Psychosocial Correlates of Religious Approaches to Same-Sex Attraction: A Mormon Perspective

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This study examined the psychosocial correlates of following various church-based approaches for dealing with same-sex attraction, based on a large sample (1,612) of same-sex attracted current and former members of the Church of Jesus Christ of Latter-day Saints (LDS, or Mormon). Overall, this study found that biologically based views about the etiology of same-sex attraction (vs. psychosocial views), LDS church disaffiliation (vs. activity), sexual activity (vs. celibacy), and legal same-sex marriage (vs. remaining single or mixed-orientation marriage) were all associated with significantly higher levels of self-esteem and quality of life, and lower levels of internalized homophobia, sexual identity distress, and depression. The divorce rate for mixed-orientation marriages was 51% at the time of survey completion, with projections suggesting an eventual divorce rate of 69%.

KEYWORDS psychology, LGBTQ, religion, celibacy, marriage, Mormon

Approximately 83% of U.S. adults self-identify as religious (Pew, 2008), with 11% (25.6 million) acknowledging at least some form of same-sex attraction, and an estimated 3.8% (9 million) self-identifying as lesbian, gay, bisexual,
or transgender (SSA; Gates, 2012). While virtually every major medical association has declared SSA and same-sex behavior (SSB) to be normal and healthy variants of human sexuality (APA, 2009), many conservative religious traditions continue to condemn both SSA and SSB as being inconsistent with God’s will (Barry, 2001; For Faith & Family, 2005; Hinckley, 1998). These religious teachings lead millions of LGBT adults to experience psychological conflict between their sexuality and their religiosity (APA, 2009; Bradshaw, Dehlin, Crowell, Galliher, & Bradshaw, in press; Dehlin, Galliher, Bradshaw, & Crowell, in press; Dehlin, Galliher, Bradshaw, Hyde, & Crowell, 2014).

To assist lesbian, gay, bisexual, and transgender (LGBT) church members in this conflict, many conservative religious traditions offer various teachings and recommendations. For example, many discourage the belief that SSA has a biological foundation (Mustanski et al., 2002), and instead attribute SSA to one or more psychosocial factors (Abbott & Byrd, 2009; Byrd, 2008; Dahle et al., 2009; Eldridge, 1994; Mansfield, 2011; Park, 1997, 2006). Such beliefs are theorized to help LGBT church members feel hopeful that their same-sex sexuality can be “fixed,” with proper support. These religion-based theories are often accompanied by promoting lifestyle choices that encourage LGBT individuals to downplay or suppress their SSA in order to live in harmony with church teachings. These recommendations often include (a) increased religiosity, including increased church attendance and activity; (b) sexual orientation change efforts (SOCE); (c) celibacy; and (d) mixed-orientation marriages (APA, 2009; Beckstead & Morrow, 2004; Dehlin et al., in press; Dehlin et al., 2014; Jones & Yarhouse, 2007; Nicolosi et al., 2000; Throckmorton & Welton, 2005). While select “success stories” are often publicized to tout the viability of such lifestyle options (Mansfield, 2011), little research has been conducted regarding their psychosocial implications (APA, 2009).

BELIEFS ABOUT THE ETIOLOGY OF SAME-SEX ATTRACTION

Considerable evidence implicates various biological influences on same-sex sexuality including genetics, neurohormonal development (e.g., psychoneuroendocrinology, prenatal stress, cerebral asymmetry), and fraternal birth-order in men (LeVay, 2011; Mustanski et al., 2002). Nonetheless, many religious organizations have a history of either explicitly denying the biological etiology of SSA or of emphasizing less scientifically substantiated psychosocial theories of SSA etiology (Dobson, 2013; LDS Church, 2010; JONAH, 2001). A number of studies over the past ten years have sought to explain the reasons for and implications of psychosocial versus biological views on SSA etiology (Arseneau, Grzanka, Miles, & Fassinger, 2013). For example, Whitehead and Baker (2012) found that sources of moral authority (e.g., religion) heavily influence views about the etiology of
homosexuality. Literal beliefs about the Bible, belief that God is active in the world, and high levels of religious behavior were all strongly associated with belief that homosexuality is a choice (Whitehead, 2010). Positive attitudes towards homosexuality have been associated with the belief that its origins are biological, whereas negative attitudes are associated with the view that its origin is personal choice (Sheldon, Pleffer, Jayaratne, Feldbaum, & Petry, 2007). Smith, Zanotti, Axelton, and Saucier (2011) reported that stronger belief that same-sex sexuality was due to nurture-related factors predicted less support for LGBT-affirming legislation, and was mediated by sexual prejudice, suggesting that beliefs about the origins of sexual orientation may serve as a justification factor in the expression of LGBT prejudice. While Dehlin et al. (in press) found higher prevalence rates of psychosocially based beliefs about SSA etiology among same-sex attracted Mormons who identify more closely with the church, no known research exists exploring the impact of such beliefs on the overall health and well-being of LGBT individuals.

RELIGION-CONSISTENT APPROACHES TO SSA

Given the incompatibility of same-sex sexuality with many conservative religious traditions, four of the most common approaches offered by conservative religious organizations to sexual minorities are (a) sexual orientation change efforts (SOCE); (b) increased church activity; (c) living a single, celibate life; and (d) entering into a mixed-orientation marriage (APA, 2009; Besen, 2012; O'Donovan, 2004). While religious and therapeutic SOCE continue to be heavily promoted by religious institutions as a means to deal with SSA (APA, 2009), SOCE will not be directly addressed through this study, as the SOCE-related data from this study have been discussed elsewhere (Bradshaw et al., in press; Dehlin et al., 2014).

Increased Church Activity

While religious involvement is often associated with better physical health, mental health, and longer survival, the interpretation of such studies is often complicated by factors such as sample quality and diversity, failure to control for confounding variables, and failure to isolate the specific mechanisms underlying associations with greater well-being (George et al., 2002; Smith et al., 2003). George et al. (2002) suggested the following as possible mechanisms underlying religion-associated well-being: (a) superior health practices, (b) increased social support, (c) the development of psychosocial resources (e.g., self-esteem, self-efficacy), and (d) a greater sense of coherence and meaning.
With regard to LGBT religiosity specifically, multiple studies indicate that sexual minorities with positive, personal relationships with God have higher self-esteem (e.g., Dahl & Galliher, 2010; Woods et al., 1999), and that personal religious devotion among sexual minorities positively correlates with mental health (Hackney & Sanders, 2003; Yarhouse & Tan, 2005). As an example, one qualitative study indicated that sexual minorities' exploration of sexual identity within their religious contexts ultimately helped to increase self-acceptance and open-mindedness towards other people, while allowing them to incorporate many positive values into their lives, such as the importance of service, family, and avoidance of substance abuse (Dahl & Galliher, 2012). In another study, Rosario, Yali, Hunter, and Gwadz (2006) found that LGBT youth who no longer identified with their childhood religion were more likely to have engaged in risky sexual behaviors, evidenced more emotional distress, indicated less social support, and had lower self-esteem than those who maintained identification with religion.

On the negative side, numerous potential psychosocial risks are associated with maintaining and increasing religiosity as a sexual minority. Shilo and Savaya (2012) found that religiosity correlated with lower levels of family and friends' support and acceptance, lower levels of disclosure, and higher levels of internalized homophobia. Dahl and Galliher (2010) found that increased religious commitment, participation, and social support were not protective factors for sexual minorities. According to their study, negative religious experiences (e.g., seeing God as unkind, finding religion too demanding) were related to higher levels of depression, lower levels of self-esteem, and increased conflict about sexual orientation, with negative religious experiences having a larger impact than positive experiences. These authors also found that same-sex attracted young adults experienced feelings of inadequacy and religious-related guilt, often persisting even after disaffiliation from their religion; depression related to coming out; and considerable difficulties in relationships with friends/family. As a result, many LGBT individuals felt apprehensive about coming out to others in the future (Dahl & Galliher, 2012). Finally, in another study with this sample of same-sex attracted Latter-day Saints, Dehlin et al. (2014) found that religious attempts to cope with or change sexual orientation were the most damaging and least effective of all methods chosen, including psychotherapy, psychiatry, and group therapy.

When an LGBT individual is unable to find success through one of these faith-based methods, religious disaffiliation often becomes the next logical choice. This is also problematic, however, since religious disaffiliation is often associated with several psychologically distressing consequences including anxiety, depression, family rejection, loss of social connections and support, less satisfaction with life, and suicidality (Bjorck & Thurman, 2007; Edmondson, Park, Chaudoir, & Wortmann, 2008; Exline, Yali, & Sanderson, 2000; Gauthier et al., 2006; Ryan et al., 2010; Wortmann, Park, & Edmondson,
2012). These negative associations often hold true even when controlling for the positive effects of religion (Bjorck & Thurman, 2007; Exline et al., 2000; Wortmann, Park, & Edmondson, 2012). What remains unclear in the literature is whether or not the benefits of religious disaffiliation outweigh the costs for LGBT individuals.

Staying Single and Celibate versus Getting Married

Since many religious denominations prohibit sexual activity outside the bounds of legal, heterosexual marriage, one common recommendation made by religious leaders is for religious SSA individuals to remain celibate (Olson, 2007; Sobol & Bell, 2001). However, as Richard Sipe (2008, p. 548) wrote, “Most religious commentators...are loath to address the more practical realities and difficulties of becoming celibate and maintaining the practice.” Sipe continued, “The separation or disregard of the natural foundations of celibate asceticism is a serious flaw in its achievement” (2008, p. 549). While several studies reveal difficulty in maintaining a celibate lifestyle (Brzezinski, 2000; Jones & Yarhouse, 2007; Sipe, 1990, 2003, 2008), minimal data exist on the mental health implications of celibacy (APA, 2009). Though a few studies indicate that some find the choice of celibacy to be fulfilling (Jones & Yarhouse, 2007), many other studies indicate that celibacy might lead to feelings of loneliness and depression (Beckstead & Morrow, 2004; Haldeman, 2001; Shidlo & Schroeder, 2002).

Marriage is often associated with significantly better mental health outcomes when compared with never marrying (Williams, Frech, & Carlson, 2010). As noted by Carlson (2012, p. 744), “…marriage provides people with several psychosocial and economic resources that are associated with high levels of well-being...,“ including, a sense of meaning, purpose and “mattering to others” (Marks, 1996; Schieman & Taylor, 2001; Taylor & Turner, 2001), increased levels of social integration, and increased economies of scale through the economic pooling of resources (Waite, 1995). As with the benefits/costs of church participation, studies on the benefits/costs of marriage contain important sampling limitations, are often limited in scope, fail to control for possible confounding factors, and often fail to identify the mechanisms for the improved well-being of married individuals (e.g., Carlson, 2012). Nonetheless, the general benefits frequently associated with marriage, combined with the risks associated with celibacy, raise important questions regarding religion-based recommendations to live a single, celibate lifestyle as a way to deal with the conflict between one’s religiosity and one’s sexuality.

Mixed-Orientation Marriages

A mixed-orientation marriage (MOM) involves a legal marriage wherein one spouse identifies as bisexual, gay, or lesbian, and the other identifies as
heterosexual (Buxton, 2004). While current and reliable prevalence rates are
difficult to obtain, it has been estimated that somewhere between 10% and
20% of gay men in the United States marry heterosexually at some point
in their lives (Ross, 1989), leading to an estimated two million-plus U.S.
families that have entered into a MOM (Buxton, 1994). Prevalence rates for
U.S. lesbians and bisexuals in mixed-orientation marriages were even more
difficult to obtain.

Religious socialization has been cited as one of the primary motivators
for such unions (Hernandez & Wilson, 2007; Ortiz & Scott, 1994). Unfortu-
nately, MOMs are often characterized by a considerable array of negative dy-
namics including sexual and emotional dissonance, disorientation, despair,
spiritual turmoil, insecurity, resentment, pain, and infidelity (Hernandez,
Schwenkie, & Wilson, 2011). Most significantly, estimates put the divorce
rate of MOMs somewhere between 50% and 85% (Buxton, 1994; Buxton,
2001; Wolkomir, 2004).

THE PRESENT STUDY

The present study attempts to understand and explore the prevalence and
psychosocial correlates of religion-based and non-religion-based approaches
to same-sex sexuality, based on a large survey of current and former Mor-
mons who experience SSA. Specific religious approaches to be examined
include: psychosocial (vs. biological) beliefs about the etiology of SSA, re-
ligious belief and church activity (vs. disbelief and church disaffiliation),
celibacy (vs. sexual activity), and mixed orientation marriages (vs. same-sex
committed relationships and/or marriage).

Specific research questions to be explored in this study include the
following:

- What are the psychosocial implications for LGBT individuals who espouse
  a biological versus psychosocial view of SSA etiology?
- What are the mental health implications and effectiveness rates for the
  various religion-based recommendations for dealing with SSA, including
  increased church activity, celibacy, and mixed-orientation marriages?
- What are the mental health implications of both religious disaffiliation and
  entering into committed same-sex relationships for LGBT individuals?

METHODS

Participants

Participants were recruited to participate in a web-based survey with five
main components: (a) basic demographic information; (b) sexual identity
development; (c) measures of psychosocial functioning; (d) exploration of attempts to accept, cope with, or change sexual orientation; and (e) questions regarding religious affiliation, belief, and practice. Both quantitative and open-ended questions were included in the survey, which required an average of more than one hour to complete per respondent. Inclusion criteria for participation in the study were as follows: (a) 18 years of age or older, (b) baptism in the LDS church, (c) feelings of same-sex attraction at some point in the participant's life, (d) completion of at least a majority of the items on the survey, and (e) indication that they only completed the survey once. The final sample comprised 1,612 respondents who met these criteria; the sampling design and recruitment will be described in detail below.

The basic demographic information for our sample can be found in Table 1. The mean age for respondents was 36.9 ($SD = 12.58$). Approximately 95% of participants lived in the United States (including 48 states and the District of Columbia), and 90.9% reported to be White/Caucasian. The mean Kinsey sexual attraction score reported by participants was 4.9 ($SD = 1.48$).

Measures

**Demographic Information**

Respondents answered several demographic questions, including age, biological sex, gender, country and state of residence, race, income, education, religion, sexual identity, relationship status (e.g., married, committed relationship, single, divorced), and whether or not they have ever been married heterosexually and the length of that marriage.

**Sexual Orientation History**

Regarding sexual orientation, participants were asked to rate sexual behavior/experience, feelings of sexual attraction, and self-declared sexual identity on a 7-point Likert-type scale (modeled after the Kinsey scale; Kinsey & Pomeroy, 1948), ranging from "0 – exclusively opposite sex" to "6 – exclusively same sex," with the additional option of "asexual" also provided. Participants were also asked their level of sexual activity (e.g., celibate, sexually active), and their opinions about the causes of SSA both in general, and for themselves specifically.

**LDS Church Status**

Participants were asked to specify their current status in the LDS church. Options included active (i.e., attends at least once a month), inactive (i.e., attends less than once a month), disfellowshipped (i.e., on probationary
TABLE 1  Demographic Counts of Participants

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>%</th>
<th>Variable</th>
<th>n</th>
<th>%</th>
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<td>Biological Sex</td>
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<td>Sexual Orientation</td>
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<td>Female</td>
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<td>24.1</td>
<td>Gay</td>
<td>995</td>
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<td>Male</td>
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<td>75.9</td>
<td>Lesbian</td>
<td>221</td>
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<td>Bisexual</td>
<td>234</td>
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<tr>
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<td></td>
<td></td>
<td>Heterosexual</td>
<td>79</td>
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<td></td>
<td></td>
<td>SSA or SCG</td>
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<td>1.2</td>
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<tr>
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<td></td>
<td>Other</td>
<td>62</td>
<td>3.8</td>
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<td></td>
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<td>Ever married heterosexual?</td>
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<td>31.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Currently a parent?</td>
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<td>28.9</td>
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<td></td>
<td>Relationship Status</td>
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<td></td>
<td>Single</td>
<td>657</td>
<td>42.4</td>
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<tr>
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<td></td>
<td></td>
<td>Heterosexual marriage</td>
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<td>Legal SS relationship</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Non-Legal SS relationship</td>
<td>366</td>
<td>23.6</td>
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<tr>
<td></td>
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<td></td>
<td>Divorced/Separated</td>
<td>83</td>
<td>5.4</td>
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<td>Current LDS Church Status</td>
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<td>Active</td>
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<td>28.8</td>
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<td>Inactive</td>
<td>559</td>
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<td>Disfellowship</td>
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<td>Excommunicated</td>
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<td>Resigned</td>
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<td>Church Attended Most Freq.</td>
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<td>LDS</td>
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<td>None/Agnostic/Atheist</td>
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<td>39.9</td>
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<td>Episcopal</td>
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<td>Unitarian Universalist</td>
<td>29</td>
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<td>Buddhist</td>
<td>21</td>
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<td>Other</td>
<td>131</td>
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<td>Sexual Activity</td>
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<td>Celibate by choice</td>
<td>224</td>
<td>14.0</td>
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<td></td>
<td></td>
<td>Celibate due to no partner</td>
<td>290</td>
<td>18.1</td>
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<td>Sex. active comm. rel.</td>
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<td>49.9</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Sex. active no comm. rel.</td>
<td>290</td>
<td>18.1</td>
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</table>

status), resigned membership, and excommunicated (i.e., termination of membership by the church).

QUALITY OF LIFE SCALE

The Quality of Life Scale (QOLS; Burckhardt, Woods, Schultz, & Ziebarth, 1989) is a 16-item instrument that measures six conceptual domains of quality of life: material and physical well-being; relationships with other people; social, community, and civic activities; personal development and fulfillment;
recreation; and independence. Answers are provided on a 7-point Likert-type scale. Scores are obtained by summing the items (16-112). Average total score for healthy populations is about 90. Average scores for various disease groups include: Israeli patients with posttraumatic stress disorder (61), fibromyalgia (70), psoriasis, urinary incontinence and chronic obstructive pulmonary disease (82), rheumatoid arthritis (83), systemic lupus (84), osteoarthritis (87), and young adults with juvenile rheumatoid arthritis (92; Burckhardt, Woods, Schultz, & Ziebarth, 1989). The QOLS has demonstrated internal consistency ($\alpha = .82$ to .92) and test-retest reliability ($r = 0.78$ to $r = 0.84$; Anderson, 1995; Neumann & Buskila, 1997; Wahl, Burckhardt, Wiklund, & Hanestad, 1998). Cronbach's alpha for the current sample was $\alpha = .90$.

**Rosenberg Self-Esteem Scale**

The Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965) is a 10-item measure of self-esteem developed for adolescents, but has been used with samples across the developmental spectrum. The RSES uses a Likert-type scale (1-4), with higher scores indicating higher self-esteem (reverse scoring required). The RSES has a test-retest reliability of $\alpha = .85$ and has demonstrated good validity. Cronbach's alpha for the current sample was $\alpha = .92$.

**Sexual Identity Distress Scale**

The seven-item Sexual Identity Distress scale (SID; Wright & Perry, 2006) assesses identity-related distress associated with sexual orientation. Total SID scores are calculated by summing each of the items after reverse coding negative items, so that higher scores indicate greater identity-distress. Wright and Perry (2006) reported good reliability for the measure with Cronbach's $\alpha = .83$. Cronbach's alpha for the current sample was $\alpha = .91$.

**Lesbian, Gay, Bisexual Identity Scale**

The LGBIS (Mohr & Fassinger, 2000) is a 27-item measure assessing several dimensions of lesbian, gay, and bisexual identity including internalized homonegativity/binegativity (internalized homophobia). Subscales for the LGBIS are scored by reverse scoring several of the 27-items. High scores on each subscale indicate greater distress with regard to identity development. Reliability and validity information has not yet been published on this measure. However, the authors suggest that the measure demonstrates overall good internal consistency for each of the aforementioned subscales ($\alpha = .81$, $\alpha = .75$, $\alpha = .79$, $\alpha = .79$, and $\alpha = .77$) respectively, based on comparison with a revised version of this measure that has been recently
published (Mohr & Kendra, 2011). Cronbach’s alpha for the current sample on the LGBIS subscales for Internalized Homonegativity was $\alpha = .90$.

CCAPS-34 (Counseling Center Assessment of Psychological Symptoms)

The CCAPS-34 (Locke et al., 2012) is a 34-item instrument with eight subscales related to psychological symptoms and distress. It is based on the CCAPS-62, which is widely used at university counseling centers to assess psychosocial health (Locke et al., 2011). Items are scored on a 5-point scale. Positive items are reverse scored such that higher scores indicate more severe symptoms. The only subscale used in this study is Depression, which assesses levels of nonclinical depressive symptomology. The authors reported CCAPS-34 test-retest reliability between $\alpha = .71$ and $\alpha = .84$ (depending on subscale). Cronbach’s alpha for the current sample for the Depression subscale was $\alpha = .90$.

Procedures

Data Collection and Recruitment

This study was approved by the Institutional Review Board at Utah State University. It was released as an online web survey from July 12 through September 29, 2011, and required both informed consent and confirmation that the respondent had only completed the survey once. While a more comprehensive discussion of procedures has been published (Dehlin et al., 2014), a brief overview will be offered here.

Journalists in the online and print media were contacted about this study as it was released. Because of feature coverage by the Associated Press, articles about this study appeared in over 100 online and print publications worldwide, including the Huffington Post, Salt Lake Tribune, and San Francisco Chronicle. In all, 21% of respondents indicated that they heard about the study directly through one of these sources, or through direct Internet search. Leaders of the major LDS-affiliated LGBT support groups were also contacted directly and asked to help advertise this study within their respective organizations (e.g., Affirmation, Evergreen, North Star). In total, 21% of survey respondents indicated learning about the survey from one of these support groups. Careful attention was paid to include all known groups, and to ensure inclusion across the spectrum of varying LDS belief and orthodoxy, with special emphasis on reaching out directly and in multiple ways to conservative LDS LGBT support groups. Nonreligiously affiliated LGBT support organizations such as Equality Utah and the Salt Lake City Pride Center were also helpful in promoting awareness about this survey, ultimately providing 5% of respondents. Finally, 47% of respondents indicated learning about the
survey through some form of word of mouth including email, Facebook, blogs, online forums, or other web sites.

RESULTS

Preliminary Analyses

A series of t-tests, one-way ANOVAs, chi square analyses, and bivariate correlations was conducted to assess relationships between core demographic variables and the variables of interest. Demographic variables assessed for potential inclusion as covariates in primary analyses included ethnicity (White vs. non-White), age, biological sex, education level, and residency in Utah or outside of Utah. A number of significant associations with primary variables were observed, although almost all effect sizes were small. Age demonstrated significant associations with nine of the twelve primary study variables, biological sex was significantly associated with seven, and Utah residency was associated with eight variables. Given theoretical links among those three demographic variables and the sexual identity and psychosocial health indicators assessed in the primary analyses, all were included in subsequent analyses as covariates. Ethnicity was not included as a covariate, as it was less consistently related to other study variables (three of twelve significant associations) and the lack of diversity in the sample necessitated collapsing all ethnic minority participants into one group. Educational status was significantly related to several other study variables (seven of 12 significant associations) but was not included as a covariate, as effect sizes for all significant associations were very small (i.e., $\eta^2 < .04$, Cramer's $V < .13$).

Beliefs About SSA Etiology

Approximately 81% of participants ($n = 1,306$) endorsed a biological etiology for SSA, and 35% ($n = 566$) endorsed at least one psychosocial explanation for SSA. The most commonly endorsed nonbiological explanations were early same-sex sexual experiences ($n = 356, 22.1\%$), dysfunctional parent-child relationships in the home ($n = 330, 20.5\%$), sexual abuse ($n = 318, 19.7\%$), personal choice ($n = 167, 10.4\%$), and spiritual failure or weakness to Satan's temptation ($n = 70, 4.3\%$). Almost three-fourths (73.2\%) of those who reported an “active” LDS church status endorsed a biological etiology for SSA. Active LDS participants endorsed developmental explanations for SSA etiology ($n = 254, 57.2\%$) at the following rates: dysfunctional parent-child relationships (39.9\%), early same-sex sexual experiences (39.4\%), being a victim of sexual abuse (36.9\%), and spiritual failure/Satan’s temptation
### TABLE 2 Mental Health Associations for Varying Beliefs About the Causes of Same-Sex Sexuality

<table>
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<tr>
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<th>Biological Causes</th>
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<tr>
<td></td>
<td>Selected</td>
</tr>
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<td></td>
<td>n</td>
</tr>
<tr>
<td>Intern. homophobia</td>
<td>1292</td>
</tr>
<tr>
<td>Sex. ident. distress</td>
<td>1293</td>
</tr>
<tr>
<td>Depression</td>
<td>1295</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>1296</td>
</tr>
<tr>
<td>Quality of life</td>
<td>1296</td>
</tr>
<tr>
<td></td>
<td>Spiritual failure or weakness to Satan’s temptation</td>
</tr>
<tr>
<td>Intern. homophobia</td>
<td>69</td>
</tr>
<tr>
<td>Sex. ident. distress</td>
<td>69</td>
</tr>
<tr>
<td>Depression</td>
<td>69</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>69</td>
</tr>
<tr>
<td>Quality of life</td>
<td>69</td>
</tr>
<tr>
<td></td>
<td>Dysfunctional parent-child relationship in the home</td>
</tr>
<tr>
<td>Intern. homophobia</td>
<td>327</td>
</tr>
<tr>
<td>Sex. ident. distress</td>
<td>327</td>
</tr>
<tr>
<td>Depression</td>
<td>327</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>327</td>
</tr>
<tr>
<td>Quality of life</td>
<td>327</td>
</tr>
<tr>
<td></td>
<td>Being a victim of sexual abuse</td>
</tr>
<tr>
<td>Intern. homophobia</td>
<td>315</td>
</tr>
<tr>
<td>Sex. ident. distress</td>
<td>315</td>
</tr>
<tr>
<td>Depression</td>
<td>315</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>315</td>
</tr>
<tr>
<td>Quality of life</td>
<td>315</td>
</tr>
</tbody>
</table>

(9.9%). Only 13.5% of those who reported an “Active” LDS church status endorsed the belief that SSA was a choice.

As shown in Table 2, not endorsing a biological etiology for SSA was associated with higher levels of internalized homosexuality and sexual identity distress, with medium effect sizes ($p < .001$; $\eta^2 = .041$ and .034). The endorsement of nonbiological causes of SSA were associated with higher reported levels of internalized homophobia, sexual identity distress, and depression, and lower levels of reported quality of life and self-esteem ($p < .001$). The effect sizes for internalized homophobia and sexual identity stress across all three psychosocial explanations were medium. The effect sizes for depression, quality of life, and self-esteem were small to medium.

**Church Status**

As shown in Table 3, those reporting an “active” LDS church status reported the poorest scores of all the church-related groups across all five psychosocial
### TABLE 3 Psychosocial Health Associations with Level of LDS Church Participation

<table>
<thead>
<tr>
<th></th>
<th>Active ($n = 435-437$)</th>
<th>Inactive ($n = 554-555$)</th>
<th>Distellow. ($n = 46$)</th>
<th>Resigned ($n = 381-383$)</th>
<th>Excomm. ($n = 102$)</th>
<th>One-Way ANOVA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$M$</td>
<td>$SD$</td>
<td>$M$</td>
<td>$SD$</td>
<td>$M$</td>
<td>$SD$</td>
</tr>
<tr>
<td>Intern. Homophobia</td>
<td>4.41</td>
<td>1.82</td>
<td>2.65</td>
<td>1.49</td>
<td>3.09</td>
<td>1.71</td>
</tr>
<tr>
<td>Sex. Ident. Distress</td>
<td>14.11</td>
<td>6.92</td>
<td>8.25</td>
<td>6.37</td>
<td>9.76</td>
<td>7.43</td>
</tr>
<tr>
<td>Depression</td>
<td>2.33</td>
<td>1.02</td>
<td>2.12</td>
<td>1.03</td>
<td>2.00</td>
<td>0.85</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>3.02</td>
<td>0.64</td>
<td>3.16</td>
<td>0.67</td>
<td>3.13</td>
<td>0.69</td>
</tr>
<tr>
<td>Quality of Life</td>
<td>80.18</td>
<td>13.89</td>
<td>81.13</td>
<td>14.32</td>
<td>82.91</td>
<td>14.60</td>
</tr>
</tbody>
</table>
measures. One-way ANOVAs for LDS church status showed significant differences among groups on all five psychosocial measures \((p < .001\), with large between-group differences for Internalized Homophobia and Sexual Identity \((\eta^2 = .29\) and .23 respectively), and small between-group differences on depression, self-esteem, and quality of life \((\eta^2 \text{ of between } .03 \text{ and } .04)\). Pairwise comparisons between groups showed medium to very large effect size differences between the “Active” group and all the other groups on Internalized Homophobia and Sexual Identity Distress \((d = .61 \text{ to } 1.66)\), and small to medium effects size differences on depression and self-esteem \((d = .17 \text{ to } .64)\). On quality of life, the effect size between “Active” and “Excommunicated” was medium \((d = .48)\).

**Relationship Status**

Regarding relationship status, 47.8% of participants reported being either “Single” (42.4%) or “Divorced/Separated” (5.4%), with the remainder falling into one of three relationship types: “Committed, Non-Legal Same-Sex Relationships” (NLSSR, 23.6%), “Legal Same-Sex Relationships” (LSSR, 12.5%), or Heterosexual Marriage (15.5%). Results regarding the psychosocial correlates of relationships status can be found in Table 4 (divorced/separated category was excluded from the results to focus on the major categories). Overall, those reporting to be in the LSSR group reported the healthiest scores in every category, with the NLSSR category consistently reporting the second healthiest scores. The single and heterosexual marriage categories reported the least healthy scores in every category, with the heterosexual marriage category reporting the highest scores in Internalized Homophobia and Sexual Identity Distress, and the Single category reporting the highest average Depression score, and the lowest scores on self-esteem and quality of life.

ANOVA for relationship status showed significant differences between groups on all five measures \((p < .001)\), with medium between-group differences for Internalized Homophobia and Sexual Identity \((\eta^2 = .19\) and .17, respectively), and small to medium between-group differences on depression, self-esteem, and quality of life \((\eta^2 \text{ between } .05 \text{ and } .08)\). Pairwise comparisons between the LSSR group and the “Single” group revealed large differences across all of the measures \((d = .74 \text{ to } .92)\). Differences between the LSSR and “Heterosexual marriage” groups were medium to large \((d = .59 \text{ to } 1.66)\). Differences between the LSSR and NLSSR groups were small to medium \((d = .21 \text{ to } .42)\). Differences between the single and heterosexually married groups for Internalized Homophobia and Sexual Identity Distress were medium \((d = .58 \text{ to } .65)\), small for quality of life \((d = .21)\), and nonsignificant for depression and self-esteem.

Regarding success/divorce rates of mixed-orientation marriages (MOMs), 31\% \((n = 500)\) of survey respondents reported entering into a
<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Intern. Homophobia</td>
<td>3.17 (1.82)</td>
<td>4.34 (1.86)</td>
<td>2.24 (1.30)</td>
<td>1.89 (0.98)</td>
<td>111.32 (3.1438)</td>
</tr>
<tr>
<td>Sex. Ident. Distress</td>
<td>9.99 (7.28)</td>
<td>14.12 (7.22)</td>
<td>6.61 (5.76)</td>
<td>4.46 (4.43)</td>
<td>96.95 (3.1439)</td>
</tr>
<tr>
<td>Depression</td>
<td>2.33 (1.01)</td>
<td>2.28 (1.08)</td>
<td>1.87 (0.92)</td>
<td>1.61 (0.73)</td>
<td>35.90 (3.1440)</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>3.05 (0.64)</td>
<td>3.09 (0.68)</td>
<td>3.32 (0.61)</td>
<td>3.47 (0.49)</td>
<td>25.74 (3.1442)</td>
</tr>
<tr>
<td>Quality of Life</td>
<td>78.34 (14.45)</td>
<td>81.36 (14.30)</td>
<td>86.31 (13.33)</td>
<td>88.83 (11.59)</td>
<td>39.54 (3.1440)</td>
</tr>
</tbody>
</table>

Note: Those self-identifying as "divorced/separated" (n = 83) were not included in this analysis.
MOM at some point in their lives, with 14.9% \( (n = 240) \) reporting a current MOM. This represents a minimum 51% divorce rate for MOMs in our sample. Since the average length for surviving MOMs is \( M = 16.6 \) years \( (SD = 11.0) \), it is reasonable to expect at least some additional MOM divorces over time. For example, since 37% \( (n = 99) \) of the MOM divorces in our sample occurred after the 16 year mark, a flat projection based on the entire sample would estimate the eventual divorce reach to reach 69%. Such projections, however, are highly speculative, and fail to take into account the possibility of multigenerational cohort effects (e.g., more recent generations might be more or less likely to divorce than previous generations), so this estimate should be viewed as such.

Finally, participants who remained in MOMs reported significantly lower Kinsey attraction scores \( (n = 225; M = 3.74) \) than those who reported being divorced \( (n = 259; M = 5.05) \) at \( t = -9.36, p < .001, d = -.86 \), possibly suggesting that bisexuality is a significant factor in keeping a MOM together.

**Sexual Activity**

The majority (68%) of participants reported to be sexually active either in a committed relationship \( (SAC, n = 801, 49.9\%) \) or not in a committed relationship \( (SANC, n = 290, 18.1\%) \), with the remainder endorsing either celibacy by choice \( (CC, n = 224, 13.9\%) \) or celibacy due to a lack of partner \( (CLP, n = 290, 18.1\%) \). As shown in Table 5, those reporting to be sexually active (whether or not in committed relationships) reported the healthiest scores in every category, with the SAC category reporting the healthiest score in every category except Sexual Identity Distress.

ANOVA's for sexual activity status across the psychosocial variables showed significant differences among groups on all five psychosocial measures \( (p < .001) \), with medium between-group differences for Internalized Homophobia and Sexual Identity \( (\eta^2 \text{ of } .10 \text{ and } .08, \text{ respectively}) \), and smaller between-group differences on depression, self-esteem, and quality of life \( (\eta^2 \text{ of between } .04 \text{ and } .08) \). Pairwise comparisons between the SAC group and the "Celibacy by Choice" group revealed medium to large differences \( (d = .53 \text{ to } .95) \). Differences between the SAC and "Celibacy No Partner" groups were small to medium \( (d = .21 \text{ to } .73) \). Differences between the SAC and SANC groups were either non-significant (Internalized Homophobia and Sexual Identity Distress) or small \( (d = .22 \text{ to } .39) \). Differences between the celibacy by choice and celibacy due to lack of partners groups were non-significant for depression, self-esteem, and quality of life, medium for sexual identity distress \( (d = .71) \), and large for internalize homophobia \( (d = .83) \).
### TABLE 5 Psychosocial Health Associations with Reported Sexual Activity Status

<table>
<thead>
<tr>
<th></th>
<th>Celibate - Choice (n = 220)</th>
<th>Celibate - No partner (n = 288)</th>
<th>Sexually Active No Committed Relationship (n = 287)</th>
<th>Sexually Active Committed Relationship (n = 788-793)</th>
<th>One-Way ANOVA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>Intern. Homophobia</td>
<td>4.36</td>
<td>1.83</td>
<td>2.92</td>
<td>1.61</td>
<td>2.66</td>
</tr>
<tr>
<td>Depression</td>
<td>2.39</td>
<td>1.02</td>
<td>2.46</td>
<td>1.03</td>
<td>2.12</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>2.98</td>
<td>0.64</td>
<td>3.01</td>
<td>0.64</td>
<td>3.17</td>
</tr>
<tr>
<td>Quality of Life</td>
<td>78.04</td>
<td>14.36</td>
<td>76.51</td>
<td>13.94</td>
<td>81.02</td>
</tr>
</tbody>
</table>
DISCUSSION

This study assessed the psychosocial health implications of observing church-recommended approaches toward same-sex attraction within one particular religious tradition—the Church of Jesus Christ of Latter-day Saints—based on a large sample \((N = 1,612)\). The four main approaches assessed included: (a) believing in nonbiological development etiologies for SSA, (b) increased church activity, (c) entering into a mixed-orientation marriage, and (d) maintaining a single status, and remaining celibate. The major findings from the study are that non-biologically-based views regarding the etiology of SSA, remaining active in the LDS church, remaining single, and engaging in mixed-orientation marriages were all associated with higher reported levels of internalized homophobia, sexual identity distress, and depression, and lower levels of self-esteem and quality of life. Conversely, those who espoused biologically based views regarding SSA etiology, disassociation from the LDS church, and engaging in committed same-sex relationships reported significantly healthier scores on all measures.

Additionally, the divorce rate for mixed-orientation marriages in our sample was reported to be 51% at the time of the sample and is projected to reach as high as 69% (though only an estimate). A 51% “ever divorced” rate is considerably higher than the U.S. averages for both males (23.3%) and females (27.8%) overall, as well as for U.S. Mormons (males = 22.0%, females 28.1%; Heaton, Goodman, & Holman, 2001), though on the low end of estimates for the national MOM divorce rate (between 50% and 85%; Buxton, 1994; Buxton, 2001; Wolkomir, 2004). Additional research is required to determine a more precise, current divorce rate for Mormon MOMs.

Beliefs About the Etiology of SSA

Participants overwhelmingly embraced biological views on SSA etiology, and tended to eschew psychosocial views. Active LDS church members reported much higher levels of endorsing psychosocial views, with early same-sex sexual experiences, dysfunctional parent-child relationships, and sexual abuse being the most commonly held "causes." Past and current LDS church teachings are likely to account for much of this difference (LDS Church, 2010; Whitehead & Baker, 2012). One example from LDS apostle Dallin H. Oaks (LDS Church, 2006) illustrates:

I think it's important for you to understand that homosexuality, which you've spoken of, is not a noun that describes a condition. It's an adjective that describes feelings or behavior. I encourage you, as you struggle with these challenges, not to think of yourself as a 'something' or 'another,'
except that you’re a member of The Church of Jesus Christ of Latter-day Saints and you’re my son, and that you’re struggling with challenges.

While no studies could be located that attempted to assess the mental health implications of believing in a developmental etiology of SSA, studies that associate nurture-related explanations of SSA with sexual prejudice (e.g., Sheldon et al., 2007; Smith et al., 2011) could account for the high levels of internalized homophobia and sexual identity distress reported by these participants. Given current interest in more precise measures of sexual orientation beliefs (e.g., Arseneau et al., 2013), future opportunities for research are ripe in this area.

Church Activity
Those who reported an “Active” LDS church status reported the poorest scores across all of the psychosocial health measures, while those who were no longer members of the church reported the healthiest scores overall, with excommunicates reporting the healthiest scores. Pairwise comparisons between groups showed medium to very large effect size differences between the “Active” group and all the other groups regarding internalized homophobia and sexual identity distress, and small to medium effects size differences on depression, self-esteem, and quality of life. These findings seem to support previous findings that LGBT church participation correlates with higher levels of internalized homophobia, internal conflict, guilt, feelings of inadequacy, depression, and lower levels of self-esteem (Dahl & Galliher, 2010; Shilo & Savaya, 2012), while also adding to the literature by showing overall quality of life advantages for LGBT religious disaffiliation. Further research is required to better understand why inactive and disfellowshipped church members reported poorer outcomes than those who are no longer members, and what specific advantages church membership resignation and/or excommunication might offer to LGBT individuals. Partially holding on to non-LGBT-affirming religious beliefs, identity, and affiliations, even when one is no longer actively attending church, might allow much of the internal conflict, guilt, inadequacy, and shame to continue.

Relationship Status and Celibacy
Findings from this study suggest higher levels of psychosocial health and well-being across the board for participants who are in committed, same-sex relationships, with those in legal relationships (e.g., marriage, civil unions, domestic partnerships) reporting better outcomes than those in nonlegal, committed relationships. Conversely, LGBT individuals who reported being
either single or in heterosexual marriages reported significantly poorer scores across all measures – with heterosexual marriage showing moderate disadvantages over being single in terms of internalized homophobia and sexual identity distress, and a small advantage over being single in terms of overall quality of life. These findings support the general research that marriage is associated with better overall mental health outcomes (Carlson, 2010; Williams, Frech, & Carlson, 2010), while adding to the literature by confirming these findings for the LGBT population specifically. These findings also provide further support to previous research which has found mixed-orientation marriages (Hernandez, Schwenkie, & Wilson, 2011), celibacy (Sipe, 2008), and family rejection of LGBT individuals (Ryan, Huebner, Diaz, & Sanches, 2009) to be problematic from a mental health perspective. We do acknowledge that there is complexity in the heterosexual marriages in our sample that we may not have adequately captured. The term “mixed-orientation marriage” was used throughout, referring to marriages between SSA participants and their heterosexual spouses. However, we did not collect data on the sexual identification of spouses, and it is certainly likely that some participants may have entered into heterosexual marriages with other non-heterosexual partners, both spouses thus gaining access to a relationship status that is in accordance with their religious values. Such marriages may be unique in their structure and trajectory and may warrant specific exploration.

Strengths and Limitations

This study’s large and diverse sample, containing detailed information regarding participant demographics, background, and experiences is certainly a strength. Regarding limitations, our reliance on convenience sampling (vs. random sampling) limits generalizability. For example, our survey likely over-represents men, Caucasians, U.S. residents, gays (vs. lesbians or bisexuals), those with higher education and income levels, and those who maintain some relationship or interest in the LDS church. At best, this survey design allows for identification of relationships between variables, but does not allow us to determine causality as would other designs (e.g., longitudinal studies, randomized clinical trials). Our reliance on self-report makes our psychosocial health measures highly subjective. The psychosocial measures used (e.g., CCAPS-34 Depression subscale) are not formal diagnostic measures, and do not provide clinical thresholds to aid in interpretation. Given the distinctive nature of the LDS church and its culture, it is reasonable to question the study’s generalizability outside of Mormonism. Finally, we acknowledge that our data represent proxies for behaviors recommended historically by LDS church leaders (e.g., celibacy, MOMs). We did not specifically assess the extent to which specific individuals actually received or attempted to follow such advice. While considerable such evidence exists in
the open-ended responses to our survey, space does not admit its inclusion in this manuscript.

Conclusions and Implications

This study does affirm and extend the existing literature by suggesting that psychosocially based beliefs about SSA etiology, active participation in non-LGBT-affirming churches, being single and celibate, and mixed-orientation marriages—all of which are common beliefs and/or practices within modern, active LDS culture—are associated with poorer psychosocial health, well-being, and quality of life for LGBT Mormons. Conversely, biological beliefs about SSA etiology, complete disaffiliation from the LDS church, legal same-sex marriage, and sexual activity are all associated with higher levels of psychosocial health, well-being, and quality of life for LGBT Mormons.

Many of the findings from this study hold potentially important implications for public policy, mental health professionals, religious leaders, and friends/family/allies of religious LGBT individuals. As public officials and voters continue to consider the legality of same-sex marriage in various U.S. states, the positive associations between psychosocial health/quality of life and same-sex marriage (vs. other types of less formal relationships) should likely be considered. Relatedly, religious institutions that continue to advocate for psychosocial views on LGBT etiology, along with celibacy and/or mixed-orientation marriage as viable lifestyle options for LGBT church members, should consider the mental health risks of promoting such positions. Those who are in a position to provide counseling to conservatively religious LGBT individuals (e.g., family, friends, religious leaders, licensed mental health professionals), should consider the development and dispersion of psycho-education regarding the possible benefits of biologically based views on LGBT etiology, disaffiliation from non-LGBT-affirming churches, and legal, same-sex committed relationships for LGBT religious individuals.

REFERENCES


Buxton, A. (2004). Works in progress: How mixed-orientation couples maintain their marriages after the wives come out. *Journal of Sexuality & Family Therapy, 1*, 57–82. doi:10.1300/J159v01n01_06


