Public Health Implications of Same-Sex Marriage

Significantly compromised health care delivery and adverse health outcomes are well documented for the lesbian, gay, bisexual, and transgender (LGBT) community in the United States compared with the population at large. LGBT individuals subject to societal prejudice in a heterosexist world also suffer from the phenomenon known as “minority stress,” with its attendant negative mental and physical health effects.

Reports in the medical and social science literature suggest that legal and social recognition of same-sex marriage has had positive effects on the health status of this at-risk community.

Improved outcomes are to be expected because of the improved access to health care conferred by marriage benefits under federal or state law and as a result of attenuating the effects of institutionalized stigma on a state law and as a result of institutionalized stigma on a state level as legislators and the courts in all states grapple with the contentious issues involved. The Indiana background and resolve read as follows:

Whereas, legal marriage status confers numerous financial and legal benefits upon married individuals that improve access to health care;

Whereas, better access to health care results in lower overall mortality;

Whereas, the Lesbian, Gay, Bisexual, Transgender (LGBT) community has diminished access to health care;

Whereas, the LGBT community suffers from significantly worse mental and physical health outcomes compared with the community at large;

Whereas, the American Medical Association, at the November 2009 convention, acknowledged that same-sex marriage bans do not contribute to health disparities in the US;

Whereas, evolving medical/social science literature attest to the health benefits conferred by the social and legal recognition of same-sex marriage;

Whereas, the ISMA is a body that is to be guided in its decision-making by science, reason, and public policy standards that promote the health and well being of all Indiana citizens;

Whereas, same-sex marriage equality has not been demonstrated to have any deleterious consequences for society in general;

Therefore, be it resolved that the Indiana State Medical Association (1) recognizes that exclusion from civil union or marriage contributes to health care disparities affecting same-sex households; (2) will work to reduce health care disparities among members of same-sex households, including minor children; and (3) will support measures providing same-sex households with the same rights and privileges to health care, health insurance, and survivor benefits, as afforded opposite-sex households.

Although the debate over this resolution took place at the state medical association convention in Indiana, a traditionally conservative state, the contentious issues involved are relevant on a national level as legislators and courts in all states grapple with the social implications of marriage equality for same-sex couples and the broader implications for all households affected by dynamics surrounding the stigma attached to being gay or having a gay family member. From a public health perspective, the LGBT community represents a substantial number of people identified to be at significant risk for poor health outcomes.

Estimates of US lesbian, gay, and bisexual prevalence from the American Community Survey suggest that about 8.8% of US residents self-identify as gay or bisexual. Researchers at Indiana University estimate that 7% of US women and 8% of US men are gay or bisexual. US census data from 2005 indicate that there are more than 770,000 same-sex couples, and they are to be found in more than 99% of US counties.

Only recently has the medical and social science literature evolved to the point of providing research and expert opinions that may answer the question of whether marriage equality for same-sex couples can be reasonably expected to have a positive impact upon health outcomes for the LGBT community. First, however, one must understand how societal prejudice adversely affects such outcomes.

MINORITY STRESS

One only has to consider the rash of recent teen suicides resulting from antigay bullying to begin to comprehend the magnitude of the public health problem faced by this country and its LGBT sexual minority. Despite the prevalence of same-sex households and campaigns to protect human rights, gay persons find the very nature of their being constantly debated within our legislative bodies, the courts, and the mainstream media. They are subject to ridicule and are commonly the targets of demeaning and derogatory slang terms or insensitive jokes. Their morality and value as human beings are frequently questioned by individuals and organizations ignorant or unaccepting of current medical and social science literature concerning the gay population.

LGBT individuals also find themselves subject to laws or constitutional amendments supported by the 1996 Defense of Marriage Act, which defined marriage as a legal union solely between a man and a woman. The
obvious inference is that same-sex marriage is somehow of lesser value than is heterosexual marriage; the underlying fear is often that marriage equality will actually cause societal harm. Being cast in such a light strongly contributes to the phenomenon known as “minority stress,” which members of this community experience in their struggle for validation and acceptance in our heterosexist society.

Unique to the LGBT form of minority stress—as opposed to minority stress engendered by societal prejudice based upon race, ethnicity, gender, or disability—is that one’s sexual orientation usually is invisible to others. As a result, in addition to being the target of overt discrimination, LGBT individuals are constantly subject to subtle, inadvertent, or insensitive attacks on the core of their very nature, even by people who profess no disdain or disrespect for them. For instance, if someone has a lesbian colleague but doesn’t know the colleague’s orientation, an innocent question—such as asking her if she has a boyfriend, rather than asking “Are you seeing someone special?”—implies a judgment regarding what is “normal.” When the “other” is invisible, faceless, or nameless, it is common for those in power to ignore the reality of the other’s existence and the challenges the other faces. This interplay of power and prejudice, whether overt or covert, constitutes the phenomenon of heterosexism. Similarities to the racism and sexism so prevalent during the civil rights movements of past generations are obvious.

INTERNALIZING PREJUDICE

This sexual-minority status, as explained by Riggle and Rostosky, is defined by a culture of devaluation, including overt and subtle prejudice and discrimination, [one that] creates and reinforces the chronic, everyday stress that interferes with optimal human development and well-being.

LGBT individuals, stigmatized by negative societal attitudes directed at the essence of their being, struggle on a daily basis to balance the dual dangers of publicly engaging their need for equality and validation and remaining closeted to find some calm through an escape from public scrutiny.

Many gay persons internalize such discrimination and prejudice. Fractured social-support mechanisms and minority-stress–associated low self-esteem contribute to a high prevalence of self-destructive behaviors, such as substance abuse, suicide, and risky sexual behavior.

Hatzenbuehler et al. studied more than 34 000 lesbian, gay, and bisexual participants and found empirical evidence of the negative health effects of discriminatory policies relative to marriage equality. They surveyed participants in 2001 and 2002 on a range of psychological health indicators, and they administered the same survey in 2004 and 2005, after 14 states approved constitutional amendments limiting marriage to opposite-sex unions. In the second set of responses, participants reported significantly higher rates of psychiatric disorders, with increases of 36% for any mood disorder, 248% for generalized anxiety disorder, 42% for alcohol use disorder, and 36% for psychiatric comorbidity. In the comparable control group from states without such amendments during the same time period, there were no significant increases in these psychiatric disorders.

Although causality may be difficult to establish, the association and prevalence of these disorders suggest that institutionalized stigma and its attendant internalized prejudice (i.e., minority stress) stand at the forefront of this cycle, begetting higher rates of sexually transmitted diseases, depression, suicide, and drug use—all of which, when combined with suboptimal access to health care and fractured family-support systems, eventually contribute to higher overall mortality as well as morbidity from various cancers, cirrhosis, hypertension, and heart disease.

We know that legally married couples, regardless of socioeconomic factors, have significantly lower incidences of such mental and physical diseases than do unmarried persons; but how can we truly know, or reasonably expect, that marriage equality would, in fact, confer such health benefits upon the LGBT community? Why are legally married individuals healthier than their single counterparts? The answer, it turns out, is complex and multifactorial, with its explanation drawing from the disciplines of medicine, economics, politics, sociology, and psychology.

HEALTH BENEFITS OF MARRIAGE

Better access to health care is known to translate into lower mortality. Wilper et al. reported in 2009 that uninsured adults have a 40% higher relative risk of death than do insured adults (after multivariate analysis controlling for demographic, health, and socioeconomic status). In a recent study by Ponce et al. evaluating the effects of unequal access to health insurance for same-sex couples in California, partnered gay men and partnered lesbians had significantly lower likelihoods (42% and 28%, respectively) of receiving employer-sponsored dependent coverage than did their married heterosexual counterparts. Furthermore, unlike dependent benefits that workers acquire through heterosexual marriage, the federal government and most affected states classify benefits received by domestic partners, civil-union spouses, and same-sex spouses as taxable earned income. The financial consequences did not stop at the individual level; Ponce et al. further note that “the effect of restrictive, differential treatment of same-sex relationships pushes the costs . . . into the public domain,” with HIV-seropositive men twice as likely to depend upon public insurance because of lack of access to affordable insurance.

Testimony at the Perry v Schwarzenegger trial—in which a federal judge heard a suit challenging the constitutionality of California’s Proposition 8, which amended the state’s constitution to prohibit same-sex marriages—detailed the economic advantages of marriage in terms of specialization of labor, reduced transition costs, economies of scale, and health insurance and survival benefits, to name a few. However, the psychology involved for married individuals may be even more significant. Expert witnesses cited the self-perceived benefits of marriage equality reported by gay and lesbian married couples in Massachusetts, as reported by the Massachusetts Department of Public Health: as a result of the legal recognition of same-sex marriage, 72% felt more committed to their partners, and 70% felt more accepted by their communities, while 93% of children with same-sex parents reported feeling happier and better off.
The testimony and conclusions of those witnesses are validated by the accumulating evidence-based literature. Rothblum et al. studied 216 lesbians and 123 gay men who had had civil unions in Vermont compared with 166 lesbians and 72 gay men who had not had civil unions. Gays in civil unions had significantly greater contact with and social and emotional support from their families and friends. They were more likely to remain in their long-term committed relationship if it was a legally recognized relationship. In so doing, they had better access to health insurance and quality health care as well as more consistent family support, which is vital to one’s emotional health.

Fingerhut and Maisel studied 239 individuals involved in same-sex relationships, and they found that social recognition and legal recognition of same-sex marriage were differentially associated with individual and relationship outcomes. They found that legally recognized same-sex marriage conferred the same benefits experienced by heterosexual couples that move from cohabitation to legal marriage. Those who were married reported significantly less depression and anxiety, and better psychological well-being. Social formalization through a public ceremony involving a community of support that provides benefits far exceeding those available to couples who only cohabit. The improved psychological well-being conferred by such support clearly has a protective effect on the health of those individuals.

Not only is marriage associated with positive health outcomes for all individuals, regardless of sexual orientation; in addition, same-sex marriage has not been demonstrated to adversely affect the institution of heterosexual marriage. In 2007 the Centers for Disease Control and Prevention reported that all five states allowing same-sex marriage had divorce rates nearly 20% lower than those found in the rest of the country. Longer-term experience with same-sex marriage in Scandinavia and the Netherlands lends further support to these reassuring statistics.

Furthermore, same-sex marriage does not diminish the prospect of successful parenting. It is well-established that children raised by same-sex couples compare favorably with other children in all performance standards assessed; the most important predictor of successful child-rearing is an intact two-parent unit. Pediatricians, psychiatrists, psychologists, anthropologists, and social workers have long recognized that one’s social environment plays a significant role in determining one’s psychological health. Position statements from numerous professional associations further support the claim that the LGBT community would receive significant health benefit if committed same-sex relationships were afforded the social validation and legal status of committed heterosexual relationships.

LIMITATIONS

Census data are limited by the self-reported nature of the data collection, which is dependent upon the willingness of those surveyed to identify themselves as gay. Though the census is presented as an anonymous data-collection process, those who are suspicious of government or who fear the potential consequences of public acknowledgment of their orientation may not report their orientation correctly, causing incomplete reporting of LGBT prevalence. Furthermore, US census questionnaires do not clearly define what it means to be gay. This lack of clarity may contribute to the widely disparate estimates of the actual prevalence of gays and lesbians in our society. With estimates ranging from 2% to 10% of the general population, it is worth noting that if “gay” were defined as same-sex attraction or experience, prevalence would be substantially higher than if it were defined by self-identification as being gay.

Regardless of prevalence, another limitation is the lack of extended longitudinal experience with the phenomenon of same-sex marriage, given that it first occurred in Denmark in 1989 and only more recently in the United States. Further time and study are clearly warranted in the ongoing assessment of the more widespread implications associated with embracing marriage equality.

In addition, demographic surveys and their interpretation are subject to investigator bias. It is important to acknowledge that when we look at books, scriptures, and even evidence-based literature, we tend to see what is already inside us. The study of an emotionally charged social issue, such as marriage equality, is fraught with such potential pitfalls; and despite academic rigor and the peer-review process, the results of such studies may ultimately be flawed.

CONCLUSIONS

“Do not believe in anything simply because you have heard it. Do not believe in anything simply because it is spoken and rumored by many. Do not believe in anything simply because it is found written in your religious books. Do not believe in anything merely on the authority of your teachers and elders. Do not believe in traditions because they have been handed down for many generations. But after observation and analysis, when you find that anything agrees with reason and is conducive to the good and benefit of one and all, then accept it and live up to it.”

—Buddha
categorically defined as the legal union of a man and a woman of the same ethnicity, race, religion, or social status, and it promoted a male-dominated unequal relationship; now marriage embodies interracial and interreligious partnerships with gender roles blurring, in striking contrast to the marriage of our forebears. Formal, legal marriage confers survival advantages to heterosexuals regardless of race/ethnicity, religion, or socioeconomic status. The recent medical and social science literature cited here assures us that the same holds true for gays and lesbians who are given the opportunity to enter into legal marriage.

While fully acknowledging the limitations described earlier and the uncertainties inherent in such discussions, the Indiana State Medical Association—on the basis of the evidence-based literature cited in this article, including research from academic experts in the fields of medicine, economics, political science, psychology, epidemiology, and public health—has joined the American Medical Association in calling for the recognition that exclusion from civil union or marriage contributes to health care disparities affecting same-sex households. The Indiana State Medical Association resolution also calls for us to “work to reduce health care disparities among members of same-sex households, including minor children” and to “support measures providing same-sex households with the same rights and privileges to health care, health insurance, and survivor benefits, as afforded opposite-sex households.” For a state such as Indiana to put aside tradition in favor of a position that “after observation and analysis . . . agrees with reason” suggests that we have reached a tipping point in the debate over marriage equality and its societal impact.

It remains to be seen when other states will follow suit, but the results of this literature review strongly suggest that the legal and social recognition of same-sex marriage are likely to impart more than just symbolic support for the gay community. Embracing marriage equality through education and legislation is sound public health policy supported by evidence-based literature. Legislation to make marriage equality a reality will change, and save, lives.

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**References**


Integrating Social Epidemiology Into Public Health Research and Practice for Maternal Depression

The impact of maternal depression on women and their families has been well documented. Given the prevalence and impact of this problem, one important strategy is to strengthen and expand our public health approaches.

Although principles of social epidemiology are increasingly used in the field of maternal and child health, few public health efforts to address maternal mental health have incorporated ecosocial frameworks such as community connectedness, quality of social relationships, and social capital.

One method to augment current public health approaches to maternal depression is through the incorporation of a perspective focusing on community, cohesion, group membership, and connectedness—a concept often described as social capital. We describe the relevance of this ecosocial perspective for mental health promotion programs for mothers. (Am J Public Health. 2011;101:990–994. doi:10.2105/AJPH.2010.196576)

DEPRESSION IS THE LEADING cause of disability for all ages and both sexes worldwide.1 The public health significance of depression in women is undeniable, with lifetime rates between 10% and 25%.2,3 The childbearing years are a particularly high-risk period for major depression in women because the increase in the risk of depression rises steeply for females just as they enter the fertile period of their lives.2,3 Evidence shows that mothers of young children and new mothers have rates of depressive symptoms ranging from 12% to 20%, with even higher rates for adolescent and low-income minority women.4–7 Despite the availability of effective treatments, depression remains undertreated.8–11 In primary care settings, close to 75% of depressed women of childbearing age do not receive any mental health treatment.9,12 Three public health approaches to address depression in pregnant and parenting women are commonly used. The first approach, screening for depression in obstetrical settings, has been recommended in the research literature,13 adopted as a best practice guideline,14 and mandated as a standard medical practice in some states.15 Despite the plausibility of this approach, studies from other general health care settings do not generally show that patient outcomes improve as a result of screening.16,17 Recent studies with diverse samples of pregnant and postpartum women have found that screening has either no or minimal effect in ameliorating depressive symptoms or increasing use of behavioral health care.18–20 The second approach to maternal depression has focused on the provision of social support through home visitation.21 The third approach has focused on the promotion of help-seeking for maternal depression via large-scale media campaigns.22 With the exception of home visitation conducted in the postnatal period by trained health care professionals,23 the effectiveness of each of these strategies has been limited.21–25 The limited effectiveness of current public health approaches means that new strategies must be developed to address depression in women. Depression constitutes one of the largest public health problems facing women of reproductive age. This fact, and the need for new public health approaches, necessitates the development of communitywide public health promotion efforts to reduce the burden of depression in mothers.

SOCIAL EPIDEMIOLOGY AND MENTAL HEALTH PROMOTION

Ecosocial frameworks are increasingly used to examine both chronic and infectious diseases such as cancer,26,27 diabetes,28,29 and AIDS and other sexually transmitted infections.30 The community-level promotion of physical activity through increased (1) opportunities for physical activity, (2) policies supporting physical activity, and (3) improvement of built and natural environments to support active living31 is an example of the application of an ecosocial framework to a public health problem. Increasingly, principles of social...