current and Blair-Holmberg Data Sets

Table 21 indicates that the structural model was not invariant across groups, $\Delta \chi^2 (3) = 102.29, p < .001$, or in other words, the model does not fit both data sets equally well. In order to determine exactly where the difference between the data sets lies, additional tests, following the procedure outlined above, were conducted.

Two of the main paths in the model were found to be significantly different between the two data sets, as depicted in Table 13. The path coefficient between Support for the Relationship and Relationship Well-Being was not significantly different, $\Delta \chi^2 (1) = 3.54, NS$. The path coefficients between Relationship Well-Being and the two outcome measures, physical and mental health were significantly different; $\Delta \chi^2 (1) = 13.83, p < .001$ and $\Delta \chi^2 (1) = 36.37, p < .001$, respectively. In both cases, the path
coefficients were stronger in the current data set; $\beta = .38$, $p = .001$ in the current data set for physical health compared to $\beta = .31$, $p = .001$ in the Blair-Holmberg data set; and $\beta = .53$, $p = .001$ in the current data set for mental health compared to $\beta = .45$, $p = .001$ in the Blair-Holmberg data set. The $R^2$ values for each factor are presented in Table 22, and indicate the proportion of the variance in each factor accounted for by the model.

Table 21

**Simultaneous Group Analysis for the Current and Blair-Holmberg (2008) Data Sets**

<table>
<thead>
<tr>
<th>Model</th>
<th>$\chi^2$</th>
<th>df</th>
<th>CFI</th>
<th>$\Delta\chi^2$</th>
<th>$\Delta df$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current data</td>
<td>137.74</td>
<td>31</td>
<td>.98</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blair and Holmberg Data</td>
<td>88.96</td>
<td>31</td>
<td>.97</td>
<td>102.29</td>
<td>3</td>
</tr>
<tr>
<td>Unconstrained model</td>
<td>224.75</td>
<td>62</td>
<td>.98</td>
<td>3.54</td>
<td>1</td>
</tr>
<tr>
<td>Constrained model</td>
<td>327.04</td>
<td>65</td>
<td>.98</td>
<td>13.83</td>
<td>1</td>
</tr>
<tr>
<td>Support to relationship well-being</td>
<td>228.29</td>
<td>63</td>
<td>.98</td>
<td>36.37</td>
<td>1</td>
</tr>
<tr>
<td>constrained</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well-being to physical health constrained</td>
<td>238.58</td>
<td>63</td>
<td>.98</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well-being to mental health constrained</td>
<td>261.12</td>
<td>63</td>
<td>.99</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

_Note._ Critical $\chi^2 (1) = 3.84, p < .05$. Critical $\chi^2 (3) = 10.83, p < .05$. Critical $\chi^2 (3) = 16.27, p < .01$. 
Figure 14A. Standardized coefficients for the current (Fig. 14A) and Blair-Holmberg (Fig. 14B) models.
Figure 14B. Standardized coefficients for the current (Fig. 14A) and Blair-Holmberg (Fig. 14B) models.
Table 22
Comparison of R² Values

<table>
<thead>
<tr>
<th></th>
<th>Relationship well-being</th>
<th>Mental health</th>
<th>Physical health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blair-Holmberg (2008)</td>
<td>.57</td>
<td>.15</td>
<td>.03</td>
</tr>
<tr>
<td>Current study Time 1 final model</td>
<td>.49</td>
<td>.23</td>
<td>.12</td>
</tr>
<tr>
<td>Blair-Holmberg comparison model</td>
<td>.53</td>
<td>.20</td>
<td>.10</td>
</tr>
<tr>
<td>Current study comparison model</td>
<td>.49</td>
<td>.28</td>
<td>.14</td>
</tr>
</tbody>
</table>

Note: Blair-Holmberg (2008) model refers to the published results; Current Study Time 1 Final Model refers to the final structural model presented in Figure 13; Blair-Holmberg and Current Study Comparison Models refer to models depicted in Figures 14A and 14B.

The Structural Model Across Relationship Type

**Hypothesis 2.2a:** The hypothesized model will fit the data for individuals in same-sex relationships.

**Hypothesis 2.2b:** The hypothesized model will fit the data for individuals in mixed-sex relationships.

In order to compare how the proposed model fit the data of subsamples divided by relationship type (same-sex versus mixed-sex), a simultaneous group analysis was conducted. The findings in Table 23 indicate that the structural model tested in Hypothesis 2.1 fit for both individuals in same-sex and individuals in mixed-sex relationships. The models are shown in Figure 15. Furthermore, the model was invariant across both types of couples, Δχ² (3) = 3.29, NS. Table 24 displays the R² values across groups; despite the discrepancies between groups, none of the path coefficients were found to vary significantly between groups.

Table 23
Simultaneous Group Analysis for Same-Sex and Mixed-Sex Couples

<table>
<thead>
<tr>
<th>Model</th>
<th>χ²</th>
<th>df</th>
<th>CFI</th>
<th>Δχ²</th>
<th>Δdf</th>
</tr>
</thead>
<tbody>
<tr>
<td>Same-sex</td>
<td>120.63</td>
<td>40</td>
<td>.97</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mixed-sex</td>
<td>128.14</td>
<td>40</td>
<td>.98</td>
<td>3.29</td>
<td>3</td>
</tr>
<tr>
<td>Unconstrained model</td>
<td>248.77</td>
<td>80</td>
<td>.98</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constrained model</td>
<td>252.06</td>
<td>83</td>
<td>.97</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. Critical χ² (3) = 7.82, p < .05.
Figure 15. Standardized coefficients for same-sex (top) and mixed-sex (bottom) models.
Table 24

*Relationship Type R-Squares*

<table>
<thead>
<tr>
<th></th>
<th>Relationship well-being</th>
<th>Mental health</th>
<th>Physical health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Same-sex</td>
<td>.38</td>
<td>.30</td>
<td>.14</td>
</tr>
<tr>
<td>Mixed-sex</td>
<td>.56</td>
<td>.26</td>
<td>.16</td>
</tr>
</tbody>
</table>

**Research Question 2.1:** Do any alternative models fit the data better than the hypothesized model?

An artifact of Structural Equation Modeling is that, due to its reliance on the sample’s correlation matrix, any theoretical model that allows for a similar factor structure, allows social support for the relationship and relationship well-being to correlate, and allows physical and mental health to correlate, is going to fit the data rather well. Thus, the theoretical basis for a hypothesized model versus any alternative models is very important for deciphering a model that provides not only the best fit to the data but also the most parsimonious and theoretically sound explanation of the data that best represents the actual experiences of the participants in question (Byrne, 2006). The following presents the results of three alternative structural models, each of which makes some theoretical sense and retains the parsimony of the hypothesized model.

The three alternative structural models tested with the current data set are depicted in Figures 15 through 18. The models run can be described as a reverse mediation model, in which the direction of the relationship between Support for the Relationship and Relationship Well-being is reversed, a fully reversed model, and a direct effects model, where Social Support for the Relationship predicts relationship well-being, mental and physical health directly. The reverse mediation model is depicted in Figure 16 and the fit indices are shown in...
Table 25. As shown in the table, the model fit the data well, although the fit indices were slightly lower than those found for the proposed structural model.
Table 25
Chi-Square Statistics and Fit Indices for the Alternative Structural Models

<table>
<thead>
<tr>
<th>Index</th>
<th>Reverse mediation</th>
<th>Fully reversed</th>
<th>Direct effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chi-square</td>
<td>273.35</td>
<td>180.18</td>
<td>496.773</td>
</tr>
<tr>
<td>Degrees of freedom</td>
<td>40.00</td>
<td>40.00</td>
<td>41.00</td>
</tr>
<tr>
<td>Sig.</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
</tr>
<tr>
<td>Comparative fit index (CFI)</td>
<td>.97</td>
<td>.98</td>
<td>.93</td>
</tr>
<tr>
<td>Root mean squared error (RMSEA)</td>
<td>.07</td>
<td>.06</td>
<td>.10</td>
</tr>
<tr>
<td>Lower bound of 90 percent confidence interval</td>
<td>.06</td>
<td>.05</td>
<td>.09</td>
</tr>
<tr>
<td>Upper bound of 90 percent confidence interval</td>
<td>.08</td>
<td>.06</td>
<td>.11</td>
</tr>
<tr>
<td>Standardized root mean square residual (SRMR)</td>
<td>.07</td>
<td>.03</td>
<td>.03</td>
</tr>
</tbody>
</table>

Figure 16. Standardized coefficients for the alternative model with relationship well-being.
To determine whether social support for the relationship mediated the association between relationship well-being and mental and physical health, a second reverse mediation model, depicted in Figure 17, was tested. Per Kline (2005), a variable is deemed a mediator when the indirect effect is statistically significant but the direct effect is not statistically significant. To test the significance of the direct and indirect effects, bootstrapping ($N$ of samples = 1000) was used to generate the two-tailed significance values of the direct and indirect effects of the model constructs.

As shown in Table 26, the direct effect of relationship well-being on physical health ($\beta = .30, p = .002$) was statistically significant. However, the indirect effect of relationship well-being on physical health was not statistically significant ($\beta = .07, p = .066$). Therefore, social support did not mediate the effects of relationship well-being on physical health. Similarly, the direct effect of relationship well-being on mental health ($\beta = .46, p = .002$) was statistically significant, but the indirect effect of relationship well-being on mental health was not statistically significant ($\beta = .05, p = .098$). Thus, social support for the relationship did not mediate the effects of relationship well-being on health.

Table 26

*Direct and Indirect Effects of Relationship Well-Being on Physical and Mental Health*

<table>
<thead>
<tr>
<th>Constructs</th>
<th>$B$</th>
<th>$SE$</th>
<th>$\beta$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship well-being and physical health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct effect</td>
<td>.19</td>
<td>.05</td>
<td>.30 **</td>
</tr>
<tr>
<td>Indirect effect</td>
<td>.04</td>
<td>.04</td>
<td>.07</td>
</tr>
<tr>
<td>Relationship well-being and mental health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct effect</td>
<td>.10</td>
<td>.05</td>
<td>.46 **</td>
</tr>
<tr>
<td>Indirect effect</td>
<td>.01</td>
<td>.03</td>
<td>.05</td>
</tr>
</tbody>
</table>

* $p < .05$. ** $p < .01$. *** $p < .001$. **
The second alternative model was the fully reversed model, where both mental and physical health were posited to affect relationship well-being, and in turn, social support for the relationship. This model is depicted in Figure 18, and as shown by the fit indices in

Figure 17. Structural model with direct effects from relationship well-being to physical and mental health.
Table 25, the model fit the data well, although the relationship between physical health and relationship well-being was negative and therefore not in the predicted direction.

The third alternative model was a direct effects model, in which social support for the relationship is predicted to have direct associations with the three outcome variables, relationship well-being, and mental and physical health. This model is depicted in Figure 19 with fit indices displayed in
Table 25. The model had a weaker fit than the hypothesized model, but the path coefficients were all significant and in the predicted direction (i.e., social support for the relationship directly predicted relationship well-being, mental and physical health). Compared to the other two alternatives models, this model had significantly weaker fit indices (CFI = .93 Versus CFI = .97 and CFI = .98 for the reverse mediation and fully reversed models respectively). The weakened fit is likely a result of relationship well-being not being allowed to correlate with the mental and physical health factors. Consequently, an additional model was run specifying the hypothesized model but also specifying direct paths between social support for the relationship and health outcome factors. In this model, depicted in Figure 20, the path coefficients between social support and the health outcome factors are not significant. Furthermore, the fit indices for this model were significantly improved over the fit indices for the model depicted in Figure 19 ($\chi^2 (38)= 176.1, p < .001, \text{CFI} = .98, \text{RMSEA} = .06, \text{SRMR} = .03$). The results from these two models combined indicate that the path between social support for the relationship and the health outcome variables is fully mediated by relationship well-being.

To determine whether relationship well-being mediated the relationship of social support for the relationship to mental and physical health, a second direct effects model, depicted in Figure 20, was tested. Per Kline (2005), a variable is deemed a mediator when the indirect effect is statistically significant but the direct effect is not statistically significant. To test the significance of the direct and indirect effects, bootstrapping (N of samples = 1000) was used to generate the two-tailed significance values of the direct and indirect effects of the model constructs.

As shown in Table 27, the direct effect of support for relationships on physical health ($\beta = .05, p = .057$) was not statistically significant. However, the indirect effect of support for relationships on physical health was statistically significant ($\beta = .21, p = .002$). Therefore, it can be concluded that relationship well-being fully mediates the effect of perceived social support for relationships on physical well-being. The same pattern of insignificant direct effects ($\beta = .05, p = .067$) and significant indirect effects ($\beta = .31, p = .002$) was found when examining the association between social support for
relationships and mental health. Thus, relationship well-being fully mediates the association between social support for relationships and both of mental and physical health.

**Figure 19. Standardized path coefficients for the direct effects alternative model, constraining the paths between relationship well-being and health factors to 0.**
Table 27

Model Mediation: Direct and Indirect Effects on Physical and Mental Health

<table>
<thead>
<tr>
<th>Constructs</th>
<th>$B$</th>
<th>$SE$</th>
<th>$\beta$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support for relationship and physical health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct effect</td>
<td>.15</td>
<td>.08</td>
<td>.05</td>
</tr>
<tr>
<td>Indirect effect</td>
<td>.30</td>
<td>.05</td>
<td>.21 **</td>
</tr>
<tr>
<td>Support for relationship and mental health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct effect</td>
<td>.04</td>
<td>.02</td>
<td>.05</td>
</tr>
<tr>
<td>Indirect effect</td>
<td>.16</td>
<td>.02</td>
<td>.31 **</td>
</tr>
</tbody>
</table>

* $p < .05$. ** $p < .01$. *** $p < .001$.
Figure 20. Standardized path coefficients for the direct effects model, allowing the paths between relationship well-being and health outcomes to vary freely.

**Objective 3: Parents Versus Friends**

*Hypothesis 3.1:* Social support for the relationship from parents will fail to predict outcome variables within the hypothesized model.

**Results of a Structural Model Assessing Differential Effects of Parents’ and Friends’ Approval of Relationship on Relationship Well-being**

To assess the relative contributions of social support for the relationship from friends versus parents, a structural model was proposed to tease apart these effects. The variables used for support were approval of the relationship from friends to indicate support from friends, and parental support for the relationship was indicated by approval from the participant’s own parents and approval from the participant’s partner’s parents.

The model depicted in Figure 21 fit the data well, as indicated by the fit indices presented in Table 28. The findings reveal that parental approval of the relationship had a stronger effect on relationship well-being ($\beta = .42, p = .001$) than did approval of the relationship from friends ($\beta = .13, p = .004$).

Thus, Hypothesis 3.1, that parents would be a non-significant predictor in the model, was not supported. However, as shown in Table 12, attempting to fit a model that included separate support from friends and support from parents, while still maintaining general social support and multiple indicators of each support for the relationship factor, produced a negative error variance for parental approval, and thus could not be used in the subsequent structural models.
Figure 21. Standardized coefficients for the model assessing differential effects of parental and friend approval on relationship well-being.

Table 28
Chi-Square Statistic and Fit Indices for the Structural Model Assessing the Differential Effects of Parental and Friend Approval on Relationship Well-Being

<table>
<thead>
<tr>
<th>Index</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chi-square</td>
<td>112.79</td>
</tr>
<tr>
<td>Degrees of freedom</td>
<td>39.00</td>
</tr>
<tr>
<td>Sig.</td>
<td>.00</td>
</tr>
<tr>
<td>Comparative fit index (CFI)</td>
<td>.99</td>
</tr>
<tr>
<td>Root mean squared error (RMSEA)</td>
<td>.04</td>
</tr>
<tr>
<td>Lower bound of 90 percent confidence interval</td>
<td>.03</td>
</tr>
<tr>
<td>Upper bound of 90 percent confidence interval</td>
<td>.05</td>
</tr>
<tr>
<td>Standardized root mean square residual (SRMR)</td>
<td>.03</td>
</tr>
</tbody>
</table>
Longitudinal Analyses

Hypothesis 4.2: The hypothesized model will be supported by the longitudinal data.

To test the hypothesis that the model would fit both the Time 2 and Time 3 samples, the proposed structural model from Time 1 was tested on each of the samples separately.

Results for the Structural Model With the Time 2 Sample

When the proposed structural model was tested with the Time 2 data, the model did not fit the data well. The fit indices for the model are presented in Table 29. The figure for the model is not shown, as AMOS 20.0 does not produce path coefficients when there is something wrong with the model. A revised version of the model was specified in which social support for the relationship was indicated by only overall perceived support for the relationship and in which anxiety was dropped from the mental health factor due to high correlations with the physical health factor. This revised model fit the data well and is presented in Figure 22 with fit indices presented in Table 29. With the exception of the link between relationship well-being and mental health, which was not significant, all of the path coefficients were significant and in the predicted directions. Path coefficients for this model are presented in Table 30.

Table 29
Chi-Square Statistics and Fit Indices for the Proposed Structural Models with Time 2 Sample

<table>
<thead>
<tr>
<th>Index</th>
<th>Proposed</th>
<th>Revised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chi-square</td>
<td>347.46</td>
<td>56.933</td>
</tr>
<tr>
<td>Degrees of freedom</td>
<td>69</td>
<td>38</td>
</tr>
<tr>
<td>Sig.</td>
<td>.00</td>
<td>.025</td>
</tr>
<tr>
<td>Comparative fit index (CFI)</td>
<td>.88</td>
<td>.99</td>
</tr>
<tr>
<td>Root mean squared error (RMSEA)</td>
<td>.12</td>
<td>.04</td>
</tr>
<tr>
<td>Lower bound of 90 percent confidence interval</td>
<td>.11</td>
<td>.01</td>
</tr>
<tr>
<td>Upper bound of 90 percent confidence interval</td>
<td>.14</td>
<td>.06</td>
</tr>
<tr>
<td>Standardized root mean square residual (SRMR)</td>
<td>.08</td>
<td>.03</td>
</tr>
</tbody>
</table>
Figure 22. Standardized coefficients for the revised Time 2 model.

Table 30
Path Coefficients for the Revised Structural Model with Time 2 Sample

<table>
<thead>
<tr>
<th>Path</th>
<th>B</th>
<th>SE</th>
<th>β</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support for relationship to relationship well-being</td>
<td>.21</td>
<td>.02</td>
<td>.55</td>
<td>8.67</td>
</tr>
<tr>
<td>General support to relationship well-being</td>
<td>.05</td>
<td>.01</td>
<td>.17</td>
<td>2.69</td>
</tr>
<tr>
<td>Relationship well-being to physical health</td>
<td>7.16</td>
<td>.05</td>
<td>.44</td>
<td>6.20</td>
</tr>
<tr>
<td>Relationship well-being to mental health</td>
<td>.16</td>
<td>.02</td>
<td>.03</td>
<td>.403</td>
</tr>
<tr>
<td>General support to physical health</td>
<td>.32</td>
<td>.02</td>
<td>.18</td>
<td>3.04</td>
</tr>
<tr>
<td>General support to mental health</td>
<td>.05</td>
<td>.01</td>
<td>.09</td>
<td>9.40</td>
</tr>
</tbody>
</table>

*p < .05. **p < .01. ***p < .001.
Results for the Structural Model With the Time 3 Sample

The proposed structural model was tested on the Time 3 sample and as indicated by the fit indices displayed in Table 31, the model fit the data well. As indicated in Figure 23, all of the factors shared the same indicator variables as the final Time 1 structural model, but the three paths from general social support to the outcome variables were not significant. All other paths coefficients were significant and in the predicted directions, and are depicted in Table 32.

Table 31
Chi-square Statistics and Fit Indices for the Proposed Structural Model in Time 3

<table>
<thead>
<tr>
<th>Index</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chi-square</td>
<td>123.382</td>
</tr>
<tr>
<td>Degrees of freedom</td>
<td>70</td>
</tr>
<tr>
<td>Sig.</td>
<td>.00</td>
</tr>
<tr>
<td>Comparative fit index (CFI)</td>
<td>.96</td>
</tr>
<tr>
<td>Root mean squared error (RMSEA)</td>
<td>.07</td>
</tr>
<tr>
<td>Lower bound of 90 percent confidence interval</td>
<td>.04</td>
</tr>
<tr>
<td>Upper bound of 90 percent confidence interval</td>
<td>.09</td>
</tr>
<tr>
<td>Standardized root mean square residual (SRMR)</td>
<td>.05</td>
</tr>
</tbody>
</table>

Table 32
Path Coefficients for the Proposed Structural Model with Time 3 Sample

<table>
<thead>
<tr>
<th>Path</th>
<th>B</th>
<th>SE</th>
<th>β</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support for relationship to relationship well-being</td>
<td>.63</td>
<td>.105</td>
<td>.77</td>
<td>6.05</td>
</tr>
<tr>
<td>General support to relationship well-being</td>
<td>-.001</td>
<td>.04</td>
<td>-.002</td>
<td>-.019</td>
</tr>
<tr>
<td>Relationship well-being to physical health</td>
<td>6.74</td>
<td>1.40</td>
<td>.45</td>
<td>4.80</td>
</tr>
<tr>
<td>Relationship well-being to mental health</td>
<td>.95</td>
<td>.18</td>
<td>.55</td>
<td>5.38</td>
</tr>
<tr>
<td>General support to physical health</td>
<td>.29</td>
<td>.50</td>
<td>.04</td>
<td>.570</td>
</tr>
<tr>
<td>General support to mental health</td>
<td>.07</td>
<td>.06</td>
<td>.09</td>
<td>1.31</td>
</tr>
</tbody>
</table>

* p < .05, ** p < .01, *** p < .001.
Figure 23. Standardized coefficients for the Time 3 structural model.
**Hypothesis 4.3:** Social support for relationships at Time 1 will be a significant predictor of outcome variables at Time 2 and Time 3.

To assess Hypothesis 4.3, that social support for the relationship at Time 1 would predict relationship well-being and mental and physical health at a later time, a structural model using data from Time 1 and Time 3 was tested. As depicted in Table 33, the proposed model matched the Time 1 Model that included hours per week spent together and the length of relationship prior to beginning Time 1 within the model. The fit indices for the model are presented in Table 33 and all indicate that the model fit the data very well. The path coefficients are presented in Table 34. All predicted paths were significant and in the predicted directions. General social support at Time 1 was not a significant predictor of any of the Time 3 outcome measures, and neither was relationship length or the amount of time a couple spent together each week (i.e., hours per week).

Table 33
*Chi-Square Statistics and Fit Indices for the Proposed Structural Model Using Time 1 Social Support and Time 3 Relationship Well-Being and Health Variables*

<table>
<thead>
<tr>
<th>Index</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chi-square</td>
<td>138.34</td>
</tr>
<tr>
<td>Degrees of freedom</td>
<td>92</td>
</tr>
<tr>
<td>Sig.</td>
<td>.001</td>
</tr>
<tr>
<td>Comparative fit index (CFI)</td>
<td>.96</td>
</tr>
<tr>
<td>Root mean squared error (RMSEA)</td>
<td>.06</td>
</tr>
<tr>
<td>Lower bound of 90 percent confidence interval</td>
<td>.04</td>
</tr>
<tr>
<td>Upper bound of 90 percent confidence interval</td>
<td>.07</td>
</tr>
<tr>
<td>Standardized root mean square residual (SRMR)</td>
<td>.15</td>
</tr>
</tbody>
</table>
Figure 24. Standardized coefficients for the model using Time 1 social support variables predicting Time 3 relationship well-being and health variables.
Table 34  
Path Coefficients for the Proposed Structural Model with Time 1 Social Support and Time 3 relationship well-being and health variables

<table>
<thead>
<tr>
<th>Path</th>
<th>B</th>
<th>SE</th>
<th>β</th>
<th>t</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Support for relationship to relationship well-being</td>
<td>.48</td>
<td>.11</td>
<td>.55</td>
<td>4.2</td>
<td>***</td>
</tr>
<tr>
<td>General support to relationship well-being</td>
<td>-.01</td>
<td>.03</td>
<td>-.03</td>
<td>-.304</td>
<td></td>
</tr>
<tr>
<td>Hours per week to relationship well-being</td>
<td>.01</td>
<td>.01</td>
<td>.09</td>
<td>1.06</td>
<td></td>
</tr>
<tr>
<td>Relationship length in months</td>
<td>-.01</td>
<td>.01</td>
<td>-.13</td>
<td>-1.50</td>
<td></td>
</tr>
<tr>
<td>Relationship well-being to physical health</td>
<td>7.42</td>
<td>1.51</td>
<td>.47</td>
<td>4.92</td>
<td>***</td>
</tr>
<tr>
<td>Relationship well-being to mental health</td>
<td>1.06</td>
<td>.194</td>
<td>.58</td>
<td>5.49</td>
<td>***</td>
</tr>
<tr>
<td>General support to physical health</td>
<td>.28</td>
<td>.433</td>
<td>.05</td>
<td>.640</td>
<td>***</td>
</tr>
<tr>
<td>General support to mental health</td>
<td>.05</td>
<td>.05</td>
<td>.07</td>
<td>.885</td>
<td></td>
</tr>
</tbody>
</table>

* p < .05. ** p < .01. *** p < .001.

**Hypothesis 4.4:** Higher levels of support at Time 1 will be associated with stability (remaining together) at Time 2 and Time 3.

In order to assess the relationship between Time 1 predictor variables on the likelihood of staying together or breaking up at a later point in time, a hazard analysis was conducted. Descriptive statistics for the sample used in the analysis are presented in Table 35. A three-step process was used in determining which variables to use in the final hazard analysis. First, bivariate analyses were conducted examining each individual predictor variable. Second, three separate Cox regression models were conducted to determine which predictor variable from each group (i.e., general social support, social support for the relationship, relationship well-being) held its significance in a multivariate analysis. The significant predicting variable from each group was then used in a final Cox regression model, displayed in Table 36. Details of the bivariate and individual Cox regression models for each group of variables can be found in Appendix AA.

Cox regression models take into account the censoring of cases while calculating the estimates for the predictor variables as well as any covariates (in this case, prior relationship length). A total of 2987
cases were used in the hazard analysis, of which 628 provided update data at either Time 2 or Time 3 of the study. Data from Time 2 and Time 3 were combined, such that the latest data point available for each participant was used (i.e., if a participant provided data at all three points, their Time 3 data was used). Eighty-three percent of the participants were still in a relationship at the latest follow up time, and thus these cases are right censored. The only information available about the dissolution of these relationships is that it occurs (if at all) beyond the largest observed date. The event of interest is the termination of the relationship. The aim was to examine the effect of various relationship well-being and social support variables on relationship dissolution, while controlling for prior relationship length.

Table 35
*Descriptive Statistics for Scales Split by Relationship Termination Status*

<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Together</th>
<th>Terminated</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean    (S.D.)</td>
<td>Mean    (S.D.)</td>
</tr>
<tr>
<td>Time between Time 1 and latest follow up (in days)</td>
<td>427.01  171.78</td>
<td>419.32  187.12</td>
</tr>
<tr>
<td>Perceived social support for relationship</td>
<td>5.89    (.91)</td>
<td>5.09    (1.12)</td>
</tr>
<tr>
<td>Perceived social support for relationship from family</td>
<td>5.62    (1.28)</td>
<td>5.18    (1.22)</td>
</tr>
<tr>
<td>Perceived social support for relationship from friends</td>
<td>6.32    (.92)</td>
<td>5.54    (1.27)</td>
</tr>
<tr>
<td>General social support</td>
<td>4.09    (.73)</td>
<td>3.93    (.75)</td>
</tr>
<tr>
<td>General social support from friends</td>
<td>3.74    (1.03)</td>
<td>3.53    (1.06)</td>
</tr>
<tr>
<td>General social support from family</td>
<td>3.94    (1.00)</td>
<td>3.90    (1.03)</td>
</tr>
<tr>
<td>General social support from partner</td>
<td>4.58    (.81)</td>
<td>4.31    (.78)</td>
</tr>
<tr>
<td>Satisfaction</td>
<td>6.08    (.85)</td>
<td>5.33    (1.11)</td>
</tr>
<tr>
<td>Dyadic adjustment</td>
<td>90.03   (9.44)</td>
<td>86.12   (9.52)</td>
</tr>
<tr>
<td>Love</td>
<td>5.60    (.93)</td>
<td>5.10    (1.14)</td>
</tr>
<tr>
<td>Trust</td>
<td>5.93    (.77)</td>
<td>5.36    (.97)</td>
</tr>
<tr>
<td>Commitment</td>
<td>7.37    (1.13)</td>
<td>5.86    (1.88)</td>
</tr>
<tr>
<td>N = 524</td>
<td></td>
<td>N = 104</td>
</tr>
</tbody>
</table>

The dependent variable in the Cox regression model is the hazard rate \( h(t) \), defined as the instantaneous risk that an event will occur at time \( t \). The main advantage of a Cox regression model is that it utilizes all of the available information. A positive parameter value shows the amount by which the predictor variable increases the rate at which an event occurs (relationship dissolution) for every unit increase in the predictor variable’s scale. Negative parameter values indicate the extent to which the hazard rate (risk of event occurring) decreases for every unit increase in the predictor variable’s scale.
Antilogs of the parameters can be calculated to determine the effect of the covariate on the actual rather than the logged hazard rate. A unit increase in the covariate multiplies the hazard rate by the value of the corresponding antilog parameter. With the exception of perceived social support for the relationship from family, general social support from friends and general social support from a significant other, all of the predictor variables had significant coefficients when examined one at a time, while controlling for relationship length. When examined together within each group of variables (i.e., general social support, social support for the relationship, and relationship well-being) only perceived social support for the relationship from friends, general social support from family and relationship satisfaction remained as significant predictors of relationship dissolution.

Thus, the multivariate model displayed in Table 36 compared the three categories of predictors, using the significant predicting variable from each group: relationship satisfaction, social support for the relationship from friends, and general social support from family. Table 36 shows the coefficients, standard errors and antilogs for the final model. The chi-square was significant at each step, indicating that each addition to the model was a significant improvement over the previous step. General social support from family was not a significant predictor after relationship length, relationship satisfaction and perceived social support for the relationship from friends were placed in the model. After entering relationship length at the first step, the remaining three variables were entered using a stepwise procedure. Using the antilogs presented in Table 36, the model indicates that for every additional month an individual was in their relationship prior to the beginning of the study, their likelihood of breaking up during the study reduced by 1.9%. Furthermore, for every one unit increase on the relationship satisfaction scale (range of 6), an individual was 39.7% less likely to have their relationship end during the course of the study. Finally, for every positive unit of change in perceived social support for the relationship from friends, the likelihood of breaking up during the course of the study decreased by 21.5%. Thus, relationship satisfaction at Time 1 and perceived support for the relationship from friends were significant predictors of not only whether or not a relationship would break up during the course of the study, but also the rate at which the relationship was likely to terminate.
Table 36
Cox Regression Model Predicting Relationship Dissolution With One of Each Category of Predictor Variables

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>Step 1</th>
<th></th>
<th>Step 2</th>
<th></th>
<th>Step 3</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B (SE)</td>
<td>Antilog</td>
<td>B (SE)</td>
<td>Antilog</td>
<td>B (SE)</td>
<td>Antilog</td>
</tr>
<tr>
<td>Relationship length</td>
<td>-.02*** (.004)</td>
<td>.98</td>
<td>-.20*** (.004)</td>
<td>.98</td>
<td>-.02*** (.004)</td>
<td>.98</td>
</tr>
<tr>
<td>Satisfaction</td>
<td>-.51*** (.082)</td>
<td>.60</td>
<td>-.38*** (.102)</td>
<td>.69</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perceived social support for relationship from friends</td>
<td>ns</td>
<td>ns</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General social support from family</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chi-square</td>
<td>20.49***</td>
<td></td>
<td>58.16***</td>
<td></td>
<td>68.13***</td>
<td></td>
</tr>
<tr>
<td>df</td>
<td>1</td>
<td></td>
<td>2</td>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>No. of events (uncensored)</td>
<td>89</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total N</td>
<td>549</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. *Due to missing data on the Love and Commitment variables, the relationship well-being model was run a second time, excluding these variables.

*** p < .001, ** p < .01, * p < .05

Comparing Participants in Same-Sex Versus Mixed-Sex Relationships

In order to investigate whether predictors of relationship dissolution differed between the two types of relationships, separate Cox regression models were run for each sample. Results indicated that the same variables predicted relationship dissolution in same-sex couples as in mixed-sex couples, but the magnitude of prediction was different in each group, such that a one unit increase in relationship satisfaction was associated with a 38% reduction in the likelihood of breaking up for same-sex couples, and a 42% reduction for those in mixed-sex relationships.

In order to determine whether this difference might be significant, further analyses were conducted after creating interaction variables between each predictor variable and relationship type. A Cox regression model was then run, entering relationship type, relationship length and their interaction at the first step, and then proceeding with the forward stepwise method for entering the remaining variables and their interactions. Relationship type was not a significant predictor in the model, nor were any of the
interactions. Thus, it can be concluded that the Cox regression model does not differ significantly between same-sex and mixed-sex couples.

**Research Question 4.1:** Does support for the relationship from friends predict relationship and health outcomes over time better than support for the relationship from parents (or vice versa)?

To determine whether social support for relationships from parents versus friends operates differently over time, a model was tested in which social support from friends and parents at Time 1 predicted relationship well-being and health outcomes at Time 3. The model fit the data well, but the path coefficient from friend approval to relationship well-being was not significant. Thus, the only significant predictor in the model was parent approval, as indicated by both the participant’s parents and their partner’s parents. This model can be directly compared to the Time 1 model presented in Figure 25. The fit indices are presented in Table 37 and the path coefficients are presented in the Table 38.

**Table 37**

*Chi-Square Statistics and Fit Indices for Parents & Friends Over Time*

<table>
<thead>
<tr>
<th>Index</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chi-square</td>
<td>54.01</td>
</tr>
<tr>
<td>Degrees of freedom</td>
<td>31</td>
</tr>
<tr>
<td>Sig.</td>
<td>.006</td>
</tr>
<tr>
<td>Comparative fit index (CFI)</td>
<td>.97</td>
</tr>
<tr>
<td>Root mean squared error (RMSEA)</td>
<td>.07</td>
</tr>
<tr>
<td>Lower bound of 90 percent confidence interval</td>
<td>.04</td>
</tr>
<tr>
<td>Upper bound of 90 percent confidence interval</td>
<td>.10</td>
</tr>
<tr>
<td>Standardized root mean square residual (SRMR)</td>
<td>.08</td>
</tr>
</tbody>
</table>
Figure 25. Approval for relationship from friends and parents predicting relationship well-being, mental health and physical health at Time 3.
Table 38
Path Coefficients for the Parents and Friends Over Time Model

<table>
<thead>
<tr>
<th>Path</th>
<th>B</th>
<th>SE</th>
<th>β</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent approval of the relationship to relationship well-being</td>
<td>.40</td>
<td>.16</td>
<td>.70</td>
<td>2.48</td>
</tr>
<tr>
<td>Friend approval of the relationship to relationship well-being</td>
<td>-.19</td>
<td>.19</td>
<td>-.19</td>
<td>-.978</td>
</tr>
<tr>
<td>Relationship well-being to physical health</td>
<td>7.64</td>
<td>1.50</td>
<td>.49</td>
<td>5.09</td>
</tr>
<tr>
<td>Relationship well-being to mental health</td>
<td>1.05</td>
<td>.194</td>
<td>.57</td>
<td>5.39</td>
</tr>
</tbody>
</table>

* p < .05. ** p < .01. *** p < .001.
CHAPTER 5
DISCUSSION

The current study examined how the social support individuals receive (or fail to receive) for same-sex or mixed-sex relationships relates to the functioning of their relationships, and how this support, in turn, relates to individuals’ mental and physical health. One of the key aims of the study was to differentiate between the social support individuals receive specifically for their relationships and the social support they receive in general, from friends and family. After establishing that these two kinds of support are in fact distinct from one another (i.e., having social support for your relationship is not redundant with having a sense of social support in general, and vice versa), the study focused on determining whether participants with higher levels of perceived support for their relationships would report greater relationship well-being (measured by satisfaction, trust and dyadic adjustment), and in turn, would report fewer mental and physical health challenges. The hypothesized model of the links among social support, relationship well-being and health was tested under various conditions: using the current study’s data as well as a previous (and comparable) dataset collected by Blair and Holmberg (2008), comparing individuals in same-sex and mixed-sex relationships, comparing support from parents versus friends, using data from multiple time points within the study, and combining multiple times within one model (i.e., Time 1 social support predicting Time 3 outcomes). Finally, in addition to examining the robustness of the hypothesized model, the study also sought to determine whether social support for relationships was a potent predictor of relationship stability (i.e., whether couples remained together throughout the course of the study).

Overall, the results of the current study indicate that, as hypothesized, individuals who perceive greater social support for their relationships report greater relationship well-being, and in turn, better mental and physical health. Furthermore, individuals’ perceptions of social support for their relationships proved independent from the social support that they perceived more generally. Each separate type of support uniquely predicted individual’s reports of love, satisfaction and trust within their relationships.
The associations detected among individual’s perceptions of social support, relationship well-being, and health also proved significant over time. Not only did individuals’ perceptions of social support for their relationships predict their future relationship well-being and physical/mental health, but these perceptions also predicted whether individuals’ relationships endured or dissolved. Specifically, individuals reporting greater support for their relationships, by a single scale unit, were more than 20% less likely to have broken up with their partners by the conclusion of the study. The results of the study were less conclusive with respect to revealing whether support from parents is more important than support from friends. In some analyses, support from parents proved more predictive of relationship and individual well-being than support from friends, whereas other analyses showed the opposite pattern; potential reasons for these discrepancies are addressed below. Finally, this study revealed that social support for relationships appears equally important for individuals in same-sex and mixed-sex couples. With several exceptions (described below), the associations among social support, relationship well-being, and mental/physical health proved consistent for same-sex and mixed-sex couples across all analyses. In summary, individuals who perceive greater levels of support for their relationship from friends and family -- whether the relationship is a same-sex or a mixed-sex relationship -- report more stable and satisfying relationships and better mental and physical health.

**Evidence for the Robustness of the Model**

Overall, the current study provided strong evidence to support the hypothesis that individuals who perceive greater social support for their relationships will also report greater relationship well-being and, in turn, fewer mental and physical health challenges. The model was successfully tested in four separate data sets, one of which was from an entirely separate study. Furthermore, the models tested in Time 1 and 3 of the current study offer a very good replication of the model proposed by Blair and Holmberg (2008). Despite the modifications required to the model in Time 2, the overall theoretical structure of the model still held, with the exception of the link to mental health. Perhaps some of the strongest evidence for the predicted associations among social support for a relationship, relationship well-being and health outcomes comes from the mediation analysis of the two direct effect alternative models, which
demonstrated that relationship well-being fully mediates the association between social support for the relationship and health outcomes. This pattern of results indicates that social support for a relationship is associated with health outcomes entirely because of its association with relationship well-being. Finally, the model fit procedures conducted were thorough and cautious in that steps have been taken to avoid overfitting the model, thereby increasing the generalizability of the hypothesized model to additional samples and time points. The results of specific analyses related to the overall hypothesized model are discussed in detail below.

Comparing the Proposed Structural Model with the Blair-Holmberg (2008) Model

In the study conducted by Blair and Holmberg (2008), social support for relationships was found to be associated with both relationship well-being and health outcomes. In order to determine whether these results could be replicated in the current study, the hypothesized model was tested on both data sets. This procedure allowed for a comparison of how each of the constructs was related to the others within two separate data sets, specifically allowing for a comparison of the extent to which various levels of social support for a relationship accounted for changes in relationship well-being, mental and physical health. A modified model fit both samples well, but yielded significantly different path coefficients in each of the datasets, such that for participants in the current study, relationship well-being proved to be a stronger predictor of mental and physical health than it was for participants in the Blair and Holmberg study (2008). Despite the differences in magnitude, all three paths were significant in each model, and in the predicted directions.

The differences in the models may be attributable to a variety of reasons. The two samples differed on several variables including size (larger in current study), age of participants in same-sex relationships (older in current study), length of relationship (longer in current study), educational background (higher in Blair and Holmberg study), and distribution of the participants in same-sex relationships from Canada versus the United States (more from the United States in the current sample). In addition, participants in each sample also differed in the amount of support for the relationship perceived from parents (higher levels in current study) and in the correlation between parental support
and the outcome measures (significant in current study). Interestingly, the published results from Blair and Holmberg (2008) indicated that the authors were not able to fit a model that included parental support for the relationship. Yet in the analysis of the current dataset, parental support was a significant predictor of relationship well-being and, in turn, mental and physical health. A potential explanation for this discrepancy may lie in the different factor loadings for parental support in each of the datasets, such that it had a much lower factor loading in the Blair-Holmberg sample, which is consistent with the results presented by Blair and Holmberg (2008). Thus, parental support may have proved a significant predictor in the current analysis (using both data sets) simply due to a difference in criteria between the two studies with respect to the requisite factor loadings within the models.

In addition to testing the hypothesized model in each of the data sets, a more theoretical comparison of the experiences of participants in each of the two studies was made. Thus, in addition to using a statistical test (i.e., invariance testing) to determine whether the overall experiences of participants in each study differed in relation to how social support for a relationship is associated with relationship well-being and health, the individual links between constructs for each group of participants were compared. A theoretical comparison of the models yields the conclusion that although the models differ slightly in how each of the four constructs (social support for the relationship, relationship well-being, mental health and physical health) is measured; the associations between the constructs remained the same, differing only in magnitude. As no other previous studies have examined all four of these constructs (social support for relationships, relationship well-being, mental and physical health) within one model (Lau & Strohm, 2011), it is difficult to compare the proportions of variance explained by the current model to results presented within the literature. However, the overall pattern of associations among social support for a relationship, relationship well-being, mental and physical health are consistent with the literature that exists on each association individually. For example, research has consistently linked relationship well-being to mental and physical health (Kiecolt-Glaser & Newton, 2001), social support for relationships with relationship satisfaction (Sprecher & Felmlee, 1992, 2000), and general social support with mental and physical well-being (Uchino et al., 1996).
Overall, the current study’s sample and proposed structural models form an excellent replication of the results reported by Blair and Holmberg (2008). The fact that an identical model can fit both samples underscores the robustness of the associations among social support for a relationship, relationship well-being, mental and physical health, thereby demonstrating that the hypothesized model adequately depicts the experiences of participants in two distinct samples with respect to how social support for their relationships is associated with relationship well-being and health outcomes.

**The Hypothesized Model at Time 1**

Additional evidence concerning the robustness of the predicted associations between social support for relationships, relationship well-being and health comes from the process through which the model was fit in the current study. Procedures were taken to avoid over fitting the model (i.e., testing on random split halves of the sample) and the model was tested with and without control variables (relationship length and time spent together each week). Both versions of the model fit the data well, such that, as predicted, participants who perceived greater levels of social support for their relationships also reported greater relationship well-being and fewer mental and physical health challenges. The main difference between the model that included the control variables and the one that did not related to the predictive power of general social support.

Specifically, when the control variables were included in the model, general social support for an individual ceased to be a significant predictor of relationship well-being, although this change was minimal given that it was a very weak predictor in the model without the control variables. General social support was indicated by perceived support from friends, and as our partner is also often considered a friend, the time we spend with our partner may influence our perceptions of the general support we receive from friends. Thus, when controlling for time spent with partner, a variable found to be a significant predictor of relationship dissolution in past research (Felmlee et al., 1990), the link between general social support and relationship well-being ceases to be significant.

Overall, the results of the structural model tests on the Time 1 sample indicate that perceived social support for relationships is a robust predictor of relationship well-being, as measured by
relationship satisfaction, trust, and dyadic adjustment. These results echo those of past researchers (Blair & Holmberg, 2008; Felmlee, 2001; Sprecher & Felmlee, 2000) in emphasizing that relationships do not function in isolation, but are part of a larger social network whose opinions matter in the prediction of relationship well-being. Sprecher and Felmlee (2000) have suggested that three theories potentially explain the link between social support for relationships and relationship wellbeing: uncertainty reduction theory (Berger, 1979), symbolic interactionist theory (Lewis, 1973), and cognitive balance theory or the concept of transitivity (Heider, 1958; Sprecher, 2011). Each of these theories suggest plausible mechanisms through which support for a relationship may have positive outcomes for relationship well-being, such that support may increase certainty in partner choice (and consequently commitment), may lead a couple to form a dyadic identity, or may generate transitive relationships within the social network (and consequently avoiding the distress associated with intransitive relationships).

Compared to the results published by Blair and Holmberg (2008), the hypothesized model in the current study demonstrated stronger links between the variables, such that perceived social support for the relationship explained a greater proportion of the variance in not only relationship well-being, but also mental and physical health. Both studies are novel in linking social support for a relationship to important personal health outcomes. In other words, the current study, taken in association with the Blair and Holmberg (2008) findings, illuminates an additional facet through which a specific domain of social support (social support for one’s relationship) relates to health, and may therefore have implications for the treatment of individuals facing familial, network or societal disapproval of their relationships. Although other studies have demonstrated links between specific domains of social support and health outcomes (Bearman & LaGrecca, 2002), the large majority of research on social support has examined the concept from a unidimensional perspective (Uchino et al., 1996), and none, until now, have linked social support specifically for a relationship to mental and physical health outcomes.

In the current study, the association between relationship well-being and mental health is substantially stronger than the association between relationship well-being and physical health. Blair and Holmberg (2008) found a similar result in their study; however, the discrepancy in the current study
between the amount of variance explained in each of these outcome factors is nearly twice as large as the discrepancy reported by Blair and Holmberg (2008). This finding makes sense, given that relational events are most likely to have an initial, or direct impact on the mental well-being of the individuals within the relationship, as opposed to directly and immediately impacting physical health outcomes (Gibb, Fergusson & Horwood, 2011). In other words, it is more likely that a negative relational event will have an immediate effect on an individual’s level of stress, anxiety, or happiness than it is likely to have an impact on their susceptibility to the common cold or other physical health ailments. As may be expected, previous research has found a stronger association between relationship well-being and mental health as compared to the association between relationship well-being and physical health (Braithwaite, Delevi & Fincham, 2010), although this finding is moderated by gender, with relationship satisfaction often playing a stronger role in mental health for women and a more salient role in physical health for men (Kiecolt-Glaser & Newton, 2001; Simon & Barrett, 2010). This gender difference is thought to be based on the different benefits that men and women bring to, and take from, a relationship: men are more likely to benefit in terms of their physical health due to having someone monitoring their health and encouraging healthy behaviour, and women are more likely to benefit emotionally (Lewis & Butterfield, 2007). Future research addressing these issues in same-sex couples may shed more light on the possible role that gender plays with respect to determining who benefits from what, and how.

Notwithstanding the discrepancy between variance explained in mental and physical health, the current model does explain quite a large proportion of the variance in physical health, especially when one considers the multitude of factors, which may be more salient in their contributions to physical health (e.g., genetics, behaviour, habits, environment). Given that the sample is relatively young and healthy, it is possible that there is more room for social factors, such as relationship well-being, to influence physical health outcomes. Perhaps as individuals age, other well-established contributors to physical health take precedence, although existing research suggests that the physical health benefits associated with marriage appear to actually accrue over time (Gibb et al., 2011). Future research collecting additional data from the current study’s sample may help to shed light on how social support for a relationship changes over time.
and whether or not the associations found within the current study will hold for the same participants as they age. Perhaps with time, changes in physical health as a function of relationship well-being and social support for the relationship will become even more salient.

**The Hypothesized Model at Time 2 and Time 3**

Participants in the current study were invited to return to the study at two follow up times and were asked to provide information on the same constructs measured in the first phase of data collection: perceived social support for their relationship, relationship well-being and mental and physical health. Collecting data on the same constructs at multiple times allowed for an examination of whether social support for a relationship shared similar associations with relationship well-being, and in turn, mental and physical health, at various stages of the same relationship. In other words, if greater social support for a relationship was associated with relationship satisfaction and overall health at Time 1, would this still be the case at Time 2 and Time 3? To test this, the hypothesized model was run on each of the data sets collected, allowing for a comparison of the model over time.

The results indicate that the proposed structural model fit the data well in Time 3 (CFI = .96, RMSEA = .07), but required slight modifications in Time 2. In order to successfully fit a model to the Time 2 sample, it was necessary for the approval from parents and friends indicator variables to be dropped, along with the anxiety indicator. As a result, social support for the relationship was indicated only by overall perceived social support for the relationship and mental health was only indicated by depression and stress. Despite this deviation from the hypothesized model, previous research has found perceived social support to be an equivalent, if not better, predictor of relationship well-being (Sprecher, 2011), and thus, the loss of the approval or “behaviour-based” measure was not likely to substantially weaken the model.

Despite the required adjustments to the Time 2 model, it should be noted that the overall conceptual structure of the model was not altered: perceived social support for the relationship was associated with relationship well-being, and relationship well-being was, in turn, associated with mental and physical health. However, the association with mental health was not significant, likely highlighting
the importance of including anxiety as an indicator of mental health, as it was the removal of this indicator that lead to the insignificant path.

The results indicate that having social support for a relationship is associated with relationship well-being, and, in turn, mental and physical health regardless of the time point within the study that the data is analyzed. This evidence, taken in conjunction with the wide range of ages and relationship duration within the sample, strongly suggests that social support for a relationship is associated with relationship well-being and health outcomes across the span of a relationship’s development.

Alternatives to the Hypothesized Model

Although the evidence reviewed above suggests that social support for a relationship influences relationship well-being, which, in turn, influences mental and physical health, it is possible that alternative explanations of the data exist, in which the order of associations is altered. In other words, it may be that healthy individuals have satisfying relationships that their social networks are keen to support, or that individuals who are satisfied in their relationships perceive greater levels of social support (regardless of whether such levels are substantiated by actual support), which then influence their mental and physical health. To shed light on the plausibility of these possibilities, three alternative models were tested: a reverse mediation model, in which relationship well-being was posited to predict social support for the relationship, and in turn, mental and physical health; a fully reversed model, in which mental and physical health were posited to predict relationship well-being, and in turn, social support for the relationship; and a direct effects model, in which social support for the relationship directly predicted the three outcome variables.

The reverse mediation model fit the data well and indicated that happier, healthier relationships might perceive more social support from their network, potentially because the network sees that the relationship is healthy. Alternatively, individuals content with their strong relationship may perceive higher levels of support for the relationship, regardless of actual levels available. Thus, a model that grants a key role to relationship well-being as a predictor of both social support and well-being is plausible (Whisman, Uebelacker & Weinstock, 2004). Furthermore, the mediation analysis demonstrated
that the association between relationship well-being and mental and physical health was *not* mediated by social support for the relationship.

In a second alternative model, mental and physical health were posited to predict better relationship well-being, and in turn, greater perceived social support for the relationship. This model also produced a good fit to the data. Contrary to what would be implied by a full reversal of the hypothesized model, the path between physical health and relationship well-being changed direction, such that better physical health was associated with lower relationship well-being. This finding is odd considering the ample evidence that positively links relationship well-being to physical and mental health outcomes (Gibb et al., 2011; Holt-Lunstad, Smith & Layton, 2010; Murphy, Grundy & Kalogirou, 2007; Simon & Barrett, 2010), however, the majority of the research in this field does assume that causal order goes from relationship well-being to physical health, and not the other way around. One possible explanation for this unexpected pattern is that individuals with particularly poor physical health may report greater relationship well-being because their poor health tends to elicit greater caregiving from their partner, and this “tender loving care” may provide an explicit demonstration of love and support which enhances overall relationship satisfaction (Schover, 1991; Simonelli et al., 2008). Additionally, the caregiving partner may feel an enhanced sense of meaning and purpose within the relationship, thereby increasing their own relationship satisfaction as well. In fact, some previous research has found support for this idea, noting that husbands whose wives are undergoing breast cancer treatment experience a number of positive benefits associated with caregiving, including feeling needed, having another way to show love for their wives, and increased feelings of closeness within the relationship (Wagner, Tanmoy, Bigatti & Storniolo, 2001). Finally, it should be noted that in the hypothesized model, relationship well-being accounts for 12% of the variance in physical health, but in the reversed model, physical health accounts for only 3.6% of the variance in relationship well-being.

The final alternative model tested was a direct effects model, in which social support for the relationship was posited to have direct effects on relationship well-being, mental and physical health (i.e., not mediated through relationship well-being). While this model had acceptable fit, the fit indices were
significantly weaker than those of the other alternative models and of the original hypothesized structural model. This model was compared to an alternate direct effects model, in which paths between relationship well-being and the health factors were allowed to vary freely. This model had a significantly improved fit over the original direct effects model.

Comparing the two direct effects model side by side suggested that, as hypothesized by the original structural model, relationship well-being fully mediated the association between social support for the relationship and health outcomes. In other words, social support for a relationship is associated with health outcomes because of its association with relationship well-being, thereby providing strong evidence for the superiority of the hypothesized model. This conclusion is further supported by the lack of any evidence for social support for the relationship mediating the association between relationship well-being and mental and physical health. Furthermore, these findings suggest an element of directionality with respect to the association between social support for relationships and relationship well-being, such that individuals who perceive support for their relationships are more likely to report greater relationship well-being, rather than individuals in satisfying relationships being more likely to perceive greater levels of support.

Taken together, the analyses discussed above strongly support the study’s main hypothesis, that individuals who perceive greater support for their relationships will be more likely to have satisfying relationships which will in turn be associated with fewer mental and physical health challenges, as compared to individuals who perceive lower levels of perceived support for their relationships. It is, however, possible that social support for a relationship is simply a manifestation of overall general social support for an individual. To exclude this possibility, the current study included a measure of general social support and the following section details the analyses establishing social support for relationships as a separate domain of support.

**General Social Support for Individuals Versus Social Support for Relationships**

Blair and Holmberg (2008) reported that even when taking into consideration the association between general social support for an individual, perceived social support for the relationship remained a
significant predictor of relationship well-being and health outcomes. This finding, however, was based on a post-hoc constructed measure of general social support as opposed to using a validated measure of general social support. As such, the authors concluded that future research should examine the issue of general social support as compared to social support for the relationship using more validated measures of general social support. The current study did just that, including the Multidimensional Scale of Perceived Social Support (Zimet et al., 1998), which measures general social support for an individual from three sources: friends, family, and a significant other.

The evidence from the current study strongly supports both of the Objective 1 hypotheses and clarifies that social support for relationships is a separate and unique domain of social support as compared to general social support for an individual. Not only do the two constructs show relatively weak correlations with one another, they also behave differently within the structural and Cox regression models, such that social support for relationships is a more potent predictor of relationship outcomes than general social support, as would be expected. The findings add to the literature concerning domain specificity of social support and the importance of matching the content of support to the outcome variable being measured, in this case, relationship well-being. Finally, it appears that this study presents some evidence that the association between general social support and relationship well-being is in fact mediated by perceived social support for the relationship, such that general social support is associated with relationship well-being, at least in part, due to its association with perceived social support for a relationship. This potential mediation effect was also suggested by the results of the structural model in which social support for the relationship was not included as a predicting factor (See Appendix AB). In this model, general social support accounted for a much larger proportion of the variance than it did in the model that included both types of social support. The following is a discussion of the specific evidence found in relation to these to the Objective 1 hypotheses.

**Interscale Correlations**

The interscale correlations presented in Table 6 demonstrate that general social support and social support for a relationship are not identical constructs. In other words, if an individual has a sense of
general social support, this will not necessarily translate into this same person having an equal sense of social support for their relationship. A large number of the correlations did not reach significance, and the correlations that did, were low to moderate in strength (Hemphill, 2003). Additionally, each scale analyzed had good reliability within both its own measure and its own construct, adding further validity to these findings.

**Multiple Regression Models**

When two constructs are significantly different from one another, it can be expected that they will predict associated outcome variables in different ways and to different extents. In the current study, it was predicted that although both general social support and social support for a relationship would be associated with relationship well-being, their associations would be unique, such that neither construct alone could tell you as much about an individual’s relationship well-being as could both constructs together. As the summary of multiple regression analyses in Table 7 demonstrates, overall perceived social support and general social support from a significant other were consistent predictors for all relationship well-being variables (love, trust, satisfaction, dyadic adjustment) across relationship types, a finding that is consistent with past research (Lehmiller & Agnew, 2007; Felmlee, 2001; Felmlee et al., 1990; Sprecher & Felmlee, 1992; Sprecher, 1988; Blair & Holmberg, 2008). Relationship approval from friends was a significant predictor of love, trust, and dyadic adjustment, but not of relationship satisfaction, a finding somewhat contrary to past research that has reported strong links between social support for the relationship from friends and relationship outcome variables (Felmlee, 2001). In the current study, however, the approval measure more closely resembles a measure of received social support rather than perceived social support. Given the research suggesting that perceived social support often acts as a better predictor of relationship well-being outcomes (Sprecher, 2011), it may be that the measure of friend approval more closely resembles a measure of actual support, rather than perceived support. Nonetheless, friend approval for the relationship was significant in predicting many of the other relationship well-being variables.
General social support for an individual from friends predicted love in both relationship types, but was not a significant predictor in any of the other regression models run. Across all regressions, the addition of the general social support scales produced a significant change in the proportion of variance in the outcome measure explained. In other words, the addition of general social support or social support for the relationship generated a better explanation of relationship well-being than did either of the social support variables alone. However, as noted above, the change following the inclusion of general social support was mostly attributable to the predictive power of general social support from a participant’s partner, a factor known to be associated with relationship well-being (Dehle & Landers, 2005).

With the exception of general social support from friends predicting love, the only general social support subscale to have consistent predictive power across the relationship variables was support from a significant other, which makes theoretical sense given that having a supportive partner is likely to influence measures of relationship well-being, and has in fact been shown to do so consistently (Dehle & Landers, 2005; Bertera, 2005; Kiecolt-Glaser & Newton, 2001). Furthermore, general social support from family did not predict any of the relationship outcome measures, and neither did approval of the relationship from the participant’s own parents. In summary, elements of both general social support and social support for the relationship are predictive of various relationship outcome measures, and the effects of one predictor are not redundant with the effects of the other.

Structural Equation Models with General Social Support

In CFA, if a measurement model is proposed that has two latent variables that are too similar to one another, the fit of the model will be poor. In the current study, if general social support and social support for a relationship were too similar to one another, the proposed measurement model that indicated that these two constructs were separate would have resulted in a poor fit and the subsequent SEM analyses would not have been possible. The CFA in the current study had good fit, and therefore indicated that general social support for an individual and social support for an individual’s relationship could be treated as separate constructs. The final proposed model for Time 1 included four indicators of general social support, which correspond with the friend subscale of the Multidimensional Scale of Perceived
Social Support (Zimet et al., 1998). The final measurement model showed significant correlations between the general social support construct and the other four factors in the model (as shown in Table 14), thus providing additional evidence of these two domains of social support being unique, as the items would have loaded too highly on each other’s factors if the constructs were theoretically the same (Elliott, Kao & Grant, 2004; Farrell, 2009).

The pattern of results found in the Time 1 measurement and structural models is consistent with the conclusion that social support for relationships is a separate and unique construct compared to general social support (although the two types of support are, not surprisingly, related to one another). If an individual perceives support from his/her friends and family in general, this does not necessarily translate into a perception of support specifically for his/her relationship. If the two constructs were measuring the same type of support, we would expect to see problems in the measurement model and the fit of the structural models. In fact, it is unlikely that general social support would even be included in the structural models, as a lack of divergent validity between the constructs would produce a poor measurement model fit. Furthermore, these findings are further substantiated by their replication in the models tested on the Time 2 and 3 samples. These findings echo those of other researchers who have emphasized the importance of studying social support from different sources (Bearman & LaGreca, 202; Brock et al., 1996), and suggest that future research on the benefits associated with social support must take care to examine support from different sources and in different domains.

**Longitudinal Survival Analysis**

Finally, social support for the relationship and general social support were both significant predictors of relationship dissolution over the course of the study. Yet notably, when considered together in a Cox regression model, only low support specifically for one’s relationship predicted the dissolution of that relationship. Bivariate estimates from Cox regression models (Appendix AA) indicate that, when entered separately, various measures of perceived support for the relationship and general social support (overall and from family) significantly predicted the likelihood of breakup over the course of the study, even when controlling for the effects of relationship length prior to beginning the study. Specifically, a
single unit increase in the overall perceived social support for relationship scale was associated with a 38% decrease in the likelihood of relationship dissolution. Comparatively, a single unit increase in the overall general social support scale (including all three subscales) was associated with a 22.8% decrease in the likelihood of relationship dissolution. However, when a multivariate Cox regression model was conducted, only relationship length, satisfaction and perceived support for the relationship remained significant predictors of the rate at which a relationship terminates. Thus, when general social support and social support for the relationship are considered at the same time, only social support for the relationship remains a significant predictor of dissolution over time, underscoring the differential strength of each variable in predicting relationship stability. This is consistent with previous research conducted by Felmlee et al. (1990), which found that social support for the relationship (specifically from the partner’s network), amount of time spent together, and relationship duration all proved to be significant predictors of the rate of relationship dissolution.

Overall, the current study has provided diverse forms of evidence to confirm that general social support and social support specifically for relationships are two separate, and unique domains of social support, each of which provides its own contribution to relationship well-being and health outcomes. Furthermore, it appears that social support specifically for relationships is a much more proximal predictor of relationship outcomes, as would be expected. The next section specifically addresses the predictive power of social support for relationships over time.

**Predictive Power of Social Support for Relationships Over Time**

The results of the Time 1 analyses indicated that individuals who perceived more social support for their relationships also reported higher levels of relationship well-being and better mental and physical health than individuals who perceived lower levels of social support for their relationships. These findings are further strengthened by their replicative nature of the findings published by Blair and Holmberg (2008). Examining individuals’ perceptions of support for their relationships at a single point in time,
however, can only tell us so much about how these perceptions are associated with relationship well-being and health throughout the duration of a romantic relationship.

Two analyses were conducted to evaluate the predictive power of social support for relationships over time. In the first analysis, a structural model was fit in which Time 1 social support for the relationship was posited to predict Time 3 outcome measures (relationship well-being, mental and physical health), which were provided, on average 17 months after the Time 1 data. In other words, are the levels of perceived support for a relationship at one point in time predictive of relationship well-being and health at a later point in time, within the same relationship? In the second analysis, partially discussed above, Cox regression models were used to conduct a survival (or hazard) analysis predicting not only whether a relationship would end during the course of the study, but also, the rate at which relationships within the study ended. The results of these analyses provide support for hypotheses 4.3 and 4.1, respectively, and indicated that social support for relationships does indeed remain a significant predictor of relationship stability and well-being over time. These findings are consistent with other longitudinal studies, in which social support for relationships was found to be a significant predictor of relationship well-being and dissolution over brief (Felmlee et al., 1990; Lehniller & Agnew, 2007) and extended (Balsam et al., 2008; Sprecher & Felmlee, 2000) periods of time.

The SEM analyses demonstrated that the amount of support an individual perceives for their relationship at an earlier point in time is strongly associated with the levels of relationship satisfaction and health that they report at a later point in time (i.e., between 3 and 29 months). Figure 24 depicts the model tested, in which Time 1 measures of general social support and social support for the relationship were posited to predict Time 3 measures of relationship well-being, mental and physical health. The model fit the data well (CFI = .96), such that social support for relationships at Time 1 accounted for 30% of the variance in relationship well-being at Time 3, which, in turn, accounted for 22% of the variance in physical health and 34% of the variance in mental health. Time 1 general social support proved to be an even weaker predictor over time, accounting for only .25% of the variance in physical health at Time 3.
Furthermore, the amount of social support for a relationship that an individual perceives at an earlier point in time is also predictive of whether or not that individual’s relationship will end at a future point in time. The survival analysis using Cox regression models provided complimentary evidence for the predictive power of social support for relationships over time. A multivariate Cox regression model found that both relationship satisfaction and perceived social support for the relationship from friends served as significant predictors of relationship dissolution, while general social support from family did not. A one unit positive change in the satisfaction scale was associated with a 31.4% decrease in the likelihood of breaking up during the course of the study and a one unit change in the social support for relationships from friends scale was associated with a further 21.5% decrease in the likelihood of breaking up during the course of the study. Hence, the amount of support an individual receives for their relationship from their friends and the extent to which they are satisfied with their relationship at any given point in time are both strongly associated with the duration of the relationship. The results once again emphasize the importance of social support in predicting relationship outcomes and echo the results of past research that have found relationship satisfaction and social support for relationships to be potent predictors of relationship dissolution (Le et al., 2010). Specifically, a meta-analytic synthesis of the literature on nonmarital relationship dissolution found relationship satisfaction, love, commitment and social support for the relationship to all be significant and important predictors of relationship dissolution over time (Le et al., 2010). Interestingly, while the current study included love, relationship satisfaction and commitment - three relationship well-being variables reported by Le et al. (2010) to be substantial contributors to relationship dissolution - only relationship satisfaction remained a significant predictor of dissolution in the current study when the variables were examined from a multivariate perspective.

**Summary of Findings for Predictive Power of Social Support for Relationships Over Time**

Taken together, the time-lapsed structural equation model and the survival analyses provide substantial and convincing evidence that the amount of support an individual perceives for their relationship at an earlier point in time is a powerful predictor of how they will later rate their relationship satisfaction and mental and physical health. For the average participant, 14 months elapsed between Time...
1 and their latest follow-up time. Thus, it can be said that relationship satisfaction and social support for the relationship from friends are both powerful predictors of relationship stability over a period greater than 1 year, and up to 2.4 years for some participants.

**Social Support for the Relationship From Parents Versus Friends**

The current study has done little in the way of clarifying the question of whether parents or friends are more important when it comes to the predictive power of their support for a relationship with respect to relationship well-being, health, and relationship stability. Hypothesis 3.1 predicted that participants’ relationship well-being and health would be associated with their perceptions of social support for their relationship from friends, but not their perceptions of social support for their relationship from parents. The current study did not find evidence to support this hypothesis. On the one hand, the survival analyses are consistent with much of the literature that suggests that support from friends plays a more important role in predicting relationship dissolution (Felmlee, 2001; Felmlee, Sprecher & Bassin, 1990). On the other hand, the SEM analyses add to the literature’s equivocal findings concerning the influence of parents versus friends. Specifically, support for the relationship from parents proved to be a stronger predictor of relationship well-being and health than was social support for the relationship from friends, standing in contrast to much of the existing literature which finds support for the relationship from friends to be the more salient predictor (LaSala, 1998; Lewis, 1973; Parks & Stan, 1983; Sprecher & Felmlee, 1992; Sprecher & Felmlee, 2000; Leslie et al., 1986). Despite the lack of clarification provided by these findings, it is important to note that none of the results in this study or in the Blair and Holmberg (2008) study find any evidence to support the Romeo and Juliet Effect (Driscoll et al., 1972). In other words, whether an effect is found for parents versus friends in the current study, the effect is always in the direction of greater support predicting greater relationship well-being and stability, and provides no evidence that low levels of support from parents (or friends) predict greater relationship well-being and stability. Reasons for these contradictory findings are discussed below.
**Time 1 Measurement and Structural Models**

The constructs of support for the relationship from parents and friends were initially posited to be separate constructs, and to test this, two versions of the measurement model were tested. The first model included a single social support for relationships construct, which included indicators from both parents and friends. This model fit the data well, thereby not experiencing the problems reported by Blair and Holmberg (2008) in fitting a measurement model that included support from parents. The second measurement model tested in the current study divided social support for the relationship into two separate factors, one representing support from friends, and the other representing support from parents. The resulting measurement model did not fit the data well, and attempts to modify the model were unsuccessful. Thus, the final model used for the structural models in the current study consisted of a single social support for relationships factor, indicated by overall perceived social support for the relationship, approval of the relationship from parents (own parents and partner parents combined), and approval of the relationship from friends. This final model differed from the structural model tested by Blair and Holmberg (2008), as they were unable to fit a model that included parental support, either as part of a single social support for relationships factor or as a separate factor representing only support for the relationship from parents. Upon examining the correlation matrices from each of the studies, it appears that the reason for this discrepancy in model fit with respect to support from parents may lie in the non-significant correlations between support for the relationship from parents and all other measures reported by Blair and Holmberg (2008). In the current study’s correlation matrix, support from parents correlate positively with other measures in the study, including social support for relationship measures as well as outcome measures. It may be that the Blair-Holmberg sample perceived significantly lower levels of parental support for their relationships and made attributional discounts that negated the influence of parental support on outcome measures. Furthermore, the inability to fit a model including parental support in the Blair-Holmberg study suggests that, in that sample, support from parents and friends may have represented distinct constructs. In the current study, the reverse seems to be true, in that it was not possible to fit a model that attempted to separate these constructs. While the current study’s pattern of
correlations between parental support and outcome measures is consistent with results presented in some past research (Sprecher & Felmlee, 1992), the current study is contradictory to past research that has reported parental approval of a relationship to be a very poor predictor of relationship well-being and stability (Leslie et al., 1986; Blair & Holmberg, 2008).

**Direct Comparison of Blair-Holmberg Sample to Current Sample**

Additional information concerning the distinction between social support for the relationship from parents versus friends comes from the comparison of the current study’s sample to the sample collected by Blair and Holmberg (2008). In order to fit an identical model with both data sets, modifications to the measurement model were required due to discrepancies between the variables used in each study. The resulting comparison model fit the data well in both samples, although the model varied significantly across groups. These differences are particularly relevant to understanding the relative contributions of support for the relationship from parents versus friends. Although the model fit the data well in both samples, support from parents had a much higher factor loading on the social support for relationships factor in the current study’s sample than it did in the Blair-Holmberg sample (.52 versus .20). Thus, although parental support was included in the modified model tested on the Blair-Holmberg sample, it is unlikely that this indicator played a significant role in the model, given its low factor loading.

It is possible that the two samples simply differed in their experiences of parental versus friend support for the relationship, such that in the sample collected by Blair and Holmberg (2008) parental support represented a different, and insignificant domain of social support for relationships, while in the current study parental and friend support for the relationship appear to represent a similar domain of social support for the relationship. Although past research has not specifically addressed the question of whether or not social support for relationships from parents and friends represent two separate constructs, the conflicting evidence within the literature (i.e., sometimes parents are important predictors, sometimes their support predicts dissolution, sometimes their lack of support predicts stability, sometimes they lack any association with relationship well-being whatsoever) does suggest that the two constructs do seem to behave differently (Felmlee, 2001; Driscoll et al., 1972; Leslie et al., 1986; Sprecher & Felmlee, 1992).
Despite the implication that social support from parents versus friends operates as a more similar construct in the current study than in Blair and Holmberg’s (2008) study, a structural model designed to directly compare support for the relationship perceived from each group yielded different conclusions. To determine the relative contributions of social support for the relationship from parents versus friends in the current sample, a structural model was fit in which a parental approval factor (indicated by own parent and partner’s parents approval) was compared to the manifest variable of friend approval. In other words, when trying to understand a participant’s relationship well-being, how much information can be gleaned from the support for the relationship provided by parents versus friends? While the two constructs were highly correlated ($r = .55, p < .001$), they each accounted for different proportions of the variance in relationship well-being. Parental approval of the relationship accounted for nearly 16% more of the variance in relationship well-being than did approval of the relationship from friends. This discrepancy was further emphasized when using Time 1 predictor variables and Time 3 outcome variables, such that only Time 1 parental approval (and not friend approval) served as a significant predictor of Time 3 relationship well-being, mental and physical health.

The final piece of evidence shedding light on the relative predictive power of social support for the relationship from parents versus friends comes from the survival analysis, in which social support and relationship well-being measures predicted relationship dissolution over time. The results of the survival analysis were somewhat contradictory to the results of the structural model analyses. In the survival analyses, social support for the relationship from family was not even significant at the bivariate level (i.e., when no other variables besides relationship length were included; see Appendix AA), while social support for the relationship from friends was significant at both the bivariate and multivariate levels. To the extent that these findings suggest that perceived social support for the relationship from friends has greater predictive power than support from parents; these findings contradict the SEM findings. However, it is possible that these findings are complimentary instead of contradictory, as the outcome being measured in each analysis is different.
In the SEM analysis, the question at hand is whether perceived approval of the relationship from parents versus friends (at Time 1) has a differential association with relationship well-being, mental and physical health (both at Time 1, and then again at Time 3). In the survival analysis, the question being answered concerns the predictive power of perceived social support for the relationship from parents versus friends with respect to the rate of relationship dissolution. Although dissolution of a relationship is linked to relationship well-being (as demonstrated by the significant bivariate and multivariate links between relationship satisfaction and rate of dissolution), actual dissolution of the relationship is a very different outcome variable. Thus, taken together, the results of these two analyses suggest that, for the current sample, approval of the relationship from parents is a stronger predictor of relationship well-being, and in turn, mental and physical health, while perceived social support for the relationship from friends is a stronger predictor (and in fact the only significant social support for relationships predictor) of the rate at which a relationship dissolves. To the extent that relationship well-being and relationship dissolution are separate constructs, it can be concluded that these findings are complimentary, rather than contradictory. Longitudinal research by Sprecher and Felmlee (1990, 1992, 2000, 2001) has found discrepancies in how social support for the relationship predicts outcomes as a function of both the source (parents versus friends) and the outcome variable in question (relationship well-being measures versus relationship dissolution), such that parents are often powerful predictors of relationship well-being over time, but not necessarily important predictors of relationship dissolution.

Future Directions for Support for Relationships from Parents Versus Friends Research

Given the inconsistent findings both within this study and within the greater literature at large, the question facing researchers in this area now is a matter of moderation, or determining when and for whom parental support of a relationship plays a significant role in predicting relationship outcomes. Some

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8 It should be noted that even when the same indicators of support that were used in the structural model (i.e., friend approval, own parent approval, partner parent approval) were tested, parental support continued to remain non-significant. Friend approval was also a non-significant predictor of the rate of relationship dissolution. This finding highlights the differences between the social support for relationship measures, with the social network variable measures most likely representing perceptions of support, and the approval measures from the Behaviour of Family and Friends Scale likely representing actual experienced approval and disapproval from parents and friends.
answers concerning this question may come from the research on ambivalent social support (Holt-Lundstad, Uchino, Smith & Hicks, 2007). Ambivalent social support refers to experiencing a member of one’s social network as being both helpful and upsetting when support is needed. Research has consistently linked ambivalent relationships with detrimental health outcomes, such that in some cases, no support is better than ambivalent support (Holt-Lundstad et al., 2007). Furthermore, ambivalent relationships among family members may be particularly difficult to cope with, as one does not often have the luxury of replacing difficult family members with new ones, as they can with friends. Although it has not yet been studied, it may be possible that social support specifically for relationships can also be ambivalent. For example, if a network member is generally positive and supportive about a relationship, taking an interest in the relationship, including the partner in events, providing material and emotional support as needed, but then is also very reactive when the relationship experiences stressors, perhaps jumping quickly to negative conclusions or being too eager to point out the down sides of the relationship, the individual within the relationship may perceive this combination of approval and disapproval as being ambivalent social support for the relationship. To the extent that ambivalent support for individuals leads to negative health outcomes, it may be possible that ambivalent support for relationships is associated with more negative relationship well-being outcomes. Applied to the question of support for relationships from parents versus friends, it may be that individuals perceiving ambivalent parental support for their relationships are clouding researchers’ abilities to assess the answer accurately. For example, if a sample contains individuals who are either high or low in perceived ambivalent support for their relationship from their parents, and the association between parental support for relationships and relationship outcomes differs as a function of this ambivalence, significant associations between parental support and relationship well-being may be lost when the ambivalence factor is not taken into consideration. To the extent that various samples in the literature contain varying proportions of individuals perceiving low to high ambivalent parental support for the relationship, this could explain the inconsistent findings across studies.
Of course, there could be any number of other potential moderators, including personality traits, family structure characteristics, or cultural factors that may help in deciphering the question of when and for whom parental support for a relationship has a significant association with relationship well-being outcomes (Felmlee, 2001; Blair & Holmberg, 2008).

**Comparing Same-Sex Versus Mixed-Sex Couples (Hypotheses 2.2a and 2.2b)**

One aspect of this study that has not yet been discussed extensively is the inclusion of individuals in same-sex and mixed-sex relationships. The inclusion of both types of relationships sets this study apart from many others that have relied wholly (or mostly) on individuals in mixed-sex couples. The goal of the study was not to find differences between same-sex and mixed-sex couples, nor was it to specifically study same-sex relationships, but rather the goal of the study was to examine perceived social support for relationships as a predictor of relationship and health outcomes, regardless of the genders within a romantic dyad. While the study does not claim to be inclusive of all relationship types (e.g., participants could not provide relationship well-being variables about more than one current partner, or complete the survey in a language other than English), it was a goal of the study to be as inclusive of all relationship experiences as possible, and as such, the eligibility criteria only required that participants be 18 years of age or older and be able to complete the survey in English. These criteria stand in contrast to many studies of relationships, which specifically require that participants be in mixed-sex relationships, or identify as heterosexual, thereby unintentionally adding to the day-to-day exclusions experienced by individuals in same-sex relationships.

With the above caveats in mind, the current study continues to add to the literature in showing that same-sex couples and mixed-sex couples are far more similar than they are dissimilar. Although there should not be a goal of establishing “no difference” as a means of promoting equal treatment, the finding of no difference does lend credence to the concept of including same-sex couples in more relationships studies. Relationship type can always be treated as a potential moderator or control variable, in a manner similar to how any other demographic variable is currently treated. For example, when designing a study in which age may or may not play a mitigating role, researchers do not limit their sample to participants.
of only one age, they simply control for age in all subsequent analyses should it prove to be an important covariate in the study. Thus, in the current study, analyses were conducted based on the major hypotheses concerning the differentiation between general social support and social support for relationships, the function of social support for relationships in predicting relationship well-being and mental and physical health outcomes (statically and over time), and comparing the relative contributions of support from parents versus friends. In each of these analyses, relationship type was treated as a potential covariate, and more often than not, the results indicated that relationship type was not a significant covariate and the analysis proceeded with the full sample. It may be argued then that the same results could have been obtained with a sample of individuals in mixed-sex relationships only, and this would be true, but such a sample would not allow for the conclusion that the findings are generalizable across relationship types.

Although the same-sex and mixed-sex samples in the current study differed significantly from one another on a variety of demographic variables, most notably age and relationship length, very few differences were found between the groups on the main variables and processes of interest. Discriminant validity for social support for relationships as compared to general social support was established in both samples, but there were a few differences in the interscale correlations as a function of relationship type. Specifically, perceived social support for the relationship and approval of the relationship from the participant’s own parents had a statistically stronger correlations with general social support from family among participants in same-sex relationships as compared to participants in mixed-sex relationships. This is not an altogether surprising finding, as it likely indicates that for individuals in same-sex relationships, their sense of general social support from family is closely linked to the extent to which they perceive social support for their relationship. To the extent that their relationship represents a marginalized aspect of their identity, and to the extent that families may express their support of this aspect of their identity through their support of the individual’s relationship, it makes theoretical sense that these variables would be more highly correlated with one another in the same-sex sample (LaSala, 1998; Rothblum, Balsam & Solomon, 2011; Lannutti, 2007). Within the mixed-sex sample, the constructs of social support for the individual and social support for the relationship, especially from family, are probably much more
discernible, as it is unlikely that any aspect of the relationship is specifically tied to a stable identity marker associated with fluctuating levels of general social support.

Social support for relationships also appears to function very similarly in both mixed-sex and same-sex relationships, such that regardless of the type of relationship a participant was in, individuals who reported higher levels of perceived support for their relationship were also likely to report higher levels of relationship satisfaction and health, as compared to individuals who reported lower levels of perceived support for their relationships. In the regression analyses comparing the ability of general social support and social support for the relationship to predict relationship well-being measures, there were no differences found in either the pattern or magnitude of associations. Similarly, the Time 1 structural model had no differences between relationship type groups. Replicating the findings of Blair and Holmberg (2008), the current study did not find any significant differences in how the hypothesized model fit as a function of relationship type. In other words, social support for a relationship predicts relationship well-being, which in turn predicts mental and physical health, regardless of whether an individual is with a partner of the same gender or a different gender. Finally, the survival analyses conducted to predict the rate at which relationships dissolved over time also found no significant differences between relationship types. Thus, it was concluded that the predictors of the rate at which couples dissolve over time are consistent across both same-sex and mixed-sex relationships in the current study.

In summary, the current study found more similarities than differences between same-sex and mixed-sex couples, despite the demographic differences between the two groups, with the same-sex couples being older and having subsequently been in their relationships for a longer period of time. The single difference found across a multitude of analyses (apart from demographic differences) was a statistically significant difference in the magnitude of a correlation between perceived social support for the relationship from parents and perceived general social support from family; a finding that makes theoretical sense given the likely links among same-sex sexuality, identity and a sense of support and belongingness from family.
Implications

Theoretical Implications

Overall, the study found evidence that social support for relationships is an important predictor of relationship well-being, and in turn, mental and physical health, with the link to health outcomes being fully mediated by relationship well-being. Furthermore, the study found that the model holds true over time, and that Time 1 social support for the relationship is a significant predictor of relationship well-being and health at a later point in time, as well as relationship stability. These findings provide important implications for understanding social support for relationships as a specific and unique domain of social support, and suggest that theories concerning the influence of social support on health and well-being may be applicable to the concept of social support for relationships.

Just as an individual can be the recipient of various forms of social support, such as emotional, instrumental, informational, and belonging (Uchino, 2004), a romantic relationship can also be the recipient of the same forms of support. Two main theories, the direct effects model and the stress-buffering hypothesis, have been posited to explain the robust associations between social support for an individual and mental and physical health outcomes, and both of these theories can be applied to social support for relationships. In the existing application of these theories, the object of interest is the individual, and the outcomes of interest are mental and physical health, with the independent variable being general social support for the individual. Applying social support theories to the concept of social support specifically for relationships makes the relationship the object of interest, and the health of that relationship, or relationship well-being, the outcome of interest, and the independent variable is social support for the relationship. Thus, where an individual might be provided with a sense of belonging from friends and family, a relationship, or dyad, can also be provided with a sense of belonging to the extent that friends and family treat the couple as a single unit, include them in social activities, and recognize the relationship as an important aspect of each individual’s identity.

The direct effects model (Cohen & Wills, 1985) of social support suggests that purely having social support available (for an individual) reduces the number of stressors experienced, and thereby
reduces negative mental and physical health outcomes (Uchino, 2004). Additionally, the model explains how the presence of social support can have a positive impact on mental and physical health through the promotion of healthy behaviours, such as smoking cessation, healthy eating, or encouragement to seek medical treatment. All four types of social support can be seen operating in the direct effects model, such that material support might lead an individual to suffer fewer financial hardships, therefore avoiding the stress associated with such hardships. Having informational support available may help an individual to avoid risky behaviour or may help them to seek appropriate treatment more efficiently. Just as having a sense of social support may directly influence one’s mental and physical well-being, a sense of social support for a relationship may also directly influence the health of the relationship. A relationship that has access to informational support may avoid common pitfalls of coupledom, and a relationship that has access to instrumental support (e.g., friends who help the couple move in together) may avoid relationship stressors that would occur without such support. Furthermore, social support for the relationship may encourage healthy relationship behaviours. To the extent that acknowledging a relationship is a form of support for the relationship, such acknowledgement may come along with a degree of social influence that treats the dyad as a couple, therefore increasing the couple’s identity as a dyad (Lewis, 1973), and reducing their uncertainty about the relationship (Berger, 1979). To the extent that the couple views themselves as a single unit, this may influence their behaviour (Lewis, 1973). For example, social support for a relationship that leads a couple to view themselves as a couple, may then lead the individuals within the dyad to be more faithful to one another, to the extent that faithfulness is an expectation of romantic coupling (Lewis, 1973). Increased faithfulness is likely to then have a positive influence on the health of the relationship, or, relationship well-being. The results from the current study are congruent with a direct effects model explanation of how social support for relationships might influence relationship well-being, such that support for the relationship may help a couple to avoid relationship stressors and encourage positive relationship maintenance behaviours, thereby generating positive associations between social support for the relationship and relationship well-being regardless of the level of relationship well-being (or distress).
The second influential and well-established theory concerning the associations between social support and health outcomes is the stress buffering model, or the buffering model (Cohen & Wills, 1985; Uchino, 2004). The buffering model posits that social support influences health outcomes by attenuating the impact of stress when it does occur in an individual’s life (Uchino, 2004). In other words, when stressful events occur, individuals who have social support in their lives (of various forms) will experience a weaker magnitude of association between that stress and their mental and physical outcomes than an individual who has less social support available. As an example, running into a financial emergency is less likely to have severe mental health outcomes (stress, anxiety, depression) if an individual has sources of material support within his or her network that are able to provide financial assistance. The stress and coping theory of social support suggests that the extent to which a stressor will influence health outcomes is mediated by an individual’s appraisal of the stressor and their method of coping with the stressor (Barrera, 1986). The theory further suggests that social support functions to promote positive and adaptive coping and appraisals, such that individuals with social support will make more positive appraisals and choose more adaptive coping mechanisms when faced with a stressor, thereby promoting better mental and physical health (Cohen & Wills, 1985; Cutrona, 1990). Within the context of relationships, when a relationship experiences a stressor (conflict, role strain, financial difficulties, value differences), relationships that have support available to them may be less likely to experience the detrimental effects associated with the stressor. In other words, the social support available to the relationship may buffer the effects of relationship stressors on relationship well-being (e.g., satisfaction or trust), or may impact the appraisals a couple makes concerning their relationship-oriented stressor as well as the coping mechanisms they choose to use for dealing with their relationship distress (Cohen & Wills, 1985). Buffering effects are known to be most effective under the conditions of the matching hypothesis, which states that the benefits of support will be most salient when the type of support offered matches the need associated with the existing stressor (Cohen & McKay, 1984). Thus, the extent to which social support will be able to ameliorate the impact of a stressor depends on how well suited the type of support offered is to the actual needs of the individual experiencing the stressor. As an
example, consider a recently bereaved individual. The loss can be considered a significant stressor with the potential to erode mental and physical health functioning. Support that directly addresses the needs of the bereaved individual will have the strongest buffering effects, while support that is unrelated to the needs of the individual (e.g., informational support that is not relevant to their current situation) will have very weak to no buffering effects. The same hypothesis may very well hold true for social support offered to relationships in times of need. If a relationship is experiencing a stressor related to conflict, social support for the relationship that provides information about conflict resolution, or emotional support for coping with the conflict may be more likely to attenuate the impact of the conflict on relationship well-being than will unrelated forms of support, such as material support. Although the current study did not measure relationship distress or specific relationship stressors (e.g., conflict, role strain), the hypothesized model is not inconsistent with a buffering model explanation, but further research would be required to support such a hypothesis. A buffering model explanation of the association between social support for relationships and relationship well-being would be supported if the correlation between relationship stressors (e.g., conflict) and relationship well-being (e.g., satisfaction) was found to be weaker for individuals high in social support for their relationship as opposed to individuals lacking in social support for their relationship.

Both the direct effects model and the stress buffering model offer potential explanations as to how and why social support for relationships influences relationship well-being. Two theories that help to explain why social support for relationships may differ across relationships are Pearlin’s social stress theory (1989) and social control theory (Vincke & Bolton, 1994). Social stress theory states that when examining the distribution of stressors within a population, it is necessary to consider individual and group factors which may contribute to uneven distributions of particular forms of stress. Although some research may seek to control for such individual differences, social stress theory emphasizes the importance of not controlling for these factors so that the role that various social stratifications play in the distribution of stress can be uncovered. With respect to relationships, social stress theory explains how some relationships may experience more stressors than others. For example, nonnormative relationships
(age-discrepant, interracial, same-sex) may experience more stressors than other relationship forms as a function of the uneven distribution of discrimination (stressor) across relationship types. Furthermore, the various distributions of stress across relationship statuses, types and categories is likely a concept that operates in a very intersectional manner, such that other social categories and stratifications come into play when influencing which relationships are most likely to experience relationship stressors. As an example, finances are often cited as one of the most frequent sources of conflict within romantic relationships (Gotta et al., 2011). Thus, a couple facing more financial constraints and challenges are likely going to be at significantly more risk for relationship stressors than couples of higher socioeconomic statuses. Add this to relationship marginalization, a lack of social support and potential personality traits predictive of relationship distress, and it becomes clear that social stress theory can be easily applied to the unequal distribution of relationship stressors across social categories and relationship types.

Following from social stress theory, social control theory steps in to explain how society, and social networks in particular, may exacerbate this uneven distribution of stressors by manipulating the extent to which they provide or withhold support for an individual (or relationship) as a function of the extent to which the individual (or relationship) conforms to social values and norms. With respect to social support for relationships, social control theory would posit that social networks offer support to individuals or relationships that are capable (or choose to) approximate the norm. A lack of support (or withholding of it), therefore, can be understood as a form of policing of those who veer from normative societal expectations and values. Knowing that support for relationships does indeed have significant associations with relationship well-being, and in turn, mental and physical health, lends credence to the usefulness of social control theory with respect to support for relationships. To the extent that a lack of social support is associated with decreased relationship well-being, mental and physical health, social control theory suggests that the withholding of social support for a relationship on the behalf of a network member (either consciously or unconsciously) may actually be a successful strategy if the goal of the network member is to deteriorate the relationship in question. However, this raises the question of
whether social network members truly intend for their actions (withholding support) to have such
detrimental implications for their loved one and their loved one’s relationship. Although a network
member who disapproves of a relationship may truly desire for the relationship to suffer (to the extent that
the relationship ends as a result), it is less likely that they desire their loved one to meet with mental and
physical health challenges. Thus, the actual enactment of social control in relation to social support for
relationships may be an area in need of further investigation. In particular, it may be useful for clinicians
and the general public to fully understand the implications of withholding support for a relationship and
that although it is possible that such withholding may contribute to the demise of the relationship, it is
also possible that they may weaken their loved one’s mental and physical well-being as a result.

Social Policy Implications

Although the enactment of social justice research by psychologists can be criticized for its
handling of human rights issues (Kitzinger & Wilkinson, 2004), through its attempts to show ‘no
difference’ or harm in the face of injustice, there are still implications of such ‘no difference’ and ‘harm
via injustice’ findings, albeit when considered cautiously. In other words, one can use the research that
presents “no difference” between two social groups, such as same-sex and mixed-sex couples, to counter
those who would argue that there are differences and that those differences should be a legitimate basis
for unequal treatment. While the truth may be that human status alone should guarantee equal treatment,
the reality of social politics may require a slightly different process. Thus, in the context of this study,
while it should not be said that same-sex couples should be given equal rights and equal access to
institutional sources of social support simply because they are not different when compared to mixed-sex
couples, it likely does not hurt to point out that same-sex couples are just as likely as mixed-sex couples
to benefit from social support of their relationships. To the extent that societal norms and values, as well
as legal developments, have trickle-down effects on the values and opinions of individuals; providing
institutionalized forms of social support for same-sex relationships is likely to increase the general levels
of social support that same-sex couples perceive for their relationships. Based on the results of the current
study and the Blair and Holmberg (2008) study, the ‘no difference’ finding can lead to the conclusion that
same-sex couples will most likely benefit from increases in social support for their relationships, just as any other relationship benefits or suffers in relation to the support they perceive from their networks.

**Clinical Implications and Applications**

Perhaps the most important finding in this study with respect to clinical implications is the understanding that general social support and social support specifically for a relationship are not interchangeable constructs. Thus, if a couple is experiencing difficulties gaining support for their relationship from their social network, it does not appear, based on the current study’s findings, that general social support will serve as much of a replacement—although this precise concept (the interchangeability of the two types of support) was not directly tested in the current study, and research does show some evidence for cross-domain buffering (i.e., support in one domain protecting against the detrimental impact of weaker support in another domain). However, understanding that general social support and social support for relationships are two separate and distinct domains of social support may help guide clinicians in how they seek to help couples facing low levels of support. Additionally, couples in general may or may not give a lot of thought to the impact that their social network’s opinions and support can have on their relationship. While individuals may anecdotally associate approval and disapproval with relationship well-being, it is unlikely that they have associated social support for their relationship with their relationship’s well-being, and in turn, their own mental and physical health, as well as the mental and physical health of their partner. Thus, clinicians working with couples may find it helpful to at least inquire about the level of support clients perceive for their relationships from their network, as this may provide useful hints as to the predictors of relationship distress. Other clinical applications may include encouraging couples to avoid discounting the potential influence of social network disapproval, and to help guide couples in finding ways to function smoothly within their existing social networks.

**General Understanding of Relationships**

The results from the current study echo the findings of many other studies concerning the fact that relationships do not exist within a vacuum and that despite our attempts to seclude ourselves from the
world and build a safe and cocooned existence with our partners or spouses, our romantic relationships are still social entities that exist within a vast social network of other social relationships, many of which have a vested interest in our own romantic relationships. The withdrawal hypothesis (Johnson & Leslie, 1982) posits that couples tend to retract from their social worlds at the point when their relationship transitions from being a casual relationship to a more serious relationship. This effect has been documented many times, and other researchers have found that during this time, couples tend to perceive less support for their relationship and more interference and hindrance from their social networks (Knobloch & Donovan-Kicken, 2006; Sprecher, 2011). While it is likely that the couple may withdraw because they are happy with one another and because they have found someone who can provide them with many of the joys and supports that they previously sought elsewhere (possibly from multiple sources), it may be wise for individuals to consider their actions during this stage of their relationship. If social support for relationships functions within a direct effects model, then simply having the support of our network for our relationship will be beneficial to our relationship’s health and well-being. Withdrawing, therefore, may not only reduce our perceptions of support, but may actually reduce the support we receive (Sprecher, 2011), thereby placing the health of our relationship at risk (and subsequently, our own mental and physical health). If, on the other hand, social support for relationships functions within a stress buffering model, then social support for our relationship is likely to play the most important role when we run into relationship problems and hiccups. If couples withdraw from their networks as their relationships become more serious, they may end up feeling very isolated and lack access to social support, thereby leading to an exaggerated effect of relationship stressors on relationship well-being. At the very least, not having access to social support during times of relationship stress would negate the possibility of such support attenuating the impact of relationship stressors on relationship well-being.

Social control theory suggests that our networks may try to manipulate our relationships by offering or withholding support for the relationship, and while it is not often good to give in to manipulation, it may be wise for individuals to at least conduct a cost-benefits analysis to determine if
what the social network is asking of them might be worth the additional support that they may gain for their relationship. For example, perhaps networks withhold support from couples seen to be withdrawing as their relationship transitions into being more serious (Sprecher, 2011). If the “cost” of retaining more of the support for the relationship available from the network is withdrawing less and making a few more efforts to be engaged socially as a couple, then this may not be too high of a price to pay for the benefits potentially associated with increased levels of support for the relationship, especially in the event that the couple encounters a relationship stressor during this time.

**Strengths and Limitations**

**Internet Methodology**

The participants for this study were predominantly recruited over the Internet and the surveys were administered via a secure online website. As such, it is difficult to be certain of each participant’s identity and motives for completing the study. It is possible that some participants could have been falsely reporting information, or completing the surveys in a haphazard fashion, simply to earn prize draw points. However, previous research has found that samples tend to be similar, regardless of whether they were collected through the Internet or through more traditional means (Gosling, Vazire, Srivastava & John, 2004). Additionally, studies have shown that the results of Internet research are similar to the results of more traditional paper-and-pen based survey research, and that participants are no more likely to provide false responses online than they are in person (see Kraut et al., 2004, for a review of the pros and cons of Internet research). One of the few differences that has been found with the use of Internet methodology is that samples recruited online tend to be, if anything, more diverse and more representative than student samples (Kraut et al., 2004). Certainly, in the case of the current study, using the Internet to recruit participants and collect survey data provides the advantage of reaching greater numbers of individuals in same-sex relationships, and providing these participants with a safe, convenient and anonymous location for the completion of the study.
Sample

One limitation of the current study is the completion rate among the participants. Although over 3500 participants completed the user registration portion of the study, the final Time 1 sample consisted of only 1281 participants. Of these, fewer than half returned to complete at least one of the follow up phases, and fewer than 200 participants provided useable data across all three phases. Methodological choices in the current study contributed to the high rate of noncompletion, attrition, and missing data.

Despite the large number of participants who could not be used in the current analysis, missing values analyses found that the pattern of missing data was missing at random, or not related to the major outcome variables of interest in the study. Thus, this finding suggests that our findings may generalize to the larger sample. Additionally, the Time 2 and Time 3 samples were very similar in their demographics to the original sample.

An additional problem with the sample concerned the demographic comparability of the same-sex and mixed-sex samples. Although it would seem fairly simple to recruit a matching sample of individuals in mixed-sex relationships after recruiting a relatively diverse sample of individuals in same-sex relationships, this task actually proved to be much more difficult than it would appear. Recruitment of individuals in same-sex relationships was aided by the wide variety of websites, mailing lists, and magazines directly aimed at individuals in the LGBTQ community, and specifically, those in same-sex relationships. While there is certainly no lack of websites, mailing lists, or magazines directed at mainstream heterosexual audiences, there are very few directed specifically at mixed-sex couples. Those that are directed at mixed-sex couples tend to be directed at very specific forms of couples, such as newlyweds or those who belong to a specific segment of society or engage in specific relational activities. In this case, being the majority made mixed-sex couples an ironically difficult group from which to draw a broad and representative sample. Consequently, the recruitment of individuals in mixed-sex relationships relied much more heavily upon university-based recruitment, leading to a younger, more student based mixed-sex sample. The same-sex sample was older, more likely to be living with their partner, more likely to be living in the United States (as opposed to Canada or elsewhere in the world) and
had been in their relationships for a longer period of time. Despite these limitations, the model still held for the sample as a whole and equally well between groups.

**Measures**

The self-report methods used in this study inherently bring a degree of bias to the data. Participants completing self-report questionnaires may be inclined to answer in a manner that makes them appear socially desirable, or to provide answers that are in line with what they believe to be the researchers’ expectations. Despite this important reservation, there is no reason to expect that there was more bias in this study than would be found in any other. Related to this issue is the fact that information regarding the actual opinions and feelings of the network members was not collected; therefore, the model relied on reported perceptions of social support and approval for the relationship. Despite this caveat, perceptions tend to have a greater association with relationship well-being, mental and physical health, as compared to measures of actual support provided (Sprecher, 2011). Future research may also wish to include more objective, physiological indicators of physical health; however, self-reported health does seem to be an important correlate/predictor of a variety of health outcomes (Coman & Richardson, 2006; Foley, Manuel & Vitolins, 2005; Kuhn, Rahman & Menken, 2004).

One of the greatest strengths of the current study was its inclusion of a measure of general social support, thereby allowing divergent validity between this construct and perceived social support for the relationship to be established. Despite this strength, it may still have been possible to select a better, even more general measure of social support, and especially one that did not rely so heavily on support from a significant other. Future research should include multiple measures of various domains of support in order to allow for an even more nuanced comparison of social support for relationships to other domains.

The study was also strengthened by its diverse measurement of sexual identity and relationship type. Instead of assuming relationship type as a function of sexual orientation or sexual identity, the sample was divided into groups based on the gender composition of the couple. Furthermore, diverse gender options were provided, including transgender and genderqueer. When discrepancies arose in the data in terms of identifying relationship types, the wide variety of measures relating to sexual orientation,
sexual identity, gender identity and the nature of the relationship, including the gender of their partner, allowed for an accurate method of determining relationship type (same-sex or mixed-sex).

**Summary of Strengths and Limitations**

Although the hypothesized model in this study fit the data for the overall sample, as well as the sample split by relationship type, and the samples collected at successive phases of the study, this does not in fact preclude the possibility of other models also fitting the data, equally well or even better. In other words, we cannot say for certain that social support for a relationship leads to improved relationship well-being, and then, in turn, improved mental and physical health; it is entirely possible that the directions of these associations may be reversed or related to constructs and experiences that have not been measured in this study. As demonstrated by the three alternative models tested, any model that allows the factors to correlate as they do within the correlation matrix is likely to produce a good fit to the data. Nonetheless, the inclusion of alternative models does help to put the hypothesized model into context. Specifically, the reverse mediation model fit the data well, indicating that it may be possible that individuals in healthy and satisfying relationships either receive more social support for their relationships or simply perceive more social support for their relationships to be available. Social network members may also choose to provide more support for relationships that seem satisfying and healthy, consistent with social control theory, in which they may withhold support from relationships that they deem to be deviating from the norm of satisfaction and healthy functioning. Nevertheless, while it is realistic to assume that there are some bidirectional links within the current model, it is still a well-supported and logically sound model which combines the variables of perceived social support for the relationship, relationship well-being, and mental and physical health in a novel fashion.

**Future Directions**

Perhaps the most interesting area for future directions related to the current study will be in attempting to determine more specifically the directionality of associations among social support for the relationship, relationship well-being and health. The current study found that alternative models did fit the data well, but a more longitudinal examination of alternative models may help to determine which model
actually represents the best fit to the data. The models run in the current study using two different time points do show that through the directionality of time, social support for relationships is associated with events at later points in time, but the small sample sizes at Time 2 and Time 3 precluded the fitting of a model that included all three time points.

As discussed above, the question concerning the relative impact of support for relationships from parents versus friends remains to be conclusively answered. Future research in this area should focus on identifying moderating variables that may be suppressing and altering the relative effects of parental and friend support for relationships across different studies. In addition to moderating effects, the question could also be further clarified through the comparison of outcome measures examined. Perhaps parental support for a relationship is more predictive of relationship well-being and health, but friendship approval is more often associated with actual relationship stability. Thus, it is necessary to very clearly define the outcomes that are being examined in the study in order to make the necessary comparisons between support from parents versus friends. Other factors influencing this question may relate to the difference between perceived and actual support, or the differences may operate at the level of behavioural differences between parents and friends. Perhaps friends are more cautious in expressing their disapproval for a relationship, not wanting to risk losing a friend, while family, and parents in particular, may feel that they have more leeway to express disapproval without the risk of losing their loved one. Differences in actual behaviour may then contribute to differences in perceptions of support. For example, perhaps more support is perceived for the relationship from friends (when this is the case) because friends are less likely to actually show their disapproval. Future research on the decision-making processes that operate within social networks concerning the disclosure of negative opinions concerning relationships may help to clarify these issues.

Another important future direction is to examine the model using dyadic data. The current study had only 150 couples, not all of whom provided valid data from each partner. Future analyses of the data set will examine the data from a dyadic perspective, but the continuation of data collection for the study
may aide in increasing the sample size to allow for a more powerful analysis of dyadic effects within the model.

Conclusion

The current study has established the divergent validity of social support for relationships as well as its associations with relationship well-being both at a single point in time and longitudinally. The findings emphasize the social dependence of romantic relationships, underscoring how perceived social support for a relationship can predict relationship well-being and stability, and in turn, mental and physical health. Further, relationship well-being was shown to fully mediate the association between social support for a relationship and mental and physical health, demonstrating that social support for a relationship is related to physical and mental health solely because of its influence on relationship well-being. The study is unique in its examination of the four main factors with the inclusion of a general social support factor, and is also set apart from the remaining literature by its use of a large sample consisting of same-sex and mixed-sex relationship types.

It is hoped that this study will serve as an example of a rather large-scale study that, with minimal additional efforts and no additional costs, recruited more than 600 individuals in same-sex relationships. This feat was no doubt facilitated by the use of Internet methodology, something that may not be appropriate for all studies, but nonetheless demonstrates that if a survey is designed to be inclusive, a diverse sample can be recruited. Relationship researchers must endeavour to ask themselves why they recruit the samples that they do, and this includes interrogating the issue of including or excluding same-sex couples from research samples. If researchers are interested in human sexuality and human relationship dynamics, then this, by definition, includes same-sex sexuality and same-sex relationships, just as it naturally includes interracial relationships, age-discrepant relationships, interfaith relationships, and a multitude of other relationship variations. The literature consistently reports more similarities between same-sex and mixed-sex couples than it does differences, and thus it would appear that it is time to stop defining the relationships we study by the gender composition of the dyad, time to move away from rigid gender binaries that exclude nonbinary gender expressions, and time to begin studying human
relationships and human sexuality, without qualifications. Failure to do so places relationship researchers in a position of perpetuating the existing systems that act to stigmatize, marginalize, and exclude diversity from mainstream heteronormative society (and research) and such a position is not congruent with the aims of generating an empirically valid and socially conscious understanding of human relationships.

Within the current study, regardless of the type of relationship participants were in (i.e., same-sex versus mixed-sex), participants who perceived greater support for their relationships were also more likely to report more satisfying and healthy relationships and fewer mental and physical health challenges. Furthermore, this pattern of associations held over time, such that participants who perceived support for their relationship at an earlier point in time continued to report higher levels of relationship satisfaction up to 2.4 years later, compared to individuals who perceived less support for their relationship. Not only was support for the relationship an important predictor of relationship well-being and health over time, having support for a relationship from friends was associated with a 21% reduction in the likelihood of a relationship breaking up during the course of the study.

Future research in this area should focus on more clearly deciphering the role that the source of support for relationships plays, attempting to determine when, and for whom does support from parents and friends matter, and under what conditions does support from one of these sources serve as a better predictor of relationship outcomes than the other. Overall though, the current research found no evidence to support the assumption that support from either of these sources should be considered inconsequential, as both have significant associations with relationship and health outcomes, under various conditions, varying mostly as a function of which outcomes are being examined.
REFERENCES


APPENDIX A: ADVERTISEMENTS

Ethics Section 4.6: Recruitment Materials

Participant Recruitment

Participants will be recruited through a variety of methods, including flyers, online advertisements (websites, social networking groups, search engine listings and advertisements), print advertising (magazines, newspapers), email (listservs and snowballing), and in person at relevant events (various Pride celebrations). Copies of all the recruitment materials can be found below. Recruited participants will be directed to the study’s website (www.klbresearch.com), the Sexual Health Research Laboratory (SHRL) website (http://psyc.queensu.ca/faculty/pukall/projects.htm), the study’s email address (info@klbresearch.com), the SHRL email address (shrl@queensu.ca), and the SHRL’s phone line. Through any of these means a participant would be able to express their interest in participating and request additional information about the study, either through speaking with a researcher in person on the telephone, through email, or having a request answered through the website. In addition, information about the study will be presented on the study’s website and the SHRL website. Any participant deciding they would like to participate in the study would then be directed to the participant registration website.

Magazine Advertisements

Advertisements to be placed in magazines targeted at the GLBTQ community, such as The Advocate, Girlfriends, Curve, Xtra, GLBT World Review, etc.

39-Word Ad

Participants needed for a comprehensive online, queer-positive study on relationships. Cash & Gift Certificate prizes. Select “Magazine Ad” when registering and you’ll be entered into an exclusive $50.00 draw. Must be 18+, read/write English. For more information, visit http://klbresearch.com or email info@klbresearch.com
24-Word Ad

Research participants needed. Online, comprehensive, queer-positive study on relationships is offering Cash and Gift Certificate prizes to participants. For more information, visit http://klbresearch.com or email info@klbresearch.com.

50-Word Ad

Participants needed for comprehensive online, queer-positive study on relationships based out of Queen’s University in Kingston, Canada. Cash & Gift Certificate prizes. Select “Magazine Ad” when registering and you’ll be entered into an exclusive $50.00 draw. Open to those 18+ & fluent in English. For more information, visit http://klbresearch.com or email info@klbresearch.com
Newspaper Advertisements

Queen’s University’s Department of Psychology needs individuals to participate in a comprehensive research study about relationships, social support or health. Participation involves the completion of online questionnaires on relationship well-being, mental health, physical social support and sexuality.

If you are:

• Over the age of 18
• Fluent in English
• Have access to the Internet

Please contact the Sexual Health Research Laboratory (SHRL) if you are interested. 613-533-3276

www.klbresearch.com   info@klbresearch.com

* Prize Draws Available*

Website Listings

Various websites that allow postings for studies available to the public (Social Psychology Research Sites, CPA Section group sites, etc.) will have the following postings made.

Participants needed for comprehensive online study on relationships, social support and health. All types of relationships and experiences are welcomed. Participants must be 18 years of age or older and able to read and write in English. The study is conducted entirely online by researchers at Queen’s University in Kingston, Ontario, Canada. Prize draws for cash, gift certificates, ipods and travel will be available to participants. For more information visit: http://www.klbresearch.com, email info@klbresearch.com, or phone 613.533.3276 and ask for information about the Online Relationships study.

Participants needed for online study on relationships and health. Prizes available, must be 18 years of age or older and fluent in English. For more information visit: http://www.klbresearch.com, email info@klbresearch.com or phone 613.533.3276

Email (snowballing)

Dear Friends and Colleagues,

I am ready to begin collecting data for my dissertation study, which is a comprehensive longitudinal study of social support, relationships, health & sexuality. All of the questionnaires are hosted
online, and anyone over the age of 18 is eligible to participate so long as they are fluent in English (reading and writing) and have access to the Internet.

Participation can be 100% anonymous, and there are prize draws available. The entire participation process is completed online.

The questionnaires cover topics such as sociodemographics, mental and physical health, relationship well-being, social support, and sexuality.

If you would be interested in participating, you may find more information at the study’s website: http://www. klbresearch. com or you may email info@klbresearch. com or phone the Sexual Health Research Lab 613.533.3276 to speak with a research assistant.

This study has been approved by the Queen’s University Research Ethics Board.

Please forward this message to anyone you may know who may be interested in participating or any relevant listservs.

Thank you!
Karen L. Blair, MSc
PhD Student
Sexual Health Research Lab
Psychology Department
Queen’s University
Kingston, Ontario
info@klbresearch.com
Participants Needed

- Online studies
- Topics: relationships, health & social support
- Prizes: Cash, iPods, & Much More

All relationship types, views and experiences are welcome.

Funding provided by:
CIHR  SSHRC
NSHRF  GLMA-LHF
Facebook Advertisements

In A Relationship?
klbresearch.com
Participants are needed for an online survey being conducted by researchers at Queen's University. Great prizes available.

Sponsored
See all

Same-Sex Relationship?
klbresearch.com
Participants are needed for an online survey being conducted by researchers at Queen's University. Great prizes available.

Introducing Sponsored Stories
Back to Album

Sponsored
See all

Participants are needed for an online survey being conducted by researchers at Queen's University. Great prizes available.
Participants are needed for an online survey being conducted by researchers at Queen's University. Great prizes available.
Participants Needed!

Are you in a relationship?

Online Study conducted by researchers at Queen's University requires individuals in all forms of intimate relationships to participate in a study on Relationships, Social Support & Health.

You can participate from ANYWHERE so long as you have access to the Internet.

Cash, Travel and Gift Certificate Prize Draws Available to Participants.

For more information:

www.klbresearch.com
info@klbresearch.com
Research Participants Needed!

ONLINE STUDY

Participants are needed for a comprehensive longitudinal study on social support, relationships and health.

To be eligible you must be 18 years of age or older, have access to a computer and the Internet at least once every 8 months, and be able to communicate fluently in English.

All questionnaires are completed online, at your own convenience.

All relationship types and experiences are welcomed.

Queen’s University
Kingston, Ontario, Canada

PRIZES AVAILABLE!

- Cash
- Gift Certificates
- iPods
- Travel Vouchers

www.klbresearch.com
613.533.3276
shrl@queensu.ca
APPENDIX B: SUPPORT MEASURES

Social Support Questionnaires

Social Network Support
Behaviours of Parents, Friends & In-laws
The Multidimensional Scale of Perceived Social Support

Social Network Support – Sprecher & Felmlee, 1992

1 = very much disapproves, 2 = disapproves, 3 = somewhat disapproves, 4 = neither approves nor disapproves, 5 = somewhat approves, 6 = approves, 7 = very much approves.

1. To what degree do you think your family disapproves/approves of your current relationship?

2. To what degree do you think your partner’s family disapproves/approves of your current relationship?
   1 = very much disapproves, 7 = very much approves.

3. To what degree do you think your friends disapprove/approve of your current relationship?
   1 = very much disapproves, 7 = very much approves.

4. To what degree do you think your partner’s friends disapprove/approve of your current relationship?
   1 = very much disapproves, 7 = very much approves.

5. Overall, how much actual discouragement or encouragement do you get from others to continue to date (or remain married)?
   1 = discouraged a great deal; 7 = encouraged a great deal.

6. Overall, to what degree do you think others view you as a perfect couple that should marry someday (or stay married)?
   1 = not at all; 7 = a great deal.
Identification of Parents

The following questionnaires are going to ask you about the behaviour of your parents, or those who have been like parents to you. For these purposes, we need to know a little bit of information about your parents and your partner’s parents.

Please answer the following questions with your own parents in mind. We have provided space for up to four parents; for example, if your parents are divorced and both re-married, you may want to list your parents and their new spouses. However, please choose only two parents as being your “primary parents.” (If you only have one primary parent, you may select only one. If you have no parents, or no one that you would consider a primary parent, you may opt to not select any as primary parents). These are the people you feel have had the strongest influence on you (whether that influence was good or bad).

**Parent 1:**
Drop down list of descriptors: mother, father, step-mother, step-father, grandmother, grandfather, other  
(box to fill in “other” if selected)  
Gender : M, F, T  
Check box for primary parent.

**Parent 2:**
Drop down list of descriptors: mother, father, step-mother, step-father, grandmother, grandfather, other  
(box to fill in “other” if selected)  
Gender : M, F, T  
Check box for primary parent.

**Parent 3:**
Drop down list of descriptors: mother, father, step-mother, step-father, grandmother, grandfather, other  
(box to fill in “other” if selected)  
Gender : M, F, T  
Check box for primary parent.

**Parent 4:**
Drop down list of descriptors: mother, father, step-mother, step-father, grandmother, grandfather, other  
(box to fill in “other” if selected)  
Gender : M, F, T  
Check box for primary parent.

Now think about your partner’s parents and provide the same information. Again, please select only two as being your partner’s primary parents.

**Partner’s Parent 1:**
Drop down list of descriptors: mother, father, step-mother, step-father, grandmother, grandfather, other  
(box to fill in “other” if selected)  
Gender : M, F, T  
Check box for primary parent.
Partner’s Parent 2:
Drop down list of descriptors: mother, father, step-mother, step-father, grandmother, grandfather, other
(box to fill in “other” if selected)
Gender: M, F, T
Check box for primary parent.

Partner’s Parent 3:
Drop down list of descriptors: mother, father, step-mother, step-father, grandmother, grandfather, other
(box to fill in “other” if selected)
Gender: M, F, T
Check box for primary parent.

Partner’s Parent 4:
Drop down list of descriptors: mother, father, step-mother, step-father, grandmother, grandfather, other
(box to fill in “other” if selected)
Gender: M, F, T
Check box for primary parent.


Read over the following list of behaviours and then indicate which behaviours your ________ (descriptor of primary parent 1) has engaged in, with respect to your current relationship, n/a, never, once, twice, or frequently.
1. Ask how my partner is doing.
2. Be pleasant when my partner is around.
3. Respects my need for privacy with my partner.
4. Tell me she likes my partner.
5. Helps to make our relationship easier / more feasible.
6. Ask about relationship or future plans with my partner.
7. Invite my partner and me to go out with her.
8. Suggest things my partner and I might do.
10. Talk about other people I could date.
11. Tell me to wait until I have finished school to get involved with someone.
12. Ask me what I see in my partner.
13. Caution me about getting involved with my partner.
15. Tell me to wait until I am older to get involved with someone.
16. Not talk to partner.
17. Leave the room or house when partner is there.
18. Tell me my partner isn’t right for me.
19. Fix me up with other dates.

Repeat above for primary parents and partner’s primary parents.
Read over the following list of behaviours and then indicate which behaviours your friends have engaged in, with respect to your current relationship, n/a, never, once, twice, or frequently.

1. Ask how my partner is doing.
2. Be pleasant when my partner is around.
3. Tell me they like my partner.
4. Ask about relationship or future plans with my partner.
5. Invite my partner and me to go out with them.
6. Suggest things my partner and I might do.
7. Joke with my partner.
8. Talk about other people I could date.
9. Ask me what I see in my partner.
10. Caution me about getting involved with my partner.
11. Nickname my partner something strange.
12. Not talk to partner.
13. Ignore partner when partner is present.
14. Tell me my partner isn’t right for me.
15. Fix me up with other dates.


1. There is a special person who is around when I am in need.
   1 = strongly disagree, 5 = strongly agree

2. There is a special person with whom I can share my joys and sorrows.
   1 = strongly disagree, 5 = strongly agree

3. My family really tries to help me.
   1 = strongly disagree, 5 = strongly agree

4. I get the emotional help and support I need from my family.
   1 = strongly disagree, 5 = strongly agree

5. I have a special person who is a real source of comfort to me.
   1 = strongly disagree, 5 = strongly agree

6. My friends really try to help me.
   1 = strongly disagree, 5 = strongly agree

7. I can count on my friends when things go wrong.
   1 = strongly disagree, 5 = strongly agree

8. I can talk about my problems with my family.
   1 = strongly disagree, 5 = strongly agree

9. I have friends with whom I can share my joys and sorrows.
   1 = strongly disagree, 5 = strongly agree
10. There is a special person in my life who cares about my feelings.  
   1 = strongly disagree, 5 = strongly agree

11. My family is willing to help me make decisions.  
    1 = strongly disagree, 5 = strongly agree

12. I can talk about my problems with my friends.  
    1 = strongly disagree, 5 = strongly agree
APPENDIX C: RELATIONSHIP MEASURES

Relationship Information

Hendricks’ Relationship Assessment
Rubin Love Scale
Trust Scale
Dyadic Adjustment Scale
Investment Model Scale: Commitment


Each answer is rated on a 7 point scale, but only each end of the scale is given a qualitative descriptor – each of which is listed below the question. So for question one, the scale would be:

1. How well does your partner meet your needs?
   poorly – extremely well
2. In general, how satisfied are you with your relationship?
   unsatisfied – extremely satisfied
3. How good is your relationship compared to most?
   poor – excellent
4. How often do you wish you hadn’t gotten in this relationship?
   never – very often
5. To what extent has your relationship met your original expectations?
   hardly at all – completely
6. How much do you love your partner?
   not much – very much
7. How many problems are there in your relationship?
   Very few – Very Many

Rubin Love Scale

Not at all true; disagree completely  1  2  3  4  5  6  7  8  9  Definitely True; agree completely

1. If my partner was feeling badly, my first duty would be to cheer him (her) up.
2. I feel that I can confide in my partner about virtually everything.
3. I find it easy to ignore my partner’s faults.
4. I would do almost anything for my partner.
5. I feel very possessive toward my partner.
6. If I could never be with my partner, I would feel miserable.
7. If I were lonely, my first thought would be to seek out my partner.
8. One of my primary concerns is my partner’s welfare.
9. I would forgive my partner for practically anything.
10. I feel responsible for my partner’s well-being.
11. When I am with my partner, I spend a good deal of time just looking at him (her).
12. I would greatly enjoy being confided in by my partner.
13. It would be hard for me to get on with out my partner.

Trust Scale

Rempel, Holmes & Zanna 1985 – Trust Within Close Interpersonal Relationships

Using the 7 point scale shown below, indicate the extent to which you agree or disagree with the following statements as they relate to your partner.

Strongly Disagree 1
Disagree 3
Somewhat Disagree 3
Neutral 4
Somewhat Agree 5
Agree 6
Strongly Agree 7

1. My partner has proven to be trustworthy and I am willing to let him/her engage in activities which other partners find too threatening.
2. Even when I don’t know how my partner will react, I feel comfortable telling him/her anything about myself, even those things of which I am ashamed.
3. Though times may change and the future is uncertain, I know my partner will always be ready and willing to offer me strength and support.
4. I am never certain that my partner won’t do something that I dislike or will embarrass me.
5. My partner is very unpredictable. I never know how he/she is going to act from one day to the next.
6. I feel very uncomfortable when my partner has to make decisions which will affect me personally.
7. I have found that my partner is unusually dependable, especially when it comes to things which are important to me.
8. My partner behaves in a very consistent manner.
9. Whenever we have to make an important decision in a situation we have never encountered before, I know my partner will be concerned about my welfare.
10. Even if I have no reason to expect my partner to share things with me, I still feel certain that he/she will.
11. I can rely on my partner to react in a positive way when I expose my weaknesses to him/her.
12. When I share my problems with my partner, I know he/she will respond in a loving way even before I say anything.
13. I am certain that my partner would not cheat on me, even if the opportunity arose and there was no chance that he/she would get caught.
14. I sometimes avoid my partner because he/she is unpredictable and I fear saying or doing something which might create conflict.
15. I can rely on my partner to keep the promises he/she makes to me.
16. When I am with my partner, I feel secure in facing unknown new situations.
17. Even when my partner makes excuses which sound rather unlikely, I am confident that he/she is telling the truth.

Dyadic Adjustment Scale (DAS) – Spanier, 1989

Please answer the following questions if you are currently involved in a relationship/dating. If you are not currently involved in a relationship/dating, please go to the questionnaire called CES-D.

Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list. Choose the number under one answer for each item.

<table>
<thead>
<tr>
<th>Item</th>
<th>Always agree</th>
<th>Almost always agree</th>
<th>Occasionally disagree</th>
<th>Frequently disagree</th>
<th>Almost always disagree</th>
<th>Always disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Handling finances</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>2. Matters of recreation</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>3. Religious matters</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>4. Demonstrations of affection</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>5. Friends</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>6. Sex relations</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>7. Conventionality (correct or proper behavior)</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>8. Philosophy of life</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>9. Ways of dealing with parents or in-laws</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>10. Aims, goals, and things believed important</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>11. Amount of time spent together</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>12. Household tasks</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>13. Career decisions</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

13.
<table>
<thead>
<tr>
<th>Question</th>
<th>All The Time</th>
<th>Most Of The Time</th>
<th>More Often Than Not</th>
<th>Occasionally</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often do you discuss or have you considered divorce, separation, or termination your relationship?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often do you or your mate leave the house/apartment after a fight?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In general, how often do you think that things between you and your partner are going well?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you confide in your mate?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you ever regret that you married (or lived together) (or dated)?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often do you and your partner quarrel?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often do you and your mate get on each others’ nerves?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often do the following occur between you and your mate?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have a stimulating exchange of ideas</td>
<td>Never</td>
<td>Less Than Once a Month</td>
<td>Once Or Twice a Month</td>
<td>Once Or Twice a Week</td>
<td>Once a Day</td>
<td>More Often</td>
</tr>
<tr>
<td>Laugh together</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Calmly discuss something</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Work together on a project</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
These are some things about which couples sometimes agree or disagree. Indicate if either item caused differences of opinions or were problems in the past few weeks.

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>29. Being too tired for sex</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>30. Not showing love</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

31. The numbers on the following line represent different degrees of happiness in your relationship. The middle point, “happy,” represents the degree of happiness of most relationships. Please choose the number above the phrase which best describes the degree of happiness, all things considered, of your relationship.

<table>
<thead>
<tr>
<th>Degree</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely Unhappy</td>
<td>0</td>
</tr>
<tr>
<td>Fairly Unhappy</td>
<td>1</td>
</tr>
<tr>
<td>A Little Unhappy</td>
<td>2</td>
</tr>
<tr>
<td>Happy</td>
<td>3</td>
</tr>
<tr>
<td>Very Happy</td>
<td>4</td>
</tr>
<tr>
<td>Extremely Happy</td>
<td>5</td>
</tr>
<tr>
<td>Perfect</td>
<td>6</td>
</tr>
</tbody>
</table>

32. Which of the following statements best describes how you feel about the future of your relationship? Choose the number for one statement.

<table>
<thead>
<tr>
<th>Number</th>
<th>Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>I want desperately for my relationship to succeed, and would go to almost any length to see that it does.</td>
</tr>
<tr>
<td>4</td>
<td>I want very much for my relationship to succeed, and will do all I can to see that it does.</td>
</tr>
<tr>
<td>3</td>
<td>I want very much for my relationship to succeed, and will do my fair share to see that it does.</td>
</tr>
<tr>
<td>2</td>
<td>It would be nice if my relationship succeeded, but I can’t do much more than I am doing now to keep the relationship going.</td>
</tr>
<tr>
<td>1</td>
<td>My relationship can never succeed, and there is no more that I can do to keep the relationship going.</td>
</tr>
<tr>
<td>0</td>
<td>My relationship can never succeed, and there is no more that I can do to keep the relationship going.</td>
</tr>
</tbody>
</table>
Investment Model Scale – Commitment Subscale – Rustbult, Martz & Agnew (1998)

Response Scale: 0 (Do not agree) 1 2 3 4 (Agree Somewhat) 5 6 7 8 (Agree Completely)

1. I want our relationship to last for a very long time.
2. I am committed to maintaining my relationship with my partner.
3. I would not feel very upset if our relationship were to end in the near future.
4. It is likely that I will date someone other than my partner within the next year.
5. I feel very attached to our relationship - very strongly linked to my partner.
6. I want our relationship to last forever.
7. I am oriented toward the long-term future of my relationship (for example, I imagine being with my partner several years from now).
APPENDIX D: MENTAL HEALTH

Mental Health

Perceived Stress Scale

CES-D

State-Trait Anxiety (Trait Version)

Perceived Stress Scale – 10 item version.

The questions in this scale ask you about your feelings and thoughts during the last month. In each case, indicate how often you felt or thought a certain way.

Scale: 0 = never, 1, = almost never, 2 = sometimes, 3 = fairly often, 4 = very often.

1. In the last month, how often have you been upset because of something that happened unexpectedly?
2. In the last month, how often have you felt that you were unable to control the important things in your life?
3. In the last month, how often have you felt nervous and “stressed”?
4. In the last month, how often have you felt confident about your ability to handle your personal problems?
5. In the last month, how often have you felt that things were going your way?
6. In the last month, how often have you found that you could not cope with all the things that you had to do?
7. In the last month, how often have you been able to control irritations in your life?
8. IN the last month, how often have you felt that you were on top of things?
9. In the last month, how often have you been angered because of things that were outside of your control?
10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

**CES-D Scale Radloff, 1977**

Below is a list of the ways you might have felt or behaved. Please indicate how often you have felt this way during the past week.

Use the following scale:

1 = Rarely or none of the time (less than 1 day).
2 = Some or little of the time (1-2 days)
3 = Occasionally or a Moderate amount of time (3-4 days)
4 = Most or all of the time (5-7 days)

During the past week:

1. I was bothered by things that usually don’t bother me.
2. I did not feel like eating; my appetite was poor.
3. I felt that I could not shake off the blues even with help from my family or friends.
4. I felt that I was just as good as other people.
5. I had trouble keeping my mind on what I was doing.
6. I felt depressed.
7. I felt that everything I did was an effort.
8. I felt hopeful about the future.
9. I thought my life had been a failure.
10. I felt fearful.
11. My sleep was restless.
12. I was happy.
13. I talked less than usual.
15. People were unfriendly.
16. I enjoyed life.
17. I had crying spells.
18. I felt sad.
19. I felt that people dislike me.
20. I could not get ‘going.’
State-Trait Anxiety Inventory – Spielberger

A number of statements which people have used to describe themselves are given below. Read each statement and then select the appropriate answer based on how you have predominantly felt over the past two weeks. There are no right or wrong answers. Do not spend too much time on any one statement, but give the answer which seems to describe your present feelings best.

Scale:
1 = not at all, 2 = somewhat, 3 = moderately so, 4 = very much so.

1. I feel calm
2. I feel secure
3. I am tense
4. I feel strained
5. I feel at ease
6. I feel upset
7. I am presently worrying over possible misfortunes.
8. I feel satisfied
9. I feel frightened
10. I feel comfortable
11. I feel self-confident
12. I feel nervous
13. I feel jittery
14. I feel indecisive
15. I am relaxed
16. I feel content
17. I am worried
18. I feel confused
19. I feel steady
20. I feel pleasant.
APPENDIX E: PHYSICAL HEALTH

Physical Health

CHIPS

SF12

CHIPS -

Select the number for each statement that best describes how much that problem has bothered or distressed you during the past month, including today. Select only one number for each item. At one extreme, 0 means that you have not been bothered by the problem. At the other extreme, 4, means that the problem has been an extreme bother.

How much were you bothered by:

1. Sleep problems (can’t fall asleep, wake up in the middle of the night or early morning.)
2. Weight change (gain or loss of 5 lbs or more.)
4. Constipation
5. Dizziness
6. Diarrhea
7. Faintness
8. Constant fatigue
9. Headache
10. Migraine headache
11. Nausea and/or vomiting
12. Acid stomach or indigestion
13. Stomach pain (e.g. cramps)
14. Hot or cold spells
15. Hands trembling
16. Heart pounding or racing
17. Poor appetite
18. Shortness of breath when not exercising or working hard.
19. Numbness or tingling in parts of your body
20. Felt weak all over
21. Pains in heart or chest
22. Feeling low in energy
23. Stuffy head or nose
24. Blurred vision
25. Muscle tension or soreness
26. Muscle cramps
27. Severe aches and pains
28. Acne
29. Bruises
30. Nosebleed
31. Pulled (strained) muscles
32. Pulled (strained) ligaments
33. Cold or cough

SF-12: Version 2

This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

Please answer every question by choosing one response per question. If you are unsure about how to answer, please give the best answer you can.

1. In general, would you say your health is:
   a. Excellent
   b. Very Good
   c. Good
   d. Fair
   e. Poor
   f. Decline Response

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

2. Moderate activities such as moving a table, pushing a vacuum cleaner, bowling or playing golf?
   a. Yes, limited a lot
   b. Yes, limited a little
   c. No, not limited at all
   d. Decline Response

3. Climbing several flights of stairs:
   a. Yes, limited a lot
   b. Yes, limited a little
   c. No, not limited at all
   d. Decline Response

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?
4. Accomplished less than you would like:
   a. Yes
   b. No
   c. Decline Response
5. Were limited in the kind of work or other activities:
   a. Yes
   b. No
   c. Decline Response

**During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?**

6. Accomplished less than you would like:
   a. Yes
   b. No
   c. Decline Response

7. Didn’t do work or other activities as carefully as usual:
   a. Yes
   b. No
   c. Decline Response

8. During the past 4 weeks, how much did PAIN interfere with your normal work (including both work outside the house and housework)?
   a. Not at all
   b. A little bit
   c. Quite a bit
   d. Extremely
   e. Decline Response

---

**These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.**

**How much of the time during the past 4 weeks:**

9. Have you felt calm and peaceful?
   a. All of the time
   b. Most of the time
   c. A good bit of the time
   d. Some of the time
   e. A little of the time
   f. None of the time
   g. Decline Response

10. Did you have lots of energy?
    a. All of the time
    b. Most of the time
    c. A good bit of the time
    d. Some of the time
    e. A little of the time
    f. None of the time
    g. Decline Response

11. Have you felt downhearted and blue?
    a. All of the time
b. Most of the time
c. A good bit of the time
d. Some of the time
e. A little of the time
f. None of the time
g. Decline Response

12. During the past 4 weeks, how much of the time has your PHYSICAL HEALTH or EMOTIONAL PROBLEMS interfered with your social activities (like visiting with friends, relatives, etc.)?
   a. All of the time
   b. Most of the time
c. Some of the time
d. A little of the time
e. None of the time
f. Decline Response
APPENDIX F: DEMOGRAPHICS

Demographics

Personal Demographics
Kinsey Scale
Relationship Demographics

Personal Demographics

1. Age: - drop down list: 17 to 100.
2. Your Gender: Female, Male, Trans, Other.
3. Ethnicity: normal list of options.
4. Nationality: list of countries
5. Highest Level of education completed
6. Personal annual gross income
7. Household annual gross income

8. Sexual Orientation (for the purposes of this survey, sexual orientation is a clinical term that describes a person’s consistent sexual attractions over time): homosexual, heterosexual, bisexual, queer.
9. Sexual Identity (for the purposes of this survey, Sexual Identity refers to the label a person uses to describe their sexual orientation or personal identity): lesbian, gay, queer, straight, other.
10. Which of the following best describes the nature of your current relationship? - my partner is a woman, my partner is a man, my partner is transgendered, I have more than one partner, I am single, Other.

Kinsey Scale -

0- Exclusively heterosexual
1- Predominantly heterosexual, only incidentally homosexual
2- Predominantly heterosexual, but more than incidentally homosexual
3- Equally heterosexual and homosexual
4- Predominantly homosexual, but more than incidentally heterosexual
5- Predominantly homosexual, only incidentally heterosexual
6- Exclusively homosexual
Relationship Demographics

11. At which of the following stages would you put your current relationship: Casually dating, seriously dating, I’ve thought about marriage but we haven’t discussed it, We’ve discussed marriage but we have no formal plans, engaged, married.

12. How long have you and your partner been together? Years:  , Months, Weeks

13. Are you and your partner living together? Y/n

14. Starting with your first dating relationship, and including your current relationship, how many people have you dated? Number box

15. How many of these relationships would you classify as serious? Open box for a number

16. How long was the longest of these relationships? Years, Months, Weeks

17. Is your longest relationship also your current relationship? Y/n

18. Approximately how many hours per week, on average, do you spend with your partner? (0-12, 13-24, 25-36, 37-48, 49-64, 65-72, 73-84, 85-168)

19. How long would you guess your current relationship will last? (1 = days – 5 = decades).
APPENDIX G: TIME 2 UPDATE QUESTIONNAIRE

Participants completed the update questionnaire prior to beginning the 2nd phase of the study. This questionnaire was used to help determine if the participant needed to be moved into a different category of participant (i.e., single vs. coupled), as well as to gather information on any specific changes that may have occurred between the current time and the last time they participated in the study.

Welcome back to KLB Research!

Welcome to the first follow-up to the KLB Research Contemporary Relationships Study. Before you begin the survey, we would like to collect some ‘update’ information about you and your relationship status.

The last time you participated you indicated the following information:

Gender:

Sexual Orientation:

Relationship Status:

Is the above information still correct for you at this time?

a. Yes, it is all correct
b. No, some or all of it is no longer correct

*** If participants indicated that any of the information was no longer correct, they were given the opportunity to update the information ***

What is your current relationship status?

a. I am single
b. I am in a same-sex relationship
c. I am in a mixed-sex relationship
d. Other:

What WAS your relationship status when you last participated (approximately 6 months ago)

a. I was single
b. I was in a same-sex relationship
c. I was in a mixed-sex relationship
d. I was in another kind of relationship
e. I don’t remember what my relationship status was
f. I don’t remember participating previously

*For those who indicated they were in a relationship:

Are you still in the same relationship that you were in when you last participated?

a. Yes, I am with the same person
b. Yes, I am with the same person, but we were separated for a while since I last participated and we are now back together.
c. No, I am with a new partner now.
d. No, I am now single because my partner and I broke up (separated, divorced)
e. No, I am now single because my partner died.
f. I was single when I last participated
g. Other

How many partners have you had (of each of the specified types) since you last participated in this study?
Casual Dating Partners
Dating Partners
Serious Partners

For each of the types of partners above, were they predominantly:
Male
Female
More females than males
More males than females
Equal number of males and females
Other
I had no partners of this type

If you are in the same relationship now as you were the last time you participated in this study, has there been any infidelity since you last participated?

a. Yes, on my part
b. Yes, on my partner’s part
c. I suspect infidelity on behalf of my partner, but I am not certain
d. Yes, we have both been unfaithful
e. I don’t know
f. No
g. No, but there has been consensual extra-dyadic sexual activity mutually agreed upon in advance
h. Decline Response
APPENDIX H: TIME 3 UPDATE QUESTIONNAIRE

Participants completed the update questionnaire prior to beginning the 2nd phase of the study. This questionnaire was used to help determine if the participant needed to be moved into a different category of participant (i.e., single vs. coupled), as well as to gather information on any specific changes that may have occurred between the current time and the last time they participated in the study.

Welcome back to KLB Research!

Welcome to the first follow-up to the KLB Research Contemporary Relationships Study. Before you begin the survey, we would like to collect some ‘update’ information about you and your relationship status.

The last time you participated you indicated the following information:

Gender:

Sexual Orientation:

Relationship Status:

Is the above information still correct for you at this time?

c. Yes, it is all correct
d. No, some or all of it is no longer correct

*** If participants indicated that any of the information was no longer correct, they were given the opportunity to update the information ***

What is your current relationship status?

e. I am single
f. I am in a same-sex relationship
g. I am in a mixed-sex relationship
h. Other:

What WAS your relationship status when you last participated (approximately 6 months ago)

g. I was single
h. I was in a same-sex relationship
i. I was in a mixed-sex relationship
j. I was in another kind of relationship
k. I don’t remember what my relationship status was
l. I don’t remember participating previously

*For those who indicated they were in a relationship:

Are you still in the same relationship that you were in when you last participated?

h. Yes, I am with the same person
i. Yes, I am with the same person, but we were separated for a while since I last participated and we are now back together.
j. No, I am with a new partner now.
k. No, I am now single because my partner and I broke up (separated, divorced)
l. No, I am now single because my partner died.
m. I was single when I last participated
n. Other

How many partners have you had (of each of the specified types) since you last participated in this study?
   Casual Dating Partners
   Dating Partners
   Serious Partners

   For each of the types of partners above, were they predominantly:
   Male
   Female
   More females than males
   More males than females
   Equal number of males and females
   Other
   I had no partners of this type

If you are in the same relationship now as you were the last time you participated in this study, has there been any infidelity since you last participated?

   i. Yes, on my part
   j. Yes, on my partner’s part
   k. I suspect infidelity on behalf of my partner, but I am not certain
   l. Yes, we have both been unfaithful
   m. I don’t know
   n. No
   o. No, but there has been consensual extra-dyadic sexual activity mutually agreed upon in advance
   p. Decline Response
APPENDIX I: TIME 2 BREAK UP QUESTIONNAIRE

If participants indicated that they were no longer in the same relationship as they had been when they last participated in the study, they were forwarded to a questionnaire about the dissolution of their relationship.

What is your current relationship status?
   a. I am single
   b. I am in a same-sex relationship
   c. I am in a mixed-sex relationship
   d. Other

What WAS your relationship status when you last participated (approximately 6 months ago)
   a. I was single
   b. I was in a same-sex relationship
   c. I was in a mixed-sex relationship
   d. I was in another kind of relationship
   e. I don’t remember what my relationship status was
   f. I don’t remember participating previously

With respect to the relationship that you were in the last time you participated, when did that relationship begin and end?
   When did the relationship Begin: Year / Month
   When did the relationship End: Year / Month

When did your current relationship begin?
   Year / Month

Why did your previous relationship end?
   - Open Ended

If you could identify ONE reason why your previous relationship ended, what would it be?
   a. Financial disagreements
   b. Loss of attraction
   c. Loss of love
   d. Infidelity on my behalf
   e. Infidelity on my partner’s behalf
   f. My partner was physically abusive
   g. My partner was verbally abusive
   h. My partner left – I don’t know why
   i. My parents disapproved of the relationship
   j. My partner’s parents disapproved of the relationship
   k. My friends disapproved of the relationship
   l. My partner’s friends disapproved of the relationship
   m. Religious differences
   n. Life goal differences
   o. I wanted kids, my partner did not
p. My partner wanted kids, I did not
q. We had to move away from each other
r. Other:

Did the amount of support you received for your relationship from your friends and/or family have any impact on your relationship or its demise?
- Open ended

How many partners have you had (of each of the specified types) since you last participated in this study?
  a. Casual Dating Partners
  b. Dating Partners
  c. Serious Partners

For each of the types of partners above, were they predominantly:
  a. Male
  b. Female
  c. More females than males
  d. More males than females
  e. Equal number of males and females
  f. Other
  g. I had no partners of this type
APPENDIX J: TIME 3 BREAK UP QUESTIONNAIRE

If participants indicated that they were no longer in the same relationship as they had been when they last participated in the study, they were forwarded to a questionnaire about the dissolution of their relationship.

What is your current relationship status?
   a. I am single
   b. I am in a same-sex relationship
   c. I am in a mixed-sex relationship
   d. Other

What WAS your relationship status when you last participated (approximately 6 months ago)
   a. I was single
   b. I was in a same-sex relationship
   c. I was in a mixed-sex relationship
   d. I was in another kind of relationship
   e. I don’t remember what my relationship status was
   f. I don’t remember participating previously

With respect to the relationship that you were in the last time you participated, when did that relationship begin and end?
   - When did the relationship Begin: Year / Month
   - When did the relationship End: Year / Month

When did your current relationship begin?
   Year / Month

Why did your previous relationship end?
   - Open Ended

If you could identify ONE reason why your previous relationship ended, what would it be?
   a. Financial disagreements
   b. Loss of attraction
   c. Loss of love
   d. Infidelity on my behalf
   e. Infidelity on my partner’s behalf
   f. My partner was physically abusive
   g. My partner was verbally abusive
   h. My partner left – I don’t know why
   i. My parents disapproved of the relationship
   j. My partner’s parents disapproved of the relationship
   k. My friends disapproved of the relationship
   l. My partner’s friends disapproved of the relationship
   m. Religious differences
   n. Life goal differences
   o. I wanted kids, my partner did not
p. My partner wanted kids, I did not
q. We had to move away from each other
r. Other:

Did the amount of support you received for your relationship from your friends and/or family have any impact on your relationship or its demise?
- Open ended

How many partners have you had (of each of the specified types) since you last participated in this study?
  a. Casual Dating Partners
  b. Dating Partners
  c. Serious Partners

  For each of the types of partners above, were they predominantly:
  a. Male
  b. Female
  c. More females than males
  d. More males than females
  e. Equal number of males and females
  f. Other
  g. I had no partners of this type
APPENDIX K: WEBSITE

Sexual Health Research Lab website:

http://www.psyc-research.com

The URL for the study’s website is:

http://www.klbresearch.com

http://www.klbsurveys.com

Recruitment materials will direct participants to this URL, where they will be able to learn more about the study and express interest in participating. While the survey is still under development, participants can register their interest by completing a form indicating that they would like to be contacted in the future when there is a study beginning. A copy of the form participants will complete is below:

The contents of this email are sent through email to the researcher’s email address.

Other Content on the Website
Main Page

Thank you for taking the time to visit this website. This site has been developed in order to facilitate the recruitment of participants for a longitudinal research study, which is being conducted online. The research will be examining the links between social network support, sexuality, relationships and health.

The study is currently under development and the site will be updated periodically with information on how to become involved with the study as a participant. Information about past studies will also be posted on this site.

Participate Page

At the present time, there are no studies running, but the next study is expected to begin in October 2008. If you would like to be contacted when the study begins, please click here to complete a form indicating your interest.

If you are interested in participating in studies run by other researchers, please click here to see some of the available studies. (this link directs a participant to the SHRL website).
APPENDIX L: SCREENING

The following is a questionnaire that participants will complete to verify their age and ability in English Language.

1. How old are you? (select answer from drop down list)
2. What month were you born in? (select answer from drop down list)
3. In what year were you born? (select answer from drop down list)
4. Please select your comfort level with the English Language:
   a. English Read, Write, Speak Fluently*

* Each will have a checkbox to be selected.
APPENDIX M: CHECKBOX PROGRAM

The questionnaires will be made available to participants online through a software program called Checkbox. This program has been installed on the Queen’s Server, and a secure SSL certificate was purchased for the entire subdomain on which the program is hosted, thus ensuring that all data transferred through this program is done so over a secure connection. In plain terms, this means that the data is protected from any third party that would try to view the data as it is being transmitted. The same level of security is used by banks to protect the data transfer process that takes place when an individual uses online banking features, or participates in any online transaction that requires the transfer of sensitive information, such as credit card purchases completed online.

Checkbox is a user-friendly survey development program that allows for the development and deployment of complex surveys. The program allows for conditional skip logic and branching, which allows the survey to adapt to each participant’s unique responses. This is a useful feature as it reduces the level of redundancy built into the survey by allowing participants to automatically skip over questionnaires that are irrelevant based on their own particular demographics or previous questionnaire responses.

More information about the checkbox survey program can be found here:


To view the program as it has been installed for our purposes, you may follow this link:

https://psycserver.psyc.queensu.ca/checkbox/Login.aspx

A screen shot of this page is below:

From this page, the survey administrators (members of the Sexual Health Research Lab) can login and design questionnaires or check the responses to existing questionnaires and then download the data that has been collected. This process all takes place over the secure SSL connection, and logging into the Checkbox program requires a user name and password. Members of the Sexual Health Research Lab have access to this user name and password, and all individuals with access to the program have signed a
lab confidentiality statement concerning proper use of data and treatment of confidential/private information.

The data collected by the checkboxes system are identified by participant number, and this number does not in any way link back to an individual’s personal identity, and thus, even with access to the data, a researcher does not gain access to being able to decipher a particular individual’s questionnaire responses.
APPENDIX N: CONSENT

Letter of Information

Social Support, Relationships and Health: A Longitudinal Study

Investigators

Karen Blair, MSc., PhD Graduate Student, Department of Psychology, Queen’s University
Caroline F. Pukall, PhD, Department of Psychology, Queen’s University

Introduction

This study is being conducted by Karen Blair, a PhD Graduate Student (613.533.3276) and Dr. Caroline Pukall (613.533.3200), Department of Psychology, Queen’s University.

Purpose of Study

The purpose of this study is to examine social support, relationship well-being and health (both mental and physical) over time. Individuals aged 18 and older who have access to the Internet at least once every six months and who can read and write in English are invited to participate in this study. All relationship types, views and experiences are welcomed.

Study Procedures

Your participation in this study involves the completion of a variety of questionnaires once every six months for two years. The questionnaires will be made available to you through the Internet and you will create a unique username and password that you will use to access the questionnaires, which will be hosted on a secure server. Each phase of the study will include questionnaires about your sociodemographic information, your relationship status and well-being, your sexuality, sexual identity, life experiences, mental and physical health, and sense of social support. By using your username and password, you will be able to access the available surveys on your own time from any location that allows you to access the Internet. It is not necessary to complete all the questionnaires in one sitting, but it is important that you complete each individual phase of the study within a two-week period. The core questionnaires will take approximately 2 hours to complete. In addition to the core questionnaires, you will have the opportunity to complete optional questionnaires as well. Again, it is not necessary to complete all questionnaires in one sitting: you may save your progress and return at a later time to continue completing the questionnaires.

Compensation

As a thank you for your time and effort, you will be awarded with participation points as you progress through the questionnaires. You may use these points towards various prize draws that will be conducted throughout the study. Each question that you complete is equal to one participation point, and each point is equal to one entry to a prize draw of your choice. In addition, a copy of the findings will be made available to you through the study’s website at the completion of the study. Prizes include gift certificates, travel vouchers, iPods and cash draws. Cash prizes will be delivered one of three ways. 1) To receive payment by PayPal, email bank transfer (major Canadian Banks only), or cheque. Paypal requires that you have a paypal account, which is then linked to your credit card or bank account. Visit www.paypal.com for more information. 2) To receive payment by cheque, you will need to provide your name and a mailing address. 3) To receive payment through certapay (email bank transfer) you will need
to have a bank account that uses online banking with one of the 5 major Canadian banks and you will need to provide us with an email address.

**Advantages of participating in this study**

There are no direct benefits of participating in this study. The information gathered in the study will potentially help increase our understanding of how relationships function and interact with various aspects of an individual’s life. Some participants may find the opportunity to reflect on their own life experiences and relationships to be personally rewarding.

**Disadvantages of participating in this study**

There are no known physical, psychological, economic, or social risks associated with participating in this study. However, some of the questionnaires cover sensitive topics, such as mental illness, sexuality, sexual functioning, and discrimination. It is possible that you may experience some discomfort answering these questions. However, you are not in any way obligated to answer any material that you find objectionable or that makes you feel uncomfortable; there will be a decline response option for each question. You may also withdraw from the study at any time. Withdrawing from the study will not impact your participation point balance, and you will still be free to enter your points into any existing prize draws.

**Confidential nature of this study**

Your participation in this study is strictly confidential. The data are being collected using a survey software program called Checkboxes developed by Prezzatech technology and hosted on the secure Psychology Department Server at Queen’s University. The server has an SSL Certificate providing encryption similar to that used by many banks for online banking, thus keeping the information you provide secure. The investigators will take all reasonable measures to protect the confidentiality of your records. When you register for the study, your data will be assigned a participation number, which will be associated with all the questionnaires you complete. These participation numbers are stored in an encrypted file to preserve your privacy. Any contact information provided will be stored in a password protected encrypted file, and will only be used to contact you with information about your participation in this study. At the completion of the study, your contact information will be purged unless you indicate an interest in being contacted for future studies. All files linking your contact information to your participation number will be permanently erased at the completion of this study. At no time will your name be connected to the data you provide, as you will be identified to the researchers by your email address only. Should you choose to create a separate email address for your participation in this study, it is possible to remain completely anonymous to the researchers. Finally, no individual will be identified in any publication, reports or presentations of this research; data will be aggregated and analyzed as a whole for all parts of the study.

**Discontinuation of this study**

Your participation in this study is completely voluntary and you may choose to withdraw at any time without penalty. Your participation point balance will remain intact and you will still be eligible for any available prize draws. Furthermore, you are free to refuse to answer any of the questions asked without providing an explanation. All of the online questionnaires have been programmed to either not require an answer, or provide a “decline response” option.
If you would like further information about the study, or have additional questions or concerns, please feel free to contact any of the above researchers. You may also contact the Head of the Department of Psychology at Queen’s University (613.533.2492), or the Chair of the Queen’s University General Research Ethics Board, 613-533-6081 or chair.GREB@queensu.ca.
CONSENT FORM

Social Support, Relationships & Health: A Longitudinal Study

Please read the following with regards to your participation in the study entitled ‘Social Support, Relationships & Health: A Longitudinal Study.’

I consent to the information contained in the Letter of Information and understand what is required for my participation in the study. I understand that I will complete a series of questionnaires, and that I am to complete these questionnaires by myself. However, I also understand that trained members of the research team are available by telephone or email should I have any questions or require further information about any aspect of the study. I understand that some of the questions may be quite personal in nature, and that some of them concern mental illness, sexual functioning and discrimination. I understand that my participation in the study is completely voluntary and that I am free to withdraw at any time. If I choose to withdraw, my participation point balance will not be impacted and I can still use these points to enter the various prize draws available. I also understand that my confidentiality will be protected throughout the study, and that the information I provide will be available only to researchers with relevant scholarly interests.

Should I have further questions, I understand that I can contact any of the following individuals:
Karen L. Blair, (613.533.3276, info@klbresearch.com), Primary Investigator, PhD Graduate Student, Department of Psychology, Queen’s University
Dr. Caroline Pukall (613.533.3200; caroline.pukall@queensu.ca), Assistant Professor, Department of Psychology, Queen’s University
Dr. Ron Holden (613.533.2492; holdenr@queensu.ca), Head of the Psychology Department, Queen’s University
Dr. Joan Stevenson (613.533.6000 ext. 74579; stevensj@queensu.ca), Chair of the General Research Ethics Board, Queen’s University

Please select one of the following:
I have read the above statements and freely consent to participate in this research.
I have read the above statements and do not wish to participate at this time.
APPENDIX O: PRIZE SYSTEM

Prizes and Participation Points Information

Dear Participant,
To thank you for your participation in this study, you will be awarded participation points for every questionnaire that you complete. One point is equal to one entry into one of our many prize draws. Each questionnaire will indicate how many points it is worth. In order to receive points for a questionnaire, you must complete the majority of the questions within the questionnaire; however, you do retain the right to leave out any questions that make you uncomfortable or that you do not wish to answer. Bonus participation points will be awarded whenever you complete an entire section of questionnaires and whenever you complete a Phase of the study (there are 4 phases in total).

It is entirely up to you how you decide to use your participation points. If you do nothing at all, your points will be entered into our Grand Prize Draw, which will take place at the end of the study (approximately in 2 years’ time). If you’d like a chance to enter some draws taking place throughout the study, you can distribute your points among the different draws. In addition to prize draws, you will also have the option to ‘donate’ your participation points to a variety of different charities. More detail on how you can turn your participation points into cash donations to charities can be found below.

The “Participation Points & Prizes” section of the Survey Portal will keep an updated record of your participation point balance that you can check at any time. From this area, you will also be able to view the available prize draws and see how many other entries have been made (so that you can calculate your own odds of winning). A sample Prize Draw Listing will contain the following information:

<table>
<thead>
<tr>
<th>Prize Description:</th>
<th>$500.00 Cash</th>
</tr>
</thead>
<tbody>
<tr>
<td>Draw Date:</td>
<td>April 20, 2060</td>
</tr>
<tr>
<td>Number of Entries To Date:</td>
<td>50</td>
</tr>
</tbody>
</table>

Once you have entered your points into a specific draw, those points are considered “used” and you can no longer move them to another available draw. There are, however, no limits as to how many points you can put into each draw. It is up to you whether you place 1 point in a particular draw, or all of your points in to that draw, or any number in between!

The majority of the prizes in this study can be delivered through the Internet and will not require a considerable amount of identifying information to be divulged. Cash Prizes will be delivered through PayPal or through an Internet Money Transfer (for Canadian Participants only). All that is needed for either of these methods is a valid email address. If you would like more information on how these payment processes work, please visit [http://www.paypal.com](http://www.paypal.com) or [http://www.certapay.com](http://www.certapay.com). In order to receive payments through PayPal, you will need to register for a Premium Account. If either of these payment methods are not possible for an individual winner, we can also mail a cheque payment (in Canadian or US funds only), but this will require your full name and a valid postal address. Disclosure of any personal contact information for the purposes of receiving a prize will in no way associate your identity with your data. At all times in this study, your data will remain confidential and unidentifiable.

Check back often to view your participation point balance. Also, don’t forget, as the study continues, the participation points for questionnaires and bonus points will increase.

Donate your Participation Points to Charity

In addition to being able to enter your participation points into various prize draws, you can also donate your participation points to charity. There are two ways in which you can do this.
The first way is through Charity Prize Draws. These prize draws operate like the regular prize draws, where one point is equal to one entry, but if you “win” the draw, instead of receiving a prize, a cash donation will be made to a charity that you select (from a list provided). The Prize Draw will contain the details about the size of the donation and the different charities you may choose.

Alternatively, you may donate your participation points directly to a charity of your choosing. Each donation listing will provide information about the ratio of participation points to dollars, but roughly, 1000 points will be equal to a $1.00 donation. This may not seem like much, but over the course of the study that could add up to over $5000.00 or more in charitable donations. A special page of the KLB Research Website will post a rolling total of how much has been donated to charity through the donation of Participation Points.

Please note, the Researchers and other Financial Donors will fund the cash donations – You the participant need only donate your participation points, not actual cash.

Good luck! If you have any questions, please contact us using the Contact Form on the Survey Portal administration page, or email info@klbresearch.com.

Participation Zone for Managing Points and Draw Entries

<table>
<thead>
<tr>
<th>Draw ID</th>
<th>Draw Title</th>
<th>Value</th>
<th>Your Pts</th>
<th>Total Pts</th>
<th>Manage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1062</td>
<td>1 Week Stay at Lake Louise Inn, Lake Louise, Alberta</td>
<td>$1000.00</td>
<td>0</td>
<td>183482</td>
<td>View Details</td>
</tr>
<tr>
<td>1070</td>
<td>Grand Prize Draw - $500.00</td>
<td>$500.00</td>
<td>0</td>
<td>178661</td>
<td>View Details</td>
</tr>
<tr>
<td>1069</td>
<td>Grand Prize Draw - $500.00</td>
<td>$500.00</td>
<td>0</td>
<td>102408</td>
<td>View Details</td>
</tr>
<tr>
<td>1074</td>
<td>Apple iPad2</td>
<td>$600.00</td>
<td>0</td>
<td>139026</td>
<td>View Details</td>
</tr>
</tbody>
</table>

Donate Your Points to Charity
For every 1000 points entered, we will donate $1.00 to that charity. Donations will be made based on all points donated by all participants. Click Here For More Information

<table>
<thead>
<tr>
<th>Draw ID</th>
<th>Draw Title</th>
<th>Value</th>
<th>Your Pts</th>
<th>Total Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1055</td>
<td>Red Cross Haiti Fund</td>
<td>$5.00</td>
<td>2</td>
<td>16654</td>
</tr>
<tr>
<td>1036</td>
<td>cites Canada</td>
<td>$5.00</td>
<td>0</td>
<td>11151</td>
</tr>
<tr>
<td>1037</td>
<td>Product Red</td>
<td>$5.00</td>
<td>0</td>
<td>14090</td>
</tr>
<tr>
<td>1038</td>
<td>Canadian Breast Cancer</td>
<td>$5.00</td>
<td>0</td>
<td>26555</td>
</tr>
</tbody>
</table>
Entering a Prize Draw

Participation Draws Available:
You currently have 3436 points to enter into the draws.

Donating Points to Charity Screen Shot

Participation Draws Available:
You currently have 3436 points to enter into the draws.
APPENDIX P: NO CONSENT

Participants who do not give their consent to participate are shown the following screen and are not directed into the survey.

Letter of Information

Thank you for your time.
APPENDIX Q: USER REGISTRATION

1. How old are you? (open ended)
2. What is your month of birth?
3. What is your year of birth?
4. Gender: (male, female, mtf, ftm, other)
5. Sexual Orientation: (heterosexual, homosexual, bisexual, queer, other)
6. Relationship status:
   a. Single
   b. Same-sex relationship
   c. Opposite-sex (mixed-sex) relationship
   d. Other

If you are in a relationship:

It would be helpful for us if we could link your data to your partner’s data. You do not need to know whether or not your partner has participated in order to allow us to link your data with that of your partner’s. By providing the codes asked for below, we will be able to link your data to your partner’s data, without compromising your or your partner’s identity. This information will be used only to link your data for statistical purposes.

If you would like to give us permission to do so, please answer the following questions.

1. What are the last three digits of your phone number:
2. What are the first three letters of your mother’s first name? (if your mother’s name has fewer than 3 letters, use Q for the third letter)
3. In what month were you born?
4. On what day of the month were you born?

1. What are the last three digits of your PARTNER’s Phone number
2. What are the first three letters of your PARTNER’s mother’s first name?
3. In what month was your PARTNER born?
4. On what day of the month was your PARTNER born?

The information provided by these questions will create codes that look like this:

442CAR1007  034JAQ0622

If your partner participates in the study and provides the same answers to each question (in opposite order), then we will have codes that link your responses without having compromised the anonymity of the participation process.
APPENDIX R: PARTNER INVITATION

Email Generated to Send to Partner if Invited by Participant

Dear Friends & Family,

I thought you might be interested in learning more about a research study that I'm participating in. The study involves questionnaires completed over the Internet, on the topics of social support, relationships, sexuality and health.

As you complete the surveys, you will earn participation points which you can use to enter prize draws for things like iPods, Cash, Travel Vouchers and gift certificates. You also have the option of donating your points to charity!

Participants could add or edit this message. A link to the study was automatically included.

Participants could invite their partner at any time through a static link on the study’s website, and they could also use this function to tell their friends about the study.
APPENDIX S: COUPLE MATCHING

Partner Link

In order to increase our ability to properly analyze the data resulting from this study, it would be helpful if we could have your permission to link your data with the data entered by your partner, should you both happen to participate in the study. The data will be linked only to help us have a better understanding of how relationships operate, and will not in anyway compromise the confidentiality of either yourself or your partner. You will not have access to your partner’s data, nor will your partner have access to yours.

We are asking you here to indicate whether or not you grant your consent to have your data linked with that of your partner. There is no need for you to confirm this process with your partner before granting your individual consent, as we will only be linking data when both partners separately have granted consent. If you grant your consent, but your partner does not, then your data will not be linked.

If you would like to grant permission for us to link your data with that of your partner, please complete the question below. The information in these questions will only be used to create unique identification codes, and will not in any way be used to compromise your confidentiality.

Do you give consent for your data to be linked with your partner’s?

Yes / No

If yes, please complete:

What is your Date of Birth:   Month/Day/Year

What are the last three digits of your primary home phone number?

What are the last three letters of your mother’s maiden name? (if your mother’s maiden name only contains 2 letters, please enter a Q as the third and last letter.)

What is your partner’s Date of Birth?   Month/Day/Year

What are the last three digits of your partner’s primary home phone number? (it is okay if your partner has the same phone number as you).

What are the last three letters of your partner’s mother’s maiden name? (if your partner’s mother’s maiden name only contains 2 letters, please enter Q as the third and last letter.)

The information provided by these questions will create two unique codes, one for each partner. For example, my code would be 100781849APE and my partner’s code would be 062276849UDD. When the time comes, the computer can search through the database for matching codes, and connect your data to your partner’s.
APPENDIX T: REGISTRATION EMAIL

Thank you for registering to participate in the Longitudinal Study of Social Support, Relationships & Health conducted by Karen Blair (KLB Research) at Queen's University in Kingston, Ontario, Canada.

***** THIS EMAIL CONTAINS IMPORTANT INFORMATION ---- PLEASE READ *********

Save this email in a safe place, as it contains your Username and Password which you will need to access the site, as well as some useful links.

Important Links:

Main Participant Website: http://www.klbsurveys.com


Participation Points System (Prize Draws)Login: https://surveys.psyc.queensu.ca/Checkbox/points.aspx

Important Instructions:

If you use the "save and exit" option while completing the surveys, it will email you a link that will directly take you back to the part of the survey where you left off.

Your Login Information (needed to access the survey portal and all questionnaires)

Username:
Password:
Email:

Should you have any questions, please feel free to email:

Karen Blair:

The Sexual Health Research Laboratory:

Thanks again for your participation! I hope you enjoy the questionnaires!

Sincerely,
Karen L. Blair, MSc
Psychology Department
Queen's University
Kingston, Ontario
http://www.klbresearch.com
http://www.klbsurveys.com
1 (613)533.3276
APPENDIX U: SECTIONS

User Registration

Basic demographics used to automatically generate appropriate survey questions in subsequent sections.

Part 1A
- Personal Demographics
- Relationship Demographics
- Social Support for Relationship Measures

Part 1B
- Relationship Well-being Measures

Part 2
- Mental Health Measures
- Physical Health Measures

Part 3
- Additional Measures not used in current study

Part 4
- Social Network Circles (not used in current study)
APPENDIX V: DEBRIEF

Debrief at the End of Time 1

Perceived Network Support for Relationships as a Predictor of Physical and Mental Health

You have now completed Time 1 of this study. Your data will be compiled and stored in a secure location. Please remember that all information provided is confidential and will be stripped of any identifying information. This study consists of three more phases, which will occur at approximately six-month intervals. Phases 2, three and four will take you approximately 40 to 50% of the length of time it took you to complete this first phase of the study. We will contact you through the email address you have provided when the next phase of the study is ready to begin. If you have any questions or concerns about your participation up to this point, or your future participation, please do not hesitate to contact either Karen Blair or Dr. Caroline Pukall.

More detailed information about the results and implications of this study, as well as any publications resulting from this study will be posted on the study's website at the conclusion of all four phases. If you have any questions about the results that are not answered on the website, please do not hesitate to contact us for more information.

Please keep in mind that in participating in this study, there is a small risk that unpleasant thoughts or feelings about your own romantic or familial relationships may surface. Should any material in this study cause you concern at any time, we would encourage you to consider discussing your feelings with someone you trust. Information about counselling services can be found in your local telephone directory. We hope, however, that you found the opportunity to think about these issues to be beneficial and that you have not suffered any undue stress.

Karen Blair: 613.533.3276 info@klbresearch.com
Dr. Caroline Pukall: 613.533.3200 caroline.pukall@queensu.ca
Dr. Kevin Munhall (613.533.2492; kevin.munhall@queensu.ca), Head of the Psychology Department, Queen’s University
Dr. Joan Stevenson (613-533-6081 or chair.GREB@queensu.ca) of the General Research Ethics Board, Queen’s University

Resources

Distress Centres Ontario http://www.dcontario.org/
Canadian Mental Health Association http://www.cmha.ca/bins/index.asp
Crisis Line Resources http://www.crisisline.ca/links.htm
Telephone Aid Line Kingston (TALK) (613)544-1771

You may also wish to consult your local Yellow Pages or telephone directory for more local support services.

Final Debrief Form

Debriefing Form

Perceived Network Support for Relationships as a Predictor of Physical and Mental Health
You have now completed all four parts of this study. Your data will be compiled and stored in a secure location. Please remember that all information provided is confidential and will be stripped of any identifying information. This study has now been completed. Your contact information will be deleted from our system unless you indicate below that you would like to be contacted about future participation opportunities. In this case, your email address will be stored in a secure database of individuals interested in future studies. Your contact information will not be shared with any third parties. If you have any questions or concerns about your participation, please do not hesitate to contact either Karen Blair or Dr. Caroline Pukall.

More detailed information about the results and implications of this study, as well as any publications resulting from this study will be posted on the study's website when the data has been analyzed. If you have any questions about the results that are not answered on the website, please do not hesitate to contact us for more information.

In general, this study was designed to investigate the links between perceived social support for relationships, that is, whether or not you feel that your relationship is supported (approved of) by your friends and family, and the well-being of your relationship (satisfaction, levels of love, commitment), and in turn, how this impacts your mental and physical health. The data will be analyzed as a whole, and is looking for general trends within the entire sample, to see whether or not higher levels of perceived social support are, in general, associated with better relationship well-being, and in turn, better mental and physical health. No individual or couple will be analyzed in isolation, and thus the results, when published, may not specifically relate to your own personal experiences. In addition to examining these general concepts, the study was also designed to determine whether or not there are differences in these concepts and how they interact with each other based on the type of relationships being examined: same-sex or mixed-sex (heterosexual). If social support is indeed an important predictor of relationship well-being and health, this would lend credence to the importance of providing all relationships with equal access to social support so that everyone can enjoy the benefits that support may offer.

Please keep in mind that in participating in this study, there is a small risk that unpleasant thoughts or feelings about your own romantic or familial relationships may surface. Should any material in this study cause you concern at any time, we would encourage you to consider discussing your feelings with someone you trust. Information about counselling services can be found in your local telephone directly. We hope, however, that you found the opportunity to think about these issues to be beneficial and that you have not suffered any undue stress.

Karen Blair: 613.533.3276 info@klbresearch.com
Dr. Caroline Pukall 613.533.3200 caroline.pukall@queensu.ca
Dr. Ron Holden (613.533.2492; holdenr@queensu.ca), Head of the Psychology Department, Queen’s University
Dr. Joan Stevenson (613-533-6081 or chair.GREB@queensu.ca), Chair of the General Research Ethics Board, Queen’s University

Resources

Distress Centres Ontario http://www.dcontario.org/
Canadian Mental Health Association http://www.cmha.ca/bins/index.asp
Crisis Line Resources http://www.crisisline.ca/links.htm
Telephone Aid Line Kingston (TALK) (613)544-1771

You may also wish to consult your local Yellow Pages or telephone Directory for more local agencies providing support services.
APPENDIX W: TIME 2 INVITATION

Email automatically generated to invite participants – Encrypted usernames and passwords automatically generated (i.e., not accessible to the researcher).

You have been invited to take the survey: KLB Research - Participant Update Questionnaire - Time 2.

@@SURVEY_URL_PLACEHOLDER__DO_NOT_ERASE

Dear @@UserName,

At some point in the last year you began participating in an online study about relationships, social support and health. We have now begun the second phase of the study and are eager to invite you to participate again.

Please follow the link in this email to begin the second phase of the study. Once again you will earn participation points which you may use to enter various prize draws.

If you have ANY problems at all, please contact me ASAP and I will do my best to resolve the problem. My email address is: info@klbresearch.com

Username: @@UserName

Password: @@Password

Email: @@Email

You may also visit the study's website: http://www.klbsurveys.com to receive more information about the study, gain access to the prize draw portal, or find links to the various sections of the survey.

You participation is GREATLY appreciated.

Karen L. Blair
PhD Candidate
Queen's University
Kingston, Ontario
http://www.klbsurveys.com
http://www.klbresearch.com
http://www.queensu.ca

Reminder Email

You have been invited to take the survey: KLB Research Participant Update Questionnaire - Time 2.

@@SURVEY_URL_PLACEHOLDER__DO_NOT_ERASE

Dear Participant,

You were recently invited to participate in the follow up questionnaire for the 2nd Phase of the KLB Research Contemporary Relationships Study. Our records show that you have not yet completed the initial update questionnaire. I would greatly appreciate it if you would consider continuing with your participation, as the follow up data is most crucial to the successful completion of the study.

Karen L. Blair
PhD Candidate
Queen's University
Kingston, Ontario
http://www.klbsurveys.com
http://www.klbresearch.com
http://www.queensu.ca
Follow the link below to continue your participation. This portion of the survey is once again divided into sections, but each section is significantly shorter than the ones you completed previously. You will once again have the opportunity to earn participation points throughout the survey, which you may then use to enter a variety of prize draws or to donate to charity.

If you have any questions or run into any difficulties, please do not hesitate to contact me directly: karen.blair@queensu.ca –

@@SURVEY_URL_PLACEHOLDER__DO_NOT_ERASE

Or copy and paste this link into your browser:
https://surveys.psyec.queensu.ca/Checkbox/ph2update.aspx

Email: @@Email
Username: @@UserName
Password: @@Password

You will be among the first to go through this section of the survey. If you have any difficulties or experience any glitches, please let me know and I will do my best to sort out the issue.

Karen L. Blair, BAH, MSC
PHD Candidate
Department of Psychology
Queen's University
Kingston, Ontario
http://www.klbresearch.com
http://www.klbssurveys.com

Please visit the following URL to remove yourself from the invitation list for this survey: Click here.

Participants Could Opt Out of Receiving Further Emails

Please visit the following URL to remove yourself from the invitation list for this survey:
APPENDIX X: TIME 2 SECTIONS

Update Questionnaire
- Personal Demographics
- Relationship Demographics

Part 2A
Social Support for the relationship
Relationship Well-being

Part 2B
Mental Health
Physical Health

Part 2C
- Additional measures
  (Not used in current study)

Part 2D
- Social Network Circles
  (Not used in current study)
APPENDIX Y: TIME 3 SECTIONS

Part 1

- Update Questionnaire
- Social Support for Relationship Questionnaires
- General Social Support
- Relationship Well-being Measures
- Mental Health Measures
- Physical Health Measures

Part 2

- Social network Circles
  (not used in current study)

Break Up Questionnaire

- Relationship Demographics (past relationship / current new relationship)
- Mental Health Measures
APPENDIX Z: COMPARING REMOVED PARTICIPANTS (W/O PARENTS)

The Structural Model Across Sample With Parents and Sample Without Parents

Simultaneous Group Analysis for Sample With Parents and Sample Without Parents

<table>
<thead>
<tr>
<th>Model</th>
<th>$\chi^2$</th>
<th>df</th>
<th>CFI</th>
<th>$\Delta\chi^2$</th>
<th>$\Delta df$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents alive</td>
<td>89.74</td>
<td>24</td>
<td>.99</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents absent or dead</td>
<td>32.05</td>
<td>24</td>
<td>.99</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unconstrained model</td>
<td>121.93</td>
<td>48</td>
<td>.99</td>
<td></td>
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</tr>
<tr>
<td>Constrained model</td>
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<td>51</td>
<td>.98</td>
<td>33.95</td>
<td>3</td>
</tr>
<tr>
<td>Approval to well-being constrained</td>
<td>136.39</td>
<td>50</td>
<td>.99</td>
<td>19.49</td>
<td>1</td>
</tr>
<tr>
<td>Well-being to physical health constrained</td>
<td>155.36</td>
<td>50</td>
<td>.98</td>
<td>.52</td>
<td>1</td>
</tr>
<tr>
<td>Well-being to mental health constrained</td>
<td>151.74</td>
<td>50</td>
<td>.98</td>
<td>4.14</td>
<td>1</td>
</tr>
</tbody>
</table>

*Note. Critical $\chi^2 (1) = 3.84, p < .05$. Critical $\chi^2 (3) = 7.82, p < .05.*
### Table 39

*Bivariate Estimates of Predictors of Rate of Relationship Dissolution*\(^a\)

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>B</th>
<th>SE</th>
<th>Antilog Exp(B)</th>
<th>Decrease in likelihood of dissolution(^b)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship length(^c)</td>
<td>-.02***</td>
<td>.004</td>
<td>.98</td>
<td>1.9%</td>
</tr>
<tr>
<td>Satisfaction</td>
<td>-.51***</td>
<td>.082</td>
<td>.60</td>
<td>40%</td>
</tr>
<tr>
<td>Love</td>
<td>-.54**</td>
<td>.207</td>
<td>.58</td>
<td>41.9%</td>
</tr>
<tr>
<td>Trust</td>
<td>-.59***</td>
<td>.111</td>
<td>.56</td>
<td>44.5%</td>
</tr>
<tr>
<td>Dyadic adjustment</td>
<td>-.04**</td>
<td>.010</td>
<td>.97</td>
<td>3.4%</td>
</tr>
<tr>
<td>Perceived social support for relationship</td>
<td>-.48***</td>
<td>.091</td>
<td>.62</td>
<td>38%</td>
</tr>
<tr>
<td>Commitment</td>
<td>-.55**</td>
<td>.209</td>
<td>.58</td>
<td>42%</td>
</tr>
<tr>
<td>Perceived social support for relationship from family</td>
<td>-.10</td>
<td>.083</td>
<td>.90</td>
<td>ns</td>
</tr>
<tr>
<td>Perceived social support for relationship from friends</td>
<td>-.45***</td>
<td>.083</td>
<td>.64</td>
<td>36.3%</td>
</tr>
<tr>
<td>General social support</td>
<td>-.26*</td>
<td>.122</td>
<td>.77</td>
<td>22.8%</td>
</tr>
<tr>
<td>General social support from family</td>
<td>-.23*</td>
<td>.097</td>
<td>.80</td>
<td>20.2%</td>
</tr>
<tr>
<td>General social support from friends</td>
<td>-.12</td>
<td>.109</td>
<td>.88</td>
<td>11.6%</td>
</tr>
<tr>
<td>General social support from significant other</td>
<td>-.18</td>
<td>.104</td>
<td>.84</td>
<td>16.1%</td>
</tr>
</tbody>
</table>

*Note.* \(^a\) Length of relationship duration prior to participating in the first phase of the study is controlled. Variables are entered one at a time. \(^b\) Percentage decrease in likelihood of breaking up during the course of the study for every unit increase in the predictor variable’s scale (i.e., not directly comparable due to differences in scales). \(^c\) Relationship length was the only significant control variable when tested at the univariate level. Thus, other potential controls were not included in the presented table (e.g., age, relationship type, stage of relationship).

Table 40 shows that one predictor variable from each group was significant after controlling for relationship length at the beginning of the study: relationship satisfaction, perceived social support for the relationship from friends, and general social support from family. Additionally, due to high volumes of missing data on the love and commitment variables, two relationship well-being models were run, the first including love and commitment and the second one dropping these variables in order to increase the sample size for the analysis. In both models, the only significant predictor after controlling for relationship length was relationship satisfaction. Additionally, the chi-square test for each model was
significant, indicating that the each model was a significant improvement over constant rate model in which the coefficients for the predictor variables are constrained to be equal to zero.

Table 40
*Cox Regression Models Predicting Relationship Dissolution Within Three Sets of Predictor Variables*

<table>
<thead>
<tr>
<th>Independent variables</th>
<th>( \chi^2 / N )</th>
<th>B</th>
<th>SE</th>
<th>Antilog Exp(B)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Relationship well-being</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship length</td>
<td>-0.02*</td>
<td>0.01</td>
<td>0.98</td>
<td></td>
</tr>
<tr>
<td>Satisfaction</td>
<td>-1.46**</td>
<td>0.44</td>
<td>0.23</td>
<td></td>
</tr>
<tr>
<td>Love</td>
<td>ns</td>
<td>ns</td>
<td>ns</td>
<td></td>
</tr>
<tr>
<td>Dyadic adjustment</td>
<td>ns</td>
<td>ns</td>
<td>ns</td>
<td></td>
</tr>
<tr>
<td>Commitment</td>
<td>ns</td>
<td>ns</td>
<td>ns</td>
<td></td>
</tr>
<tr>
<td>Chi-square</td>
<td>3.47*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>df</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of events (uncensored)</td>
<td>9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total N</td>
<td>91</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Relationship well-being(^a)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship length</td>
<td>-0.02***</td>
<td>0.01</td>
<td>0.98</td>
<td></td>
</tr>
<tr>
<td>Satisfaction</td>
<td>-0.53***</td>
<td>0.09</td>
<td>0.59</td>
<td></td>
</tr>
<tr>
<td>Dyadic adjustment</td>
<td>ns</td>
<td>ns</td>
<td>ns</td>
<td></td>
</tr>
<tr>
<td>Chi-square</td>
<td>58.98***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>df</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of events (uncensored)</td>
<td>82</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total N</td>
<td>502</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Support for relationship</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship length</td>
<td>-0.02</td>
<td>0.00</td>
<td>0.98</td>
<td></td>
</tr>
<tr>
<td>Perceived social support for relationship from family</td>
<td>ns</td>
<td>ns</td>
<td>ns</td>
<td></td>
</tr>
<tr>
<td>Perceived social support for relationship from friends</td>
<td>-0.456***</td>
<td>0.08</td>
<td>0.63</td>
<td></td>
</tr>
<tr>
<td>Chi-square</td>
<td>53.13***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>df</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of events (uncensored)</td>
<td>88</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total N</td>
<td>545</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>General Social Support</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship length</td>
<td>-0.019***</td>
<td>0.00</td>
<td>0.98</td>
<td></td>
</tr>
<tr>
<td>General social support from family</td>
<td>-0.226*</td>
<td>0.10</td>
<td>0.80</td>
<td></td>
</tr>
<tr>
<td>General social support from friends</td>
<td>ns</td>
<td>ns</td>
<td>ns</td>
<td></td>
</tr>
<tr>
<td>General social support from significant other</td>
<td>ns</td>
<td>ns</td>
<td>ns</td>
<td></td>
</tr>
<tr>
<td>Chi-square</td>
<td>20.93***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>df</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of events (uncensored)</td>
<td>92</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total N</td>
<td>552</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. \(^a\) Due to missing data on the Love and Commitment variables, the relationship well-being model was run a second time, excluding these variables.  
*** p < .001, ** p < .01, * p < .05
APPENDIX AB: ALTERNATIVE MODEL WITH GENERAL SOCIAL SUPPORT
AND NO SOCIAL SUPPORT FOR THE RELATIONSHIP

CFI = .98
GFI = .962
SRMR .026
Chi-Square = 262.832, df, 50, p <.000
RMSEA = .061   Lower .054  hi .069

Standardized Regression Weights: (Group number 1 - Default model)

<table>
<thead>
<tr>
<th></th>
<th>Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship_Well-being &lt;&lt;-- General_Support</td>
<td>.205</td>
</tr>
<tr>
<td>Physical_Health    &lt;&lt;-- Relationship_Well-being</td>
<td>.379</td>
</tr>
<tr>
<td>Mental_Health     &lt;&lt;-- Relationship_Well-being</td>
<td>.525</td>
</tr>
</tbody>
</table>
Regression Weights: (Group number 1 - Default model)

<table>
<thead>
<tr>
<th></th>
<th>Estimate</th>
<th>S.E.</th>
<th>C.R.</th>
<th>P</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship_Well-being &lt;-- General_Support</td>
<td>.080</td>
<td>.013</td>
<td>6.207</td>
<td>***</td>
<td></td>
</tr>
<tr>
<td>Physical_Health &lt;-- Relationship_Well-being</td>
<td>.537</td>
<td>.047</td>
<td>11.361</td>
<td>***</td>
<td></td>
</tr>
<tr>
<td>Mental_Health &lt;-- Relationship_Well-being</td>
<td>.253</td>
<td>.016</td>
<td>15.818</td>
<td>***</td>
<td></td>
</tr>
</tbody>
</table>
November 13, 2008

Karen L. Blair
PhD Candidate
Psychology
Queen's University

GREB Ref # GPSYC-440-08
Title: “Social Support as a Predictor of Relationship Well-Being, Mental & Physical Health in Same-Sex and Mixed-Sex Intimate Relationships: A Longitudinal Investigation”

Dear Karen Blair:

The General Research Ethics Board (GREB) has given assisted expedited approval to your proposal titled “Social Support as a Predictor of Relationship Well-Being, Mental & Physical Health in Same-Sex and Mixed-Sex Intimate Relationships: A Longitudinal Investigation”. In accordance with the Tri-Council Guidelines (article D.1.6) and Senate Terms of Reference (article G), your project has been approved for one year. At the end of each year, GREB will ask if your project has been completed and if not, what changes have occurred or will occur in the next year.

You are reminded of your obligation to advise the GREB, with a copy to your Unit REB; of any adverse event(s) that occur during this approval period (details available on webpage www.queensu.ca/vpr/greb/advforms.htm). An adverse event includes, but is not limited to, a complaint, a change or unexpected event that alters the level of risk for the researcher or participants or situation that requires a substantial change in approach to a participant(s). You are also advised that any adverse events must be reported to the GREB within 48 hours.

You are also reminded that all changes that might affect human participants must be approved by the GREB. Examples of required approvals are: changes in study procedures or implementations of new aspects into the study procedures that affect human subjects. These changes must be sent to Linda Frid at the Office of Research Services or FRIDL@queensu.ca prior to implementation. Ms. Frid will seek the approval of the GREB reviewer(s) who originally assessed your application or the GREB Chair.

On behalf of the General Research Ethics Board, I wish you continued success in your research.

Yours sincerely,

GREB Chair
For: Chris DeLuca
Member,
General Research Ethics Board

CDL/if

Copies: Chair of Unit REB: Dr. Ingrid Johnsrude
Faculty Supervisor: Dr. Caroline Pukall
Unit REB Admin: Marie Tooley

think Research
think Queen's