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BRIEF REPORT

After Obergefell: Legally Married Status Is Associated With Lower Depressive Symptoms Among Cisgender Sexual Minority Couples

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Married heterosexual couples evidence better mental health compared to unmarried couples, yet research among same-sex couples has lagged because of the history of legal same-sex marriage in the United States. The current study investigated whether marital status was associated with depression among sexual minority couples. This study used cross-sectional data from a sample of cisgender, sexual minority couples collected across the United States ($N = 60$ couples) from 2017 to 2018, after full legal marriage recognition in 2015. Multilevel models tested if married couples, relative to unmarried couples, reported lower depressive symptoms. Subsequent models probed this association by controlling for relationship qualities and demographic characteristics. The study also tested if married couples significantly differed from unmarried couples on two risk factors for depression: childhood sexual abuse and hazardous alcohol use. Married couples reported significantly lower depressive symptoms, and this finding was robust to controlling for a range of relationship qualities, including length, satisfaction, and commitment, and demographic characteristics. Controlling for income, the association between marital status and depression was not significant. There were no significant differences between married and unmarried couples in childhood sexual abuse or hazardous alcohol use. Being legally married was associated with lower depression in the current era of national same-sex marriage legalization. Married sexual minority couples did not report lower risks for depression but did report higher income than unmarried couples. Future research is needed to understand the temporality of associations between mental health and marital status and mechanisms of this effect.

Public Significance Statement
Married individuals report lower depression among heterosexual couples, but far less research has explored if this is true for sexual minority couples in the time since same-sex marriage was legalized in the United States. The current study found that married sexual minority couples reported lower depression than unmarried sexual minority couples even when accounting for several relationship and demographic characteristics.

Keywords: depression, mental health, same-sex marriage, couples

Sexual minority individuals (i.e., lesbian, gay, bisexual, queer, and others who do not identify as heterosexual) experience elevated rates of mental health concerns relative to heterosexual adults, including depression (Board on the Health of Select Populations et al., 2011; Fredriksen-Goldsen et al., 2024; King et al., 2008). U.S. Census data demonstrated that half of sexual and gender

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Nicholas S. Perry served as lead for conceptualization, formal analysis, funding acquisition, investigation, methodology, and writing–original draft. Galena K. Rhoades served in a supporting role for conceptualization. Nicholas S. Perry, Daphne Y. Liu, Dominique J. Harlan, John V. Miller, Alex Rubin, and Galena K. Rhoades contributed equally to writing–review and editing. Daphne Y. Liu, Dominique J. Harlan, John V. Miller, and Alex Rubin contributed equally to writing–original draft.

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minority individuals experience symptoms of depression and anxiety (Marlay et al., 2022). A growing body of literature supports that romantic relationships, including marriage, are critical social contexts for understanding mental health among all people (Braithwaite & Holt-Lunstad, 2017; Shrout et al., 2024). High-quality romantic relationships buffer against poor mental health, such as depressive symptoms (Braithwaite & Holt-Lunstad, 2017; Whisman et al., 2021), and the benefits of romantic relationships and marriage for mental health have been extensively supported among heterosexual individuals (Whisman et al., 2021). Emerging literature suggests that romantic relationships also have implications for the mental health of sexual minority individuals (Newcomb, 2020), though less is known about whether marriage, specifically, benefits mental health beyond being in a relationship. The nationwide legalization of marriage in the United States in 2015 (*Obergefell v. Hodges*, 2015) affords a fruitful opportunity to examine any benefit for mental health associated with marriage among sexual minority individuals. The current study investigated how marital status was associated with depressive symptoms among cisgender sexual minority couples using data collected after the federal legalization of same-sex marriage.

Marriage and Depression Among Heterosexual Adults

Extensive research has shown that heterosexual adults in a romantic relationship enjoy better mental health, such as fewer depressive symptoms, compared to their single peers (Beckmeyer & Cromwell, 2019; Braithwaite & Holt-Lunstad, 2017; Whisman & Baucom, 2012; Whisman et al., 2021; Wright & Brown, 2017). Specific to marriage, married individuals report lower depressive symptoms compared to romantically involved but unmarried individuals, including relative to cohabiting couples (Yucel & Latshaw, 2023). This highlights a consistent trend in the literature that marital status might offer the most protection from depression (Bebbington, 1987; Bulloch et al., 2009; LaPierre, 2009, 2012; Marks & Lambert, 1998; Simon, 2002; Williams et al., 1992).

The reason for the association between being married and lower depressive symptoms has been debated. Theorists posit that it may be attributed to selection into marriage or a protective effect afforded by marriage. The selection theory suggests that those who experience fewer mental health symptoms or are at lower risk for poor mental health are also more likely to be romantically involved and, ultimately, to marry (Lamb et al., 2003). In contrast, causation arguments postulate that romantic involvement brings about changes in one's life that are beneficial for mental health (Kessler & Essex, 1982). These include because partners promote adaptive health behaviors (e.g., exercise and social activity) and discourage unhealthy behaviors (e.g., alcohol and drug use) as outlined in social control theories (Umberson, 1987), because romantic relationships offer opportunities for emotional and social needs to be met in line with social integration perspectives (House et al., 1988), or because the legal and financial benefits of marriage can reduce stress (Waite & Gallagher, 2001) and increase access to health care (Karney et al., 2024).

Relationship Status, Marital Status, and Depression Among Sexual Minority People

Emerging evidence suggests that romantic relationships have implications for mental health among sexual minority adults as well. Sexual minority individuals in romantic relationships report lower depressive symptoms (Ayala & Coleman, 2000; Oetjen & Rothblum, 2000; Riggle et al., 2010; Whitton et al., 2020) and better psychological well-being (Mills et al., 2004; Wayment & Peplau, 1995; Wienke & Hill, 2009; Wilson et al., 2022) compared to their single counterparts. Longitudinal studies have found that sexual minority women report lower depressive symptoms and psychological distress when in a romantic relationship than when single (Whitton et al., 2018, 2021), providing some support for the protection effect among sexual minority individuals. Of note, evidence is not always consistent (Feinstein et al., 2016), and findings have been mixed for plurisexual identities (e.g., bisexual, pansexual, and queer; Dyar et al., 2014; Feinstein et al., 2016; Whitton et al., 2018, 2020; Wilson et al., 2022). Nonetheless, most evidence thus far supports that being in a romantic relationship may afford psychological benefits for sexual minority individuals.

Same-sex marriage was fully legalized in the United States in 2015 (*Obergefell v. Hodges*, 2015), allowing millions of sexual minority couples the freedom to decide whether to marry. Prior to then, legal access to marriage for same-sex couples was patchwork, reflecting the strong institutional stigma that led to the denial of marriage rights for same-sex couples (Hoy, 2022). Given this context, far less research has examined whether being married per se is associated with mental health benefits compared to being in a relationship without such a legal status. A handful of studies, conducted prior to the federal legalization of same-sex marriage, have demonstrated evidence for mental health benefits associated with marriage or other forms of legal recognition (e.g., registered domestic partnerships) among sexual minority individuals and couples (Bariola et al., 2015; LeBlanc et al., 2018; Riggle et al., 2010; Wight et al., 2013). One study found that sexual minority individuals in legal relationship statuses (i.e., registered domestic partnerships, civil unions, or marriage) reported lower depressive symptoms compared to those in a committed relationship without any legally recognized status (Riggle et al., 2010). Some studies have even shown that the psychological benefits associated with legal status may be specific to marriage and do not extend to registered domestic partnerships (LeBlanc et al., 2018; Wight et al., 2013). Possible reasons for this benefit include that marriage may improve connection to the lesbian, gay, bisexual, transgender, queer, and other nonheterosexual identities (LGBTQ+) community (Ocobock, 2018) or that marriage results in increased social recognition and validation by others in some contexts (Kennedy & Dalla, 2020).

Other studies have not found evidence for lower depressive symptoms or better well-being among married sexual minority women compared to their unmarried, partnered counterparts (Kornblith et al., 2016), or among those in committed relationships compared to those in dating relationships (e.g., engaged, married, and registered domestic partnerships/civil unions; Whitton et al., 2021). However, the vast majority of this prior research was conducted before federal same-sex marriage legalization in the United States (Bariola et al., 2015; Kornblith et al., 2016; LeBlanc et al., 2018; Riggle et al., 2010; Wight et al., 2013). Thus, most prior research examining marriage benefits on depression among sexual minority people uses data that reflect a starkly different social, legal, and political climate and landscape for marriage among sexual minority couples than existed after the nationwide legalization of same-sex marriage.

In addition, many of these studies have not controlled for key relationship (e.g., commitment) and demographic factors (e.g., gender and income), although some prior literature suggests there may be important differences in views of marriage, marriage experience, or the relationship status and health association among sexual

minority couples across these factors (Drabble et al., 2022; Karney et al., 2024; Spiker, 2020). Furthermore, aligned with the selection and causation theories, these variables may explain associations between marital status and mental health for sexual minority adults. Therefore, there is a lack of contemporaneous data to answer the empirical question of whether legal marriage per se is associated with mental health benefits for sexual minority adults.

Current Study

The current study aimed to address these limitations by examining the association between marital status and depressive symptoms among cisgender sexual minority couples using data collected after same-sex marriage was federally legalized in the United States in 2015. We hypothesized that sexual minority couples who were married would report lower depressive symptoms compared to those who were in an unmarried romantic relationship.

Second, we tested if the association between marital status and depressive symptoms would hold after accounting for relationship qualities (e.g., length, commitment, and satisfaction) and demographic characteristics (e.g., gender and income) that could confound the association. Given the limited, older research on marital status and depression among sexual minority adults, we did not make a priori hypotheses about the association when controlling for these factors.

Third, we also explored if we observed differences by marital status in two risk factors for depression: hazardous alcohol use and childhood sexual abuse, given their high prevalence among sexual minority individuals (Board on the Health of Select Populations et al., 2011; Fredriksen-Goldsen et al., 2024; King et al., 2008). If the selection hypothesis is broadly true, we would expect that married participants would report a lower prevalence of these risk factors. Given the inconclusive literature on selection into marriage effects on health, we did not make a priori hypotheses about these tests.

Method

Procedure

Data for the current study come from a larger study of cisgender sexual minority couple's romantic relationships and well-being. Recruitment occurred between March and July 2017 through outreach to a variety of community organizations (e.g., Parents, Families, and Friends of Lesbians, and Gays chapters, LGBTQ+-affirming religious organizations, and LGBTQ+ resource centers) and advertising on social media and social networking sites (Facebook, Craigslist, Jack'd, Twitter) to reach a diverse sample of sexual minority couples across the major geographic regions of the United States.

Participants completed an online screener assessing relationship length, their own and their partner's sex assigned at birth and gender identity, one item assessing past-year intimate partner physical aggression, and relationship satisfaction with the four-item Couples Satisfaction Index (Funk & Rogge, 2007). Couples were eligible if both partners identified as cisgender and the same gender, reported having been in a relationship for at least 3 months, and denied past-year physical intimate partner violence. To be as inclusive as possible from an ethical view and to maximize external validity, we kept our exclusion criteria to a minimum.

Of the 156 dyads where both partners completed the screener, 15% were ineligible, 10% declined to participate, and 36% were waitlisted due to stratified recruitment by gender. Both partners separately completed informed consent with research staff using an online web conferencing platform and then completed self-report questionnaires via Qualtrics. Each partner received a $40 gift card for participating. Study procedures were approved by the University of Utah Institutional Review Board.

Participants

Sixty cisgender sexual minority couples ($n = 30$ male couples and $n = 30$ female couples; $N = 120$ individuals) enrolled in the study. Participant demographics are provided in Table 1.

Measures

Demographics

Participants self-reported on their sex assigned at birth (male, female, or intersex) and gender (male, female, transgender,

Table 1
Sample Demographics (N = 60 Cisgender Sexual Minority Couples)

Variable		*M* (*SD*)
Age (years)		30 (10)
Relationship length (years)		5 (6)
Demographic characteristic		*N*
Sexual orientation		
Gay		57 (47%)
Lesbian		43 (36%)
Bisexual		15 (13%)
Pansexual		2 (1.7%)
Queer		3 (2.5%)
Gender identity		
Woman		60 (50%)
Man		60 (50%)
Race/ethnicity	Not Hispanic/Latino	Hispanic/Latino
White	84 (70%)	10 (8.3%)
Black	5 (4.2%)	0
Asian	8 (6.7%)	0
Native Hawaiian/Pacific Islander	2 (0.02%)	0
American Indian/Alaska Native	1 (0.01%)	0
Multiracial	4 (3.3%)	0
Missing response on race		6 (5%)
Annual income		
Not working		11 (9.2%)
1–$8,000		9 (7.5%)
$8,001–16,000		8 (6.7%)
$16,001–25,000		18 (15%)
$25,001–$35,000		17 (14%)
$35,001–45,000		17 (14%)
$45,001–$55,000		13 (11%)
$55,001–65,000		9 (7.5%)
$65,001–75,000		4 (3.3%)
$75,001–85,000		5 (4.2%)
$85,001–95,000		2 (1.7%)
>$95,000		7 (5.8%)
Marital status		
Dating		42 couples (70%)
Civil union		2 (3.3%)
Married		16 couples (27%)
Cohabiting		50 couple (83%)
Parents		6 couples (10%)

Note. *N* is individuals unless otherwise noted.

and self-define), sexual orientation (gay, lesbian, bisexual, or self-define), age, individual annual income ("not working," $1–8,000, $8,001–16,000, $16,001–25,000, $25,001–35,000, $35,001–45,000, $45,001–55,000–$55,001–65,000, $65,001–75,000, $75,001–85,000, $85,001–95,000, >$95,000), marital status, cohabitation (living together or no), children (having children or no), and relationship length (in months).

Marital Status

Participants' marital status was assessed by asking, "What steps have you and your partner taken to formalize your relationship?" Participants could check all that apply among the following options: "We are legally married," "We have had a civil union but are not legally married," "We share finances or have joint possessions (e.g., property, car, pets)," or "We are in a committed dating relationship." Couples were coded as 1 = *married* if they selected "We are legally married" and otherwise were coded as 0.

Relationship Length

Participants reported the month and year that they and their partner first began dating. Relationship length was computed by calculating the number of months between when they started their relationship and their study completion date.

Relationship Satisfaction

Relationship satisfaction was measured with the 16-item version of the Couples' Satisfaction Index, which is a psychometrically sound measure of overall romantic relationship quality (Funk & Rogge, 2007). In the current sample, the measure demonstrated excellent internal reliability (Cronbach's $\alpha = .94$).

Commitment

Participants' commitment to their romantic relationship was measured using a single item from the Dyadic Adjustment Scale (Spanier, 1976), which asked, "Which of the following statements best describes how you feel about the future of your relationship?" Responses ranged from 1 = *My relationship can never succeed, and there is no more I can do to keep it going* to 6 = *I want desperately for my relationship to succeed and would go to almost any length to see that it does*.

Childhood Sexual Abuse

Childhood sexual abuse was assessed using standard questions regarding experiences of sexual abuse before the age of 18 (Doll et al., 1992). The measure defined abuse as sexual contact with someone at least 5 years older (prior to 13 years old) or with someone at least 10 years older (between ages 13 and 17), which is consistent with theoretical conceptualizations of abuse as an underage sexual experience with an adult (Doll et al., 1992). Childhood sexual abuse was categorized as *any history of abuse* (1) or *no history of abuse* (0).

Alcohol Use

Alcohol use over the past year was measured with the Alcohol Use Disorders Identification Test-Consumption (Bush et al., 1998), a widely used and well-validated screening measure for hazardous drinking. We used cut scores for hazardous drinking (≥4 for men and ≥3 for women) to indicate if participants had engaged in *hazardous drinking* (1) or *not* (0) (Bush et al., 1998).

Depressive Symptoms

Depressive symptoms were assessed using the 20-item Center for Epidemiological Studies Depression scale (CES-D; Radloff, 1977). Participants rated the frequency of symptoms in the past week using a 4-point Likert scale ranging from 0 = *rarely or none of the time* to 3 = *most or all of the time*. The CES-D was developed to assess depressive symptoms in community samples, demonstrating adequate reliability and validity (Eaton et al., 2004), and has been well validated (Eaton et al., 2004; Radloff, 1977). The recommended cutoff for the CES-D that is suggestive of clinically significant depressive symptoms is a total score of 16 (Radloff, 1977). Internal reliability in the sample was excellent ($\alpha = .94$).

Analytic Plan

There were no missing data on any variables in the current study. We conducted a prior power analysis using the *n* effective formula (Kenny et al., 2020), which indicated that our sample was powered to detect correlations of .26 or greater. We used multilevel modeling to account for interdependence in the data introduced by having data from both members of each couple in the study (Raudenbush & Bryk, 2002). Models treated depression as a continuous, individual-level outcome. The initial model entered marital status (i.e., married vs. not) as the independent between-couple level variable. We then conducted sensitivity tests of that finding by running the model separately, controlling for each of the theorized covariates (relationship length, commitment, relationship satisfaction, gender, and individual income). Finally, we used chi-square tests to compare if married participants significantly differed from unmarried participants in their prevalence of childhood sexual abuse or hazardous alcohol use.

Results

Means, standard deviations, and bivariate correlations among the variables are reported in Table 2. Results from multilevel models testing the association between marital status and depression, controlling for covariates, are presented in Table 3. Results from the initial multilevel model indicated that there was a significant association between marital status and depression, such that married participants reported lower depression than unmarried participants ($B = -4.7$, $SE = 1.9$, $p < .05$). This association is equivalent to Cohen's *d* of 0.25, indicating a small effect. This association remained significant, controlling for relationship length, commitment, relationship satisfaction, and gender. The association between marital status and depression was no longer statistically significant when controlling for income ($p > .05$). The association between individual income and depression was negative and statistically significant ($B = -0.81$, $SE = 0.28$, $p < .05$).

The chi-square test examining the difference in the prevalence of childhood sexual abuse by marital status was not statistically significant, $\chi^2(1, N = 120) = 0.06$, $p = .81$, with 43% of participants who were not legally married and 45% of participants who were legally married having experienced childhood sexual abuse. The chi-square test for the difference in the prevalence of hazardous alcohol use by

Table 2
Means and Correlations Among Study Variables (N = 60 Cisgender Sexual Minority Couples)

Variable	*M* (*SD*)	1	2	3	4	5	6	7
1. Depression	19 (9.2)	—						
2. Legally married status	31 (26%)	−.23*	—					
3. Relationship length	61 (73)	−.10	.30*	—				
4. Commitment	4.0 (0.76)	−.0	.11	−.07	—			
5. Relationship satisfaction	65 (11)	−.14	.07	−.11	.46*	—		
6. Female gender	60 (50%)	.12	.02	.08	.09	−.01	—	
7. Individual income	4.6 (2.9)	−.30*	.28*	.03	.07	−.01	−.21*	—

Note. Legally married status is coded as 1 = *legally married*, 0 = *any other relationship status*; female gender coded as 1 = *female*, 0 = *male*.
* $p < .05$.

marital status was not statistically significant, $\chi^2(1, N = 120) = 0.98$, $p = .32$, with 38% of participants who were not legally married and 48% of participants who were legally married reporting hazardous alcohol use.

Discussion

In a sample of cisgender sexual minority couples living across the United States, we found that people in married relationships reported lower depression scores than those in unmarried relationships. This aligns with previous studies, conducted prior to the 2015 nationwide legalization of same-sex marriage, that found a similar association for lower depression among married sexual minority couples (Ayala & Coleman, 2000; LeBlanc et al., 2018; Oetjen & Rothblum, 2000; Riggle et al., 2010; Whitton et al., 2020; Wight et al., 2013). An important contribution of the current study to this literature is that we were able to test whether this result held when controlling for multiple qualities of the romantic relationship that could confound the association between marital status and depression, which had not been adequately accounted for in prior research. Our finding that marital status was associated with lower depressive symptoms even when controlling for these relationship qualities suggests that relationship status (i.e., legal marriage), independent of factors specific to the relationship, has an association with depression for sexual minority couples.

However, the association between marital status and depression was no longer significant when individual income was added to the model. Greater individual income was independently associated with lower depressive symptoms in this sample, a finding which is consistent with prior research on income and depression more broadly (Patel et al., 2018; Zimmerman & Katon, 2005) and extends to married couples, who may report lower depression because they are buffered against financial hardships and other stressors together (Ross & Huber, 1985). The study's cross-sectional design did not allow us to draw conclusions regarding the nature of the relationships among income, depression, and marital status. It is possible that higher earning individuals are more likely to marry and less likely to be depressed. Alternatively, it is possible that individuals' finances change beneficially as they transition into legal marriage (e.g., because of tax and other financial benefits that marriage confers) and this directly lowers depression (Badgett et al., 2024); some evidence suggests this may be particularly true for male sexual minority couples (Carpenter et al., 2021). Therefore, the interplay among these variables for sexual minority adults warrants further study. Given documented income disparities among individuals who are transgender and those who are sexual minority Black, indigenous, or people of color (Downing & Rosenthal, 2020; Hsieh & Ruther, 2016), this line of inquiry may help unpack any heterogeneity of a marriage benefit on mental health within the larger sexual minority population.

Related, we also found that there were no significant differences across marital status in childhood sexual abuse or hazardous alcohol use. This suggests that while selection effects related to income could partially account for married participants reporting lower depressive scores, it was not the case in our sample that participants who were in a legally married relationship uniformly experienced fewer health risks than participants who were not in a legally married relationship. Furthermore, our measure of childhood sexual abuse is one risk factor for depression that was definitively present prior to when couples married. In combination, these findings suggest a complex picture could exist for sexual minority couples regarding which risk and protective factors influence health among sexual minority couples in marriage.

Limitations

Results should be considered in the context of the study's limitations. The cross-sectional design precluded any conclusions about temporality or causality of the association between legal marital status and depression. The sample is relatively small, and our power analysis suggested we were slightly underpowered to detect the association we observed between marital status and depression. This also precluded our ability to test for further variation (e.g., by gender or geographic location). Although we collected an even gender ratio among cisgender couples, gender diverse (i.e., trans, nonbinary, and gender nonconforming) individuals were not included. Therefore, the findings cannot be generalized to couples with a gender minority partner. We also only collected data on each partner's individual income and therefore could not account for household income in analyses. Finally, because our sample comprises couples, all partners are currently in a relationship. This offers a methodological strength in that it allows us to consider the association of legally married status with depression above and beyond the benefits a long-term, but not legally married romantic relationship might offer. At the same time, this element of our study design did not allow us to compare the married couples in our study to uncoupled or single sexual minority people, which would provide another informative comparison group.

Additionally, couples in the study who married prior to 2015 may differ in when they considered their marriage legalized. Many states

Table 3
Results From Multilevel Models of the Association Between Marital Status and Depression (N = 60 Cisgender, Sexual Minority Couples)

	Model 1		Model 2		Model 3		Model 4		Model 5	
Variable	*B* (*SE*)	95% CI	*B* (*SE*)	95% CI	*B* (*SE*)	95% CI	*B* (*SE*)	95% CI	*B* (*SE*)	95% CI
Legally married status	**−4.6 (2.0)***	[−8.5, −0.67]	**−4.7 (1.9)***	[−8.5, −0.96]	**−4.6 (1.9)***	[−8.3, −0.80]	**−4.9 (1.8)***	[−8.5, −1.3]	−3.3 (1.9)	[−7.0, 0.44]
Relationship length	−0.0 (0.01)	[−0.0, 0.0]								
Commitment			−0.12 (1.1)	[−2.3, 2.0]						
Relationship satisfaction					−0.11 (0.1)	[−0.26, 0.04]				
Female gender							2.4 (1.6)	[−0.79, 5.6]		
Individual income									**−0.79 (0.3)***	[−1.3, −0.24]

Note. Legally married status is coded as 1 = *legally married*, 0 = *any other relationship status*; female gender coded as 1 = *female*, 0 = *male*. CI = confidence interval.
* $p < .05$, bold.

permitted same-sex marriage prior to federal recognition (*Goodridge v. Department of Public Health*, 2003), though the United States Defense of Marriage Act allowed states to deny recognition of same-sex marriages licensed by other states. This ended in 2013 (*United States v. Windsor*, 2013) though individual states could still deny marriage licenses to same-sex couples within their state. The Supreme Court then mandated that all states grant licenses for same-sex marriages in the 2015 *Obergefell v. Hodges* decision (*Obergefell v. Hodges*, 2015). This timeline of same-sex marriage legalization reflects the institutional stigma experienced by sexual minority people over time with respect to access to marriage. Furthermore, this evolution did not halt with the Supreme Court decision, and the meaning of marriage for sexual minority people may be different today than when the data were collected. It may also complicate efforts to draw comparisons with data on same-sex marriage collected prior to 2015. Despite these limitations, our study provides valuable data on the association between couples' current marital status and recent depressive symptoms collected in the era shortly after full same-sex marriage legalization when marriage's social, legal, and economic benefits had recently become available to all couples.

Directions for Future Research

Future longitudinal studies could examine changes in depressive symptoms over time, including during periods of potentially heightened stress, such as the newlywed period, to test the magnitude and boundaries of the association between marital status and depression. Research across the transition to marriage could also help disentangle questions regarding how much marriage may directly improve health or to what extent healthier people are overrepresented among married samples. Furthermore, as our study did not include heterosexual couples, we cannot draw direct conclusions about the size of the association between marital status and depression in our sexual minority sample relative to what might be observed among similar heterosexual couples. A comparative study may be able to illuminate important reasons why the impact of marriage on mental health may be similar or different for couples across sexual orientations. Specific to sexual minority couples, the effects of marriage among sexual minority couples have and likely will continue to shift as time continues to pass since the *Obergefell v. Hodges* decision (Hoy, 2022). Thus, more contemporaneous quantitative and qualitative research can contribute to our understanding of the effects of marriage on mental health in today's age. Finally, there is also an array of relationship experiences among sexual minority adults, and these associations may differ for plurisexual (e.g., bisexual, queer, and pansexual) individuals married to different-gender partners. Research could examine the experiences of individuals with intersecting marginalized identities (e.g., across race, ethnicity, sexual orientation, gender, and partner gender).

Conclusion

Findings from the current study underscore the importance of access to legalized marriage for cisgender, sexual minority couples and demonstrate its relevance for their mental health in the era after national legalization of same-sex marriage. Furthermore, results provided initial data on the types of factors that may account for associations between marital status and mental health, suggesting sociodemographic factors may do so more than relationship factors. Future research will be needed to address remaining questions regarding

associations between marriage and mental health for diverse sexual minority adults, including the temporality of these effects.

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