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Health and Health Behavior Concordance between Spouses in Same-Sex and Different-Sex Marriages

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Abstract

Research shows that heterosexual spouses are concordant on a variety of health and health behavior outcomes. Yet, little is known about patterns of concordance between spouses in same-sex marriages, or whether concordance patterns differ for spouses in same- and different-sex marriages. Using descriptive techniques, we analyze survey data from both spouses in 121 gay, 168 lesbian, and 122 heterosexual married couples to examine health and health behavior concordance. We find that gay and lesbian couples are more concordant than heterosexual couples on several health and health behavior outcomes. Differences in concordance between gay and lesbian couples are also found. Findings suggest that the pathways through which concordance occurs may differ in important ways for same-sex and different-sex unions.

Keywords

gay and lesbian; marriage; health; health behavior; concordance

INTRODUCTION

Spouses tend to be similar to each other, or concordant, on a variety of health behaviors and health outcomes (for reviews, see Di Castelnuovo et al. 2009; Meyler, Stimpson, and Peek 2007). Moreover, the benefits of marriage for health (Umberson and Montez 2010; Umberson, Crosnoe, and Reczek 2010) may depend on the degree of health concordance between spouses. Past studies show that discordant patterns of health and health behavior between partners are often detrimental for a variety of marital outcomes, including marital quality (Birditt et al. 2016; Homish and Leonard 2007), relationship adjustment (Kelley, Lewis, and Mason 2015), and risk of divorce (Leonard, Smith, and Homish 2014; Torvik et al. 2015; Torvik et al. 2013). Research on health concordance has focused on heterosexual populations, thus we do not know how concordance patterns may differ for spouses in same-

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and different-sex marriages. Therefore, a comparison of same-sex and different-sex couples can expand our understanding of health concordance in marriage, as well as shed light on potential health disparities between same-sex and different-sex couples.

Although nationally representative data are available to evaluate health in same- and different-sex couples (Umberson et al. 2015), information is typically collected from only one partner. Thus, these data can only be used to study *individuals* in same-sex relationships rather than linkages between spouses within *couples*. Dyadic data (data collected from both spouses in a marriage) are required to consider differences between same- and different-sex married spouses in spousal health and health behavior concordance. The present study uses data from 411 gay, lesbian, and heterosexual married couples to examine patterns of spousal concordance in several health and health behavior outcomes.

CONCORDANCE WITHIN COUPLES: THEORETICAL MECHANISMS

Health and health behavior concordance between spouses may result through several processes (Meyler et al. 2007). Although *assortative mating*, or partners' tendency to resemble each other as a result of pre-relationship similarities, can contribute to levels of shared health within couples, studies suggest that other processes are operating as well. First, partners may attempt to influence each other's health and health behavior by means of *social control*. According to this perspective, spouses often monitor and regulate their partners' behaviors in ways that influence their health behaviors and health (Umberson 1987, 1992). Second, *behavior diffusion* theory suggests that spouses influence each other's health and health behavior directly (Lewis et al. 2006). For example, spouses may become concordant through mutual reinforcement (e.g., partners engage in health or unhealthy behaviors together) (Reczek 2012; Reczek and Umberson 2012). Social control and behavior diffusion are two processes that may help to explain how healthy and unhealthy outcomes and behaviors are shaped within unions.

GENDERED CONCORDANCE

Research on heterosexual married couples shows that the health benefits of marriage (and health detriments of marital dissolution) are gendered, wherein men benefit from marriage more than women (for a review, see Rendall et al. 2011). Gender differences in the health benefits of marriage in heterosexual unions may indicate that the mechanisms (i.e., social control and behavior diffusion) underlying health and health behavior within couples are also highly gendered. These gendered behaviors may, in turn, have implications for health and health behavior concordance within heterosexual couples. For example, because social control is more commonly performed by women than men (Reczek and Umberson 2012; Umberson 1987, 1992), and research shows that women may be more effective at positively influencing men's health and health behaviors than vice versa (Markey, Gomel, and Markey 2008; Westmaas, Wild, and Ferrence 2002), the health and health behaviors of men and women in a marriage may differ. Through efforts to improve their partner's health and well-being, women may endure considerable stress and neglect their own health needs, which in turn may compromise their own health and health behaviors and contribute to health and health behavior discordance in heterosexual couples. Indeed, care work in heterosexual

marriages is more often performed by women and is more detrimental to women's health and well-being (Pinquart and Sörensen 2006; Thomeer, Reczek, and Umberson 2015; Umberson et al. 2017; Umberson et al. 2016).

Much less is known about the role of gender in health and health behavior spousal concordance for same-sex couples. Although evidence of larger differences in socio-demographic characteristics (e.g., race/ethnicity, age) among same-sex versus different-sex couples (Jespen and Jespen 2002; Schwartz and Graf 2009; Verbakel and Kalmijn 2014) may extend to health and health behavior concordance, such that gay and lesbian partners are less likely than heterosexual partners to resemble one another, recent research suggests the possibility of greater health and health behavior concordance among same-sex than different-sex spouses. Greater use of positive and supportive social control tactics (e.g., providing encouragement and/or praising a spouse) among those in same-sex marriages compared to different-sex marriages (Umberson, Reczek, Donnelly, and Kroeger 2015; Umberson, Reczek, Kroeger, Donnelly, and Robinson 2016), which have been shown to be effective at eliciting behavior change (Lewis and Rook 1999), may lead to more health/behavior concordance in gay and lesbian couples than heterosexual couples. Furthermore, several qualitative studies indicate that gay and lesbian partners are more likely than heterosexual partners to mutually influence each other's health behaviors (Reczek and Umberson 2012), albeit not always in positive and healthy ways (Reczek 2012). Taken together, this research suggests that same-sex spouses may exhibit more health and health behavior concordance than different-sex couples.

METHODS

Data and sample

This study uses data from a survey that includes both spouses in 411 couples (N = 822 individuals): 121 gay couples, 168 lesbian couples, and 122 heterosexual couples. The survey was designed to consider how mid-life gay, lesbian, and heterosexual spouses in long-term relationships influence each other's health behaviors, psychological distress, and physical health symptoms. All participants were aged 35 to 65 (mean = 48.5 years), legally married, and had been together (cohabiting and married) for an average of 15.4 years. The sample was recruited in several ways to create comparable groups of gay, lesbian, and heterosexual couples, with a particular focus on age and relationship duration. Massachusetts was chosen as the original study area because it was the first U.S. state to legalize same-sex marriage (in 2004) and thus had a significant population of gay and lesbian couples in long-term marriages. Approximately 70% of gay and lesbian couples were recruited through Massachusetts vital statistics records, with the remaining couples (about 30%) recruited through referrals from study participants. About two-thirds of heterosexual couples were recruited through referrals from both same-sex and different-sex participants and the remaining heterosexual couples were recruited through Massachusetts demographic city lists. Some couples married in Massachusetts lived in other states at the time of the study and some referred couples resided outside of Massachusetts (57% of the couples in the study did not live in Massachusetts). The survey was administered separately to each spouse online and took about 45 minutes to complete.

Measures

We examine spousal concordance on several measures of health and health behaviors. *Self-reported health* is measured as respondents' subjective assessment of general health based on a 5-point scale (1 = excellent, 5 = poor). From this, we created a dichotomous variable comparing those who reported fair/poor health to all others (excellent/very good/good). *Any chronic condition* reflects whether the respondent reported having ever been diagnosed with any of the following: high blood pressure, diabetes, cancer, lung disease, heart problems, stroke, arthritis, HIV, or "other." Respondents who answered "yes" to one or more of these items were coded as having a chronic condition; those who answered "no" to all items were coded as not having a chronic condition. *Body mass index* (BMI) is calculated from self-reported height and weight and is assessed as both a continuous and categorical variable (underweight/normal, overweight, obese). *Depressive symptoms* are measured with an 11-item version of the Center for Epidemiological Studies Depression Scale (CES-D). Respondents were asked to report how often they felt or behaved in the following ways during the past week: (a) I did not feel likely eating/my appetite was poor; (b) I felt depressed; (c) I felt like everything I did was an effort; (d) My sleep was restless; (e) I was happy (reverse coded); (f) I felt lonely; (g) People were unfriendly to me; (h) I enjoyed life (reverse coded); (i) I felt sad; (j) I felt that people disliked me; and (k) I could not get going. Reponses ranged from 0 (rarely/none of the time) to 3 (most of the time) (range = 0–27, with higher values indicating more depressive symptoms; $\alpha = .85$). *Current smoking behavior* is categorized as smoker or non-smoker. *Current drinking behavior* refers to the number of drinks that the respondent usually has on the days he/she drinks and is categorized into non-drinker, moderate drinker (1 or 2 drinks), or heavy drinker (3 or more drinks). *Physical activity* is constructed from two items that asked respondents how often they engage in moderate (e.g., taking a walk) and vigorous (e.g., running) activity. Responses for these questions ranged from never to several times a week or more. Respondents were considered physically inactive if they answered less than several times a week for both moderate and vigorous activity, and physically active if they answered several times a week or more for either moderate or vigorous activity.

Analysis

Descriptive statistics for all demographic and health and health behavior variables are presented in Table 1. We use two descriptive approaches to explore partner concordance. First, we present intraclass correlations for continuous variables (Table 2). When analyzing dyadic data, intraclass correlations are the preferred method to assess non-independence with distinguishable and indistinguishable dyads (Kenny, Kashy, and Cook 2006). Second, we show the percent of couples who report concordance in health (Figure 1) and health behavior (Figure 2). All analyses are conducted using Stata-MP version 14.0.

RESULTS

Table 2 displays the intraclass correlations between partners for both continuous health variables by union type (i.e., BMI and depressive symptoms). We multiply the intraclass correlation coefficient by the square root of the number of dyads to produce an unbiased z statistic to test the significance of the correlation (Kenny et al. 2006). The correlations are

statistically significant for gay, lesbian, and heterosexual spouses for both BMI and depressive symptoms. We also use Fisher's *r* to *z* transformation to test whether the correlations are significantly different between groups. We find that similarity in BMI is stronger for gay (0.558) than heterosexual partners (0.277) ($p<.01$). Lesbian partners also exhibit greater similarity in BMI than heterosexual partners (0.509 vs. 0.277, respectively) ($p<.05$). Although gay partners are more similar than lesbian and heterosexual partners in terms of depressive symptoms, these differences are not statistically significant.

Figures 1 and 2 show the percent of couples who report concordance in health (weight status, self-reported health, and chronic conditions) and health behavior (smoking, drinking, and physical activity). Specifically, we present the percent of couples who report the same health outcome/behavior (e.g., both partners currently smoke or both partners currently do not smoke). Differences in concordance between union types are assessed using chi-square tests. In terms of health outcomes (Figure 1), we find that gay and lesbian couples are more concordant than heterosexual couples with respect to weight status (n.s.), self-reported health ($p < .001$), and chronic conditions ($p < .05$). For self-reported health, we find that concordance is most common among gay couples (89 percent), followed by lesbian couples (82 percent), and then heterosexual couples (72 percent). Concordance in chronic conditions is highest among lesbian couples (67 percent), followed by gay couples (63 percent), and then heterosexual couples (56 percent).

Turning to health behaviors (Figure 2), we find similar patterns of concordance across union type, such that lesbian couples are most concordant on levels of smoking, drinking, and physical activity, followed by gay couples, and then heterosexual couples. Significant differences are found for smoking and physical activity only. Approximately 92 percent of lesbian couples report concordant smoking behavior, compared to 88 percent of gay couples and 86 percent of heterosexual couples ($p < .10$). In addition, 77 percent of lesbian couples are concordant on physical activity, whereas 74 percent of gay couples and 65 percent of heterosexual couples are concordant ($p < .01$).

DISCUSSION

Past research suggests that heterosexual spouses are fairly similar, or concordant, in their health and health behaviors (Di Castelnuovo et al. 2009; Meyler et al. 2007). We extend this body of work by examining partner health and health behavior concordance in a sample of gay, lesbian, and heterosexual married couples. Despite research showing that same-sex partners are, in general, less concordant than different-sex partners on demographic characteristics (Jespen and Jespen 2002; Schwartz and Graf 2009), a finding also supported by our data (results not shown, available on request), our results show that, overall, concordance in health and health behavior is more common between gay and lesbian spouses than between heterosexual spouses.

More concordance between same-sex spouses as compared to different-sex spouses may reflect differences in relationship dynamics. Prior studies suggest that gay and lesbian relationships are more cooperative and egalitarian than are heterosexual relationships (Kurdek 2006). This is supported by same-sex partners' greater tendency to reciprocally

influence healthy (or unhealthy) habits in each other compared to different-sex partners (Reczek 2012; Reczek and Umberson 2012). These processes of mutual influence, or diffusion, may, in turn, promote more concordance on health and health behaviors for same-sex compared to different-sex couples. Moreover, because gender is relational and acted out differently depending on the gender and sexuality of one's self in relation to the gender/sexuality of one's spouse (Umberson, Thomeer, and Lodge 2015), the spousal dynamics shaping health and health behavior concordance likely differ for men and women depending on whether they are married to a man or a woman. For example, a woman may try to influence her spouse's health habits in different ways if she is married to a woman rather than a man. In turn, two spouses of the same gender may be more likely to share approaches to health that shape concordance of behaviors and outcomes. More concordance found in same-sex couples may also reflect the type of social control tactics used by spouses. Positive and supportive social control tactics, which are more commonly used among same-sex couples (Umberson et al. 2015; Umberson et al. 2016), have been found to be associated with health behavior change (Lewis and Rook 1999).

We also find differences in concordance between gay and lesbian couples. While lesbian couples are more likely to be concordant in smoking, physical activity, and chronic conditions, gay couples are more likely to be concordant in self-reported health. Further investigation of the reasons for these differences may shed light on gendered dynamics that play an important role in shaping the health and health behavior of gay and lesbian spouses. For example, greater and more effective social control efforts on the part of women (Umberson et al. 2015) may help to explain more concordance in health behaviors among lesbian couples. Moreover, if social control is more commonly performed by women (Reczek and Umberson 2012; Umberson 1987, 1992) and women are more effective at influencing their partner's health (Markey et al. 2008; Westmaas et al. 2002), then two women may be more concordant in their health and health behavior than men married to men (or women married to men).

This study advances our understanding of health and health behavior concordance within marriage by using dyadic data from same-sex and different-sex spouses. However, a few limitations should be noted. First, with respect to the sample, 43% of couples were Massachusetts residents. In addition, some of the participants were recruited through snowball sampling. Although this limits the generalizability of the results, our findings of more health and health behavior concordance among same-sex couples compared to different-sex couples is noteworthy. Nationally representative datasets should oversample sexual minority individuals and include dyadic data from spouses (Carr and Springer 2010) to further examine how patterns of concordance may differ for same- and different-sex married couples. Second, our use of cross-sectional data does not allow us to assess possible changes in concordance over time. The use of longitudinal data would allow researchers to determine how concordance may change over the duration of a relationship. Third, given the descriptive nature of this study, we are unable to explore the mechanisms through which concordance occurs, and whether these processes differ between those in gay, lesbian, and heterosexual marriages. However, we believe this is an important first step in better understanding health and health behavior concordance in same-sex marriages. Finally, small sample sizes preclude us from exploring concordance in terms of participation in healthy

and unhealthy behaviors separately (e.g., both partners do not smoke vs. both partners smoke). We encourage future researchers to further examine patterns of partner concordance among spouses in a variety of union types.

In sum, this study advances the literature by showing that spousal concordance in health and health behavior is not limited to different-sex couples but also occurs within same-sex relationships. In fact, findings reveal that same-sex couples are more likely to exhibit concordance than different-sex couples on several health and health behavior outcomes. In other words, same-sex couples are less likely to be discrepant in their health and health behaviors. In light of health disparities in sexual minority populations (IOM 2011), more concordance may offer protection for *married* gay and lesbian individuals or marriage may compound poor health in ways that are detrimental to the health of same-sex couples. Therefore, future research examining the health and health behavior of married individuals should consider the pathways through which concordance occurs, and how these pathways may vary for men and women in gay, lesbian, and heterosexual marriages. While discordance in health and health behaviors have been shown to be associated with worse relationship outcomes among those in different-sex unions (Homish and Leonard 2007; Leonard et al. 2014; Torvik et al. 2015; Torvik et al. 2013), few studies have examined this issue among those in same-sex unions (for an exception, see Kelley et al. 2015). Considering patterns of health and health behavior concordance for same-sex and different-sex couples has the potential to shed new light on gendered marital dynamics that influence health behaviors as well as overall mental and physical health.

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References

Birditt Kira S, Cranford James A, Manalel Jasmine A, Antonucci Toni C. Drinking Patterns among Older Couples: Longitudinal Associations with Negative Marital Quality. Journals of Gerontology: Psychological Sciences. 2016; doi: 10.1093/geronb/gbw073

Carr DeborahSpringer Kristen W. Advances in Families and Health Research in the 21st Century. Journal of Marriage and Family. 2010; 72(3):743–61.

Di Castelnuovo AugustoQuacquaruccio GianniDonati Maria B, de Gaetano GiovanniIacoviello Licia. Spousal Concordance for Major Coronary Risk Factors: A Systematic Review and Meta-Analysis. American Journal of Epidemiology. 2009; 169(1):1–8. [PubMed: 18845552]

Homish Gregory G, Leonard Kenneth E. The Drinking Partnership and Marital Satisfaction: The Longitudinal Influence of Discrepant Drinking. Journal of Consulting and Clinical Psychology. 2007; 75(1):43–51. [PubMed: 17295562]

Institute of Medicine. The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding. Washington, D.C.: 2011.

Jepsen Lisa K, Jepsen Christopher A. An Empirical Analysis of the Matching Patterns of Same-Sex and Opposite-Sex Couples. Demography. 2002; 39(3):435–53. [PubMed: 12205751]

Kelley Michelle L, Lewis Robin J, Mason Tyler B. Discrepant Alcohol Use, Intimate Partner Violence, and Relationship Adjustment among Lesbian Women and their Same-Sex Intimate Partners. Journal of Family Violence. 2015; 30(8):977–86. [PubMed: 26478657]

Kenny David A, Kashy Deborah A, Cook William L. Dyadic Data Analysis. New York: Guilford Press; 2006.

Kurdek Lawrence A. Differences Between Partners From Heterosexual, Gay, and Lesbian Cohabiting Couples. Journal of Marriage and Family. 2006; 68(2):509–28.

Leonard Kenneth E, Smith Philip H, Homish Gregory G. Concordant and Discordant Alcohol, Tobacco, and Marijuana Use as Predictors of Marital Dissolution. Psychology of Addictive Behaviors. 2014; 28(3):780–89. [PubMed: 24128287]

Lewis Megan A, McBride Colleen M, Pollak Kathryn I, Puleo ElaineButterfield Rita M, Emmons Karen M. Understanding Health Behavior Change among Couples: An Interdependence and Communal Coping Approach. Social Science & Medicine. 2006; 62(6):1369–80. [PubMed: 16146666]

Lewis Megan A, Rook Karen S. Social Control in Personal Relationships: Impact on Health Behaviors and Psychological Distress. Health Psychology. 1999; 18(1):63–71. [PubMed: 9925047]

Markey Charlotte N, Gomel Jessica N, Markey Patrick M. Romanic Relationships and Eating Regulation: An Investigation of Partners' Attempts to Control Each Others' Eating Behaviors. Journal of Health Psychology. 2008; 13(3):422–32. [PubMed: 18420775]

Meyler DeannaStimpson Jim P, Peek M Kristen. Health Concordance Within Couples: A Systematic Review. Social Science & Medicine. 2007; 64(11):2297–2310. [PubMed: 17374552]

Pinquart MartinSilvia Sörensen. Gender Differences in Caregiver Stressors, Social Resources, and Health: An Updated Meta-Analysis. The Journal of Gerontology Series B: Psychological Sciences and Social Sciences. 2006; 61(1):P33–P45.

Reczek Corinne. The Promotion of Unhealthy Habits in Gay, Lesbian, and Straight Intimate Partnerships. Social Science & Medicine. 2012; 75(6):1114–21. [PubMed: 22703888]

Reczek CorinneUmberson Debra. Gender, Health Behavior, and Intimate Relationships: Lesbian, Gay, and Straight Contexts. Social Science & Medicine. 2012; 74(11):1783–90. [PubMed: 22227238]

Rendall Michael S, Weden Margaret M, Favreault Melissa M, Waldron Hilary. The Protective Effect of Marriage for Survival: A Review and Update. Demography. 2011; 48(2):481–506. [PubMed: 21526396]

Schwartz Christine R, Graf Nikki L. Assortative Matching among Same-Sex and Different-Sex Couples in the United States, 1990–2000. Demographic Research. 2009; 21:843–78. [PubMed: 20333322]

Thomeer Mieke B, Reczek CorinneUmberson Debra. Gendered Emotion Work Around Physical Health Problems in Mid- and Later-Life Marriages. Journal of Aging Studies. 2015; 32:12–22. [PubMed: 25661852]

Torvik Fartein A, Gustavson KristinRøysamb EspenTambs Kristian. Health, Health Behaviors, and Health Dissimilarities Predict Divorce: Results from the HUNT Study. BMC Psychology. 2015; 3(1):1–9. [PubMed: 25678981]

Torvik Fartein A, Røysamb EspenGustavson KristinIdstad MariannTambs Kristian. Discordant and Concordant Alcohol Use in Spouses as Predictors of Marital Dissolution in the General Population: Results from the Hunt Study. Alcoholism: Clinical and Experimental Research. 2013; 37(5):877–84.

Umberson Debra. Family Status and Health Behaviors: Social Control as a Dimension of Social Integration. Journal of Health and Social Behavior. 1987; 28(3):306–19. [PubMed: 3680922]

Umberson Debra. Gender, Marital Status, and the Social Control of Health Behavior. Social Science & Medicine. 1992; 34(8):907–17. [PubMed: 1604380]

Umberson DebraCrosnoe RobertReczek Corinne. Social Relationships and Health Behavior Across the Life Course. Annual Review of Sociology. 2010; 36:139–57.

Umberson DebraMontez Jennifer K. Social Relationships and Health: A Flashpoint for Health Policy. Journal of Health and Social Behavior. 2010; 51:S54–S66. [PubMed: 20943583]

Umberson DebraReczek CorinneDonnelly RachelKroeger Rhiannon A. Marriage, Social Control, and Health Behavior in Same-Sex and Different Sex Unions. Presented at the Annual Meeting of the Society for Longitudinal and Life Course Studies; Dublin, Ireland. 2015.

Umberson DebraReczek CorinneKroeger Rhiannon A, Donnelly RachelRobinson Brandon. Stress and the Provision of Social Support in Gay, Lesbian, and Heterosexual Marriages. Presented at the 3rd International Sociological Association Forum of Sociology; Vienna, Austria; 2016.

Umberson DebraThomeer Mieke B, Kroeger Rhiannon A, Lodge Amy C, Xu Minle. Challenges and Opportunities for Research on Same-Sex Relationships. Journal of Marriage and Family. 2015; 77(1):96–111. [PubMed: 25598552]

Umberson DebraThomeer Mieke B, Kroeger Rhiannon A, Reczek CorinneDonnelly Rachel. Instrumental- and Emotion-Focused Care Work During Physical Health Events: Comparing Gay, Lesbian, and Heterosexual Marriages. The Journal of Gerontology Series B: Psychological Sciences and Social Sciences. 2017; 72(3):498–509.

Umberson DebraThomeer Mieke B, Lodge Amy C. Intimacy and Emotion Work in Lesbian, Gay, and Heterosexual Relationships. Journal of Marriage and Family. 2015; 77(2):542–56. [PubMed: 25814771]

Umberson DebraThomeer Mieke B, Reczek CorinneDonnelly Rachel. Physical Illness in Gay, Lesbian, and Heterosexual Marriages: Gendered Dyadic Experiences. Journal of Health and Social Behavior. 2016; 57(4):517–31. [PubMed: 27799592]

Verbakel EllenKalmijn Matthijs. Assortative Mating Among Dutch Married and Cohabiting Same-Sex and Different-Sex Couples. Journal of Marriage and Family. 2014; 76(1):1–12.

Westmaas J LeeWild T CameronFerrence Roberta. Effects of Gender in Social Control of Smoking Cessation. Health Psychology. 2002; 21(4):368–76. [PubMed: 12090679]

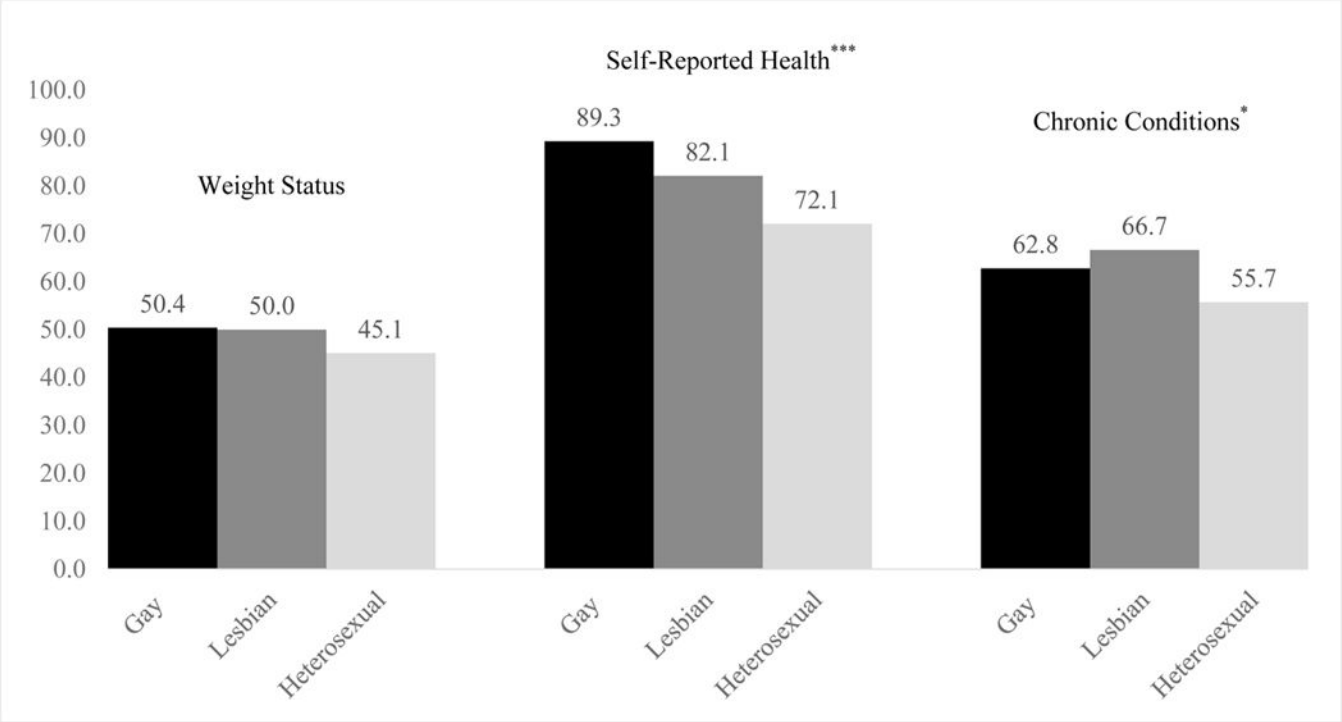

Figure 1. Health Concordance within Couples

Note: Differences based on chi-square tests. Values are percentages.

* $p<.05$. *** $p<.001$.

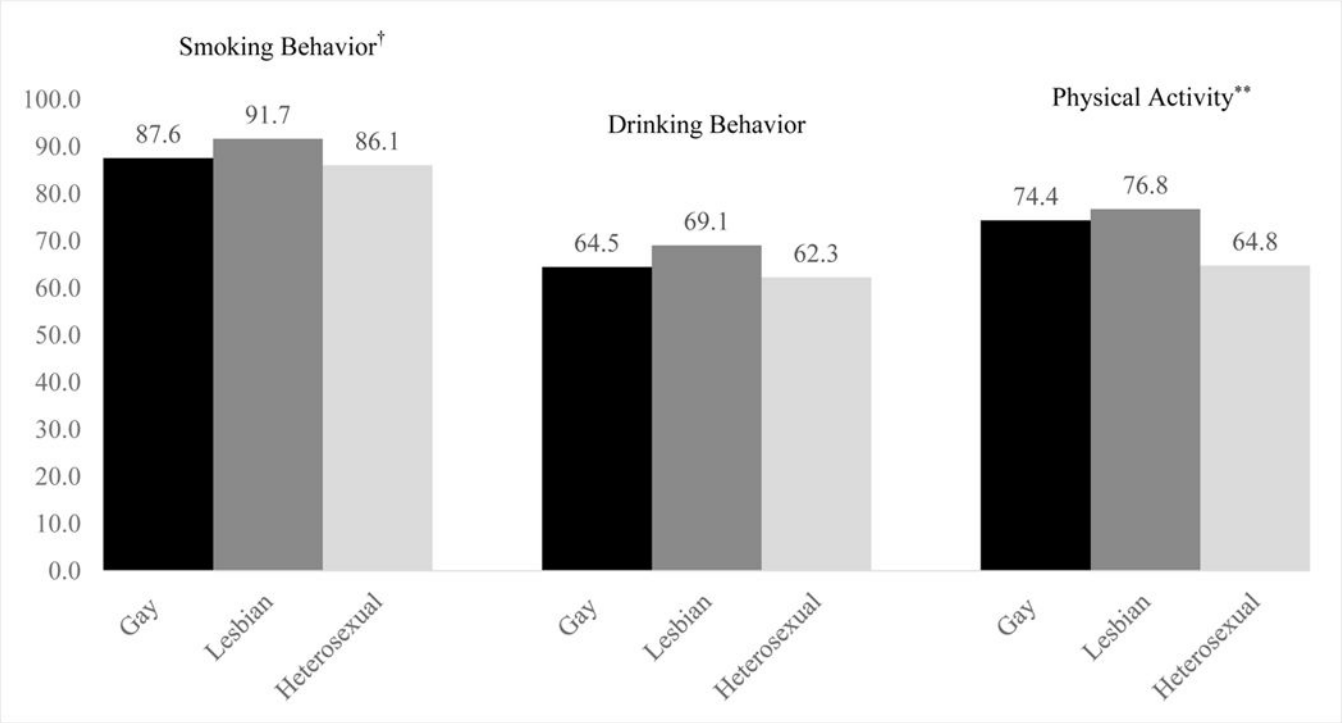

Figure 2. Health Behavior Concordance within Couples

Note: Differences based on chi-square tests. Values are percentages.

†$p<.10$. **$p<.01$.

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Table 1

Sample Characteristics, by Union Type and Partner

	Gay Couples		Lesbian Couples		Heterosexual Couples	
	Partner 1	**Partner 2**	**Partner 1**	**Partner 2**	**Female**	**Male**
Relationship Duration (range, 3.5–45 years)	16.3		13.8		16.3	
Lives in Massachusetts (%)	44.6		37.5		48.4	
Demographics						
Age (range, 35–65 years)	50.2	49.5	49.1	49.8	45.4	46.9
Non-White (%)	12.4	13.2	8.9	13.0	17.9	16.3
Education (%)						
Some College or Less	14.9	23.1	10.1	17.8	25.2	30.9
College Degree	32.2	29.8	24.3	30.2	26.0	32.5
Postgraduate/Professional	52.9	47.1	65.7	52.1	48.8	36.6
Health and Health Behaviors						
Current Smoking Behavior (%)						
Non-Smoker	88.4	87.6	94.6	92.3	90.2	87.7
Smoker	11.6	12.4	5.4	7.7	9.8	12.3
Drinking Behavior (%)						
Non-Drinker	9.9	14.1	14.9	10.1	10.7	10.7
Moderate Drinker	60.3	58.7	73.8	79.2	79.5	59.8
Heavy Drinker	29.8	27.3	11.3	10.7	9.8	29.5
Physically Inactive (%)	24.8	22.3	23.1	24.9	35.0	35.0
Fair/Poor Health (%)	5.8	6.6	10.1	13.7	23.0	14.8
Any Chronic Condition (%)	66.1	58.7	52.4	57.1	50.8	50.8
Depressive Symptoms (range, 0–27)	5.7	5.8	5.6	6.8	7.0	5.9
Body Mass Index (range, 14–67)	27.0	26.9	28.9	28.6	28.4	29.3
Weight Status (%)						
Underweight/Normal	33.1	37.2	39.1	32.5	43.1	22.8
Overweight	47.1	43.0	27.2	34.3	29.3	39.8
Obese	19.8	19.8	33.7	33.1	27.6	37.4

Note: Values are means unless otherwise noted. Percentages may not equal 100 due to rounding.

Table 2

Correlations for Partner Concordance, by Union Type

	Gay	Lesbian	Heterosexual	Fisher's *r* to z
BMI	0.558***	0.509***	0.277**	G > H**, L > H*
Depressive Symptoms	0.316***	0.199**	0.212*	------

Note: In Fisher's r to *z* transformation, G = gay, L = lesbian, and H = heterosexual.

* $p < .05$.

** $p < .01$.

*** $p < .001$.