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SEXUAL ORIENTATION CHANGE EFFORTS, IDENTITY CONFLICT, AND PSYCHOSOCIAL HEALTH AMONGST SAME-SEX ATTRACTED MORMONS

by

John P. Dehlin

A dissertation submitted in partial fulfillment
of the requirements for the degree

of

DOCTOR OF PHILOSOPHY

in

Psychology

Approved:

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UTAH STATE UNIVERSITY
Logan, Utah

2015

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ABSTRACT

Sexual Orientation Change Efforts, Identity Conflict, and Psychosocial Health Amongst Same-Sex Attracted Mormons

by

John P. Dehlin, Doctor of Philosophy

Utah State University, 2015

Major Professor: Renee V. Galliher, Ph.D.
Department: Psychology

This study examined sexual orientation change efforts, identity conflict, and psychosocial health in a sample of 1,612 same-sex attracted Mormons.

A minimum of 66% of participants reported engaging in sexual orientation change efforts, usually through multiple methods, and across more than 10 years (on average). Religious change efforts such as personal righteousness (e.g., prayer, fasting, scripture study, improved relationship with Jesus Christ) and counseling with church leaders (e.g., bishops), along with individual methods (e.g., introspection, private study, mental suppression) were found to be far more prevalent and significantly more damaging than therapist- (e.g., psychotherapy, psychiatry) or group-led change efforts. Overall, 0% of those attempting change reported an elimination of same-sex attraction, and less than 4% reported any change in sexual orientation. Conversely, the majority of participants reported these efforts to be either ineffective or damaging.

Regarding the navigation of sexual and religious identity conflict, the vast

majority of participants were found to have either rejected their religious identity (53%) or compartmentalized their religious and sexual identities (37%), with significantly fewer reporting the rejection of their same-sex sexual identity (6%) or the successful integration of the two identities (4%). Overall, the (a) acceptance of a lesbian, gay, bisexual, or transgender identity and (b) "coming out" to family, friends, work, and religious associates correlated positively with quality of life and self-esteem, and negatively with internalized homophobia, identity confusion, depression, and sexual identity distress.

Regarding various religion-based approaches to same-sex attraction, the following were generally positively associated with psychosocial health (e.g., quality of life, self-esteem) and negatively correlated with psychosocial harm (e.g., internalized homophobia, sexual identity distress, depression): (a) embracing biological (vs. developmental) views on the causes of same-sex sexuality, (b) decreased LDS Church participation, (c) eschewing celibacy, and (d) pursuing committed, legal same-sex relationships. Heterosexual marriages for same-sex attracted participants were estimated to have a 69% divorce rate, with very low average quality of life ratings for those remaining in the marriages.

(209 pages)

PUBLIC ABSTRACT

Sexual Orientation Change Efforts, Identity Conflict, and Psychosocial Health Amongst Same-Sex Attracted Mormons

by

John P. Dehlin, Doctor of Philosophy

Utah State University, 2015

Both religiosity and sexuality are acknowledged by the American Psychological Association as important considerations for overall psychosocial well-being. Consequently, the denunciation of same-sex sexuality as sinful by many religious organizations leads many lesbian, gay, bisexual, and transgender individuals to experience significant identity conflict. Historically, conservative religious institutions such as The Church of Jesus Christ of Latter-day Saints (Mormons) have offered developmental (i.e., nonbiological) explanations as to the origins of same sexuality, along with various nonaffirming approaches including: (a) sexual orientation change efforts, (b) increased religious devotion, (c) celibacy, and (d) mixed-orientation (heterosexual) marriage. However, relatively little research has been conducted as to the actual prevalence, effectiveness, and benefits/harms of these approaches.

The present study surveyed 1,612 same-sex attracted current and former members of the Mormon Church to better understand their experiences navigating conflict between their religiosity and their sexuality. Participants reported on the prevalence, effectiveness, benefits, and harm of various approaches to navigating this conflict, including attempts to

change versus accept their sexual orientation and identity, increased versus decreased religiosity, celibacy versus sexual activity, and staying single versus pursuing committed relationships (whether same-sex or heterosexual). It is hoped that these results will help religious or formerly religious lesbian, gay, bisexual, and transgender (LGBT) individuals make informed decisions about their health and well-being. It is also hoped that these findings will help to guide the policy and recommendations offered by religious leaders, family members, friends, and mental health professionals to religious LGBT individuals.

DEDICATION

This dissertation is dedicated to the memories of Stuart Matis, Curtis Rognan, and to the untold thousands of beautiful LGBT Mormons whose lives ended prematurely because of our collective ignorance and lack of compassion and courage. May we all become better at listening, learning, and loving—and may these needless tragedies cease in the years ahead. Please know that your precious lives did not end in vein.

ACKNOWLEDGMENTS

I am compelled to begin (not end) by thanking my dear wife, Margi, for taking this rather insane leap of faith with me to forego what has turned out to be almost 10 years of meaningful income to pursue a graduate education—with four children in tow (no less). Margi, you have made untold sacrifices to support me in all of this craziness, and words cannot express how deeply grateful I am for your trust, love, and companionship over the past 10 (actually 20) years. Your love is the sweetest and most sure thing that I have ever known. I am yours for as long as I live, and for as long as you will have me. I look forward to many sweet days ahead with you.

As Margi and I have not taken this journey alone, I must also thank our four wonderful children—Audrianna, Maya, Clara, and Winston—for their incredible patience and support during graduate school. You kids have all made considerable sacrifices to allow daddy to go back to school, and I am so indebted to you for your loving support and inspiration over the past 10 years. That said, I am so truly grateful for the extra time graduate school has afforded me to spend time with each of you. I will always cherish our Logan memories together.

I thank my parents, Nan and Don McCulloch and David and Carole Dehlin, for teaching me from a young age to love everyone, and that it is never bad to ask hard questions. I thank my three fabulous siblings, Gina, Julianne, and Joel, for inspiring me to do good in the world.

I would like to thank Bill Bradshaw—not only for the privilege of partnering with him on this amazing scientific journey, but for no less than 30 years of inspiring

mentorship and friendship. Bill, I am a better husband, father, and social scientist for having met you. Thank you for your example of courage, conviction, tenacity, integrity, and humble strength. I would also like to thank my incredible associate Katie Crowell for partnering with us on this project. Katie, you inspired me from my very first year in the program in very specific and meaningful ways, and this project is so much better because of your collaborative efforts. Bless you.

Renee Galliher, you took a chance on me when I felt like I was at the end of my rope. While I tend to eschew attributions of perfection, I literally cannot imagine a better advisor/advisee relationship and experience than what you have afforded me. Your flawlessly consistent trust, encouragement, and support have allowed me to achieve things I never before felt possible (or were interested in, for that matter). I identify as an identity researcher now, for heaven's sake! But seriously, thank you from the bottom of my heart. I am so very proud/honored to claim you as my chair/adviser.

I would like to thank my previous advisor, Michael Twohig, for teaching me the ropes of scientific research, and for instilling within me a passion for scientific writing. I could not have made it this far without you, Michael.

Melanie Domenech Rodríguez, Scott Bates, Carolyn Barcus, and Amy Bailey—you are not "merely" committee members to me. You are four of my very favorite people on the planet. Thank you for your unending commitment to cultural diversity, for inspiring me in untold ways, and for believing in and trusting me long before I ever believed in myself.

I would like to thank Jennifer Dobner, the Associated Press, and all the many Mormon LGBT support groups for helping us advertise this study. Our "*N*" is mind-

boggling to me.

I would like to thank Utah State University's Counseling and Psychological Services (CAPS), and specifically Drs. Luann Helms and David Bush, for their clinical mentorship over the past few years. Your unique approaches to diversity, as well as your undying commitment to client well-being, have helped to make this a more relevant study than it otherwise would have been. I am also indebted to Lee Beckstead, not only for his pioneering work in LGBT research, but also for his encouragement and support with publication over the past several years.

I would like to thank the many donors and supporters of Mormon Stories Podcast and the Open Stories foundation for helping to keep my family afloat financially during graduate school. Special thanks to Kevin Oleson, Teri Whittenberg, Tyson Jacobsen, Natasha Helfer Parker, Joanna Brooks, Dan Wotherspoon, Russell Moorehead, Jason Moore, Russ Walker, and Brian Johnson for their undying loyalty and friendship during these eventful years.

I would like to end by thanking all of the wonderful LGBT family, friends, and allies who have gently and kindly educated and inspired me over the years regarding LGBT issues, including (but not limited to) Daniel and Sam Parkinson, Scott Tallman, Buckley Jeppson, Mike Kessler, Carol Lynn Pearson, Cary Crall, John Gustav-Wrathall, Mitch Mayne, Randall Thacker, Tom Christofferson, Wendy and Tom Montgomery, Bruce Bastian, Jim Dabakis, the entire Moore clan, Carolyn Ball, Janet and Al Robert, George Parkinson, James Faust, Bob Rees, Benji Schwimmer, John Hamer, Josh and Lolly Weed, Brett Bradshaw, Eldon and Heather Kartchner, Kevin Kloosterman, D. Michael Quinn, Michael Ferguson, Seth Anderson, Kendall Wilcox, Berta Marquez,

Peter and Mary Danzig, John Kovalenko, Bruce and Chris Rognan, Clark Pingree, Nadine Hansen, Paula Goodfellow, Laura Compton, Angela Enno, Devon and Ashley Gibby, Josh DeFriez, Preston Ferguson, Chris McKenna, Hugo Olaiz, John-Charles Duffy, Ryan Yonk, Caitlin Ryan, and Ron Schow.

John P. Dehlin

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CHAPTER 1

INTRODUCTION

Overview

The purpose of this dissertation is to better understand the many ways in which lesbian, gay, bisexual, and transgender (LGBT) individuals who are raised in traditional, orthodox religious environments cope with the conflict they experience between their religiosity and their sexuality. While our sample of 1,612 was drawn from current and former members of The Church of Jesus Christ of Latter-day Saints (i.e., LDS or Mormon church), we are hopeful that these findings reflect similar experiences in other conservative religious traditions including Catholicism, Evangelical Christianity, Orthodox Judaism, and Islam.

At a high level, this collection of studies focuses on three major domains: (a) attempts to resist and/or deny one's sexual attractions through sexual orientation change efforts, (b) attempts to reconcile the identity conflict that many experience between their formative religious identities and their emerging sexual identities, and (c) the costs and benefits of various lifestyle choices that are either commonly encouraged or discouraged by conservative religious institutions including continued religious devotion, celibacy, mixed-orientation marriage, and same-sex marriage. As these three domains are simultaneously distinct and highly complementary, a three-paper format has been adopted in this dissertation (see Appendix C for copyright permission letter and manuscript information and Appendix D for author release letters)

Background

The history of the intersection of sexual orientation and the mental health profession is well-documented (Herek & Garnets, 2007). Same-sex attraction (SSA), originally dubbed homosexuality, was deemed pathological for close to a century within the field of mental health (Herek & Garnets, 2007), and was listed as such in the first two versions of the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association [APA], 1952, 1968). Therapeutic attempts to "cure" SSA (also known as sexual orientation change efforts or SOCE) dominated this era, largely to no positive effect (Friedman & Downey, 1998; Haldeman, 1991, 1994), and in spite of sometimes dramatically invasive and unethical experimental interventions including electroshock, castration, and lobotomies (Katz, 1976).

Research by Ford and Beach (1951), Kinsey, Pomeroy, and Martin (1948), Kinsey, Pomeroy, Martin, and Gebhard (1953), and others helped to provide new information about the prevalence of SSA and its existence in nonhuman animals, leading some researchers to begin viewing SSA as a normal, positive variant of human sexuality (Armon, 1960; Hooker, 1957). Others began to challenge the conventional assumptions about the pathology of SSA, demonstrating little to no difference between same-sex attracted individuals and heterosexuals in areas such as adaptation and functioning (APA Task Force, 2009). Still other research failed to validate the conventional theories regarding the etiology of SSA, including theories that attributed it to maladaptive family dynamics or trauma history (APA Task force, 2009). Such research, along with the emergence of a strong gay and lesbian civil rights movement in the 1960s and early

1970s (Adam, 1995), ultimately led to: (a) homosexuality's removal from the DSM-II (APA, 1973, 1974) as a psychological illness, (b) a general position within the field of mental health that SSA is a normal and positive variant of human sexuality that should be affirmed and supported instead of pathologized, and (c) a general condemnation of therapist-led SOCE as ineffective, and possibly damaging to client well-being (APA Task Force, 2009). Over time, virtually every major U.S. health organization has endorsed these positions, including the American Medical Association (AMA, 2013), the American Academy of Pediatrics (Frankowski, 2004), the American Psychiatric Association (2013), the American Psychological Association (APA Task Force, 2009), the National Association of Social Workers (2013), and the World Health Organization (Pan American Health Organization, 2012).

Religion, Mental Health, and Same-Sex Attraction

Based on interpretations of various religious texts, several denominations within the major world religions still condemn same-sex attraction, same-sex behavior, and same-sex relationships as sinful (Swidler, 1993). Many of them decry the decision to de-pathologize SSA as nonscientific, politically based, and ultimately detrimental to society (Hafen, 2009). Since same-sex attraction, same-sex relationships, and same-sex sexual activity are all viewed as incompatible with many of these religions, and since mainstream options for SOCE have declined significantly, several religiously oriented institutions such as Courage (http://www. couragerc.net), Focus on the Family (http://www.focusonthefamily.com), Evergreen International (http://evergreen international.org), North Star International (http://northstarlds.org), and Jews Offering

New Alternatives to Homosexuality (http://www.jonahweb.org) continue to promote religiously-motivated options for lesbian, gay, bisexual, and transgender individuals such as SOCE, increased religiosity, mixed-orientation marriage (i.e., marriage with a heterosexual partner), and celibacy as ways to manage, cope with, or change sexual orientation for same-sex attracted church members (Besen, 2012).

Same-Sex Attraction and the LDS Church

Founded by Joseph Smith in 1830, the LDS Church is a U.S.-based Christian denomination claiming over 15 million members worldwide, making it one of the largest churches in the United States (Church of Jesus Christ of Latter-day Saints [LDS], 2013; Pew Forum on Religion and Public Life, 2008). Although the LDS Church is well-known for its participation in nontraditional marriage in the 1800s (i.e., polygamy, polyandry), it has maintained a relatively conservative position regarding SSA, same-sex behavior, and same-sex marriage (O'Donovan, 2004)—consistent with many other conservative U.S. churches.

While the LDS Church is by no means singular in this regard, several statements made by top church leaders throughout the mid-1900s help to illustrate the challenging environment in which many LDS LGBT church members have been raised. In 1965, during a speech to the entire student body of Brigham Young University, President Ernest Wilkinson stated:

> We do not intend to admit to our campus any homosexuals. If any of you have this tendency and have not completely abandoned it, may I suggest that you leave the university immediately after this assembly….we do not want others on this campus to be contaminated by your presence. (p. 11)

A few years later, LDS apostle Spencer W. Kimball (1971) wrote:

> Now let us assure you that you are not permanently trapped in this unholy practice if you will exert yourself. Though it is like an octopus with numerous tentacles to drag you to your tragedy, the sin is curable and you may totally recover from its tentacles. One of Satan's strongest weapons is to make the victim believe the practice is incurable regardless of one's effort. Lucifer is the "Father of all lies." (pp. 10-11)

Throughout the 1960s-1980s, several such comments were made by top LDS Church leaders, and options such as celibacy, various forms of SOCE including electro-shock therapy (McBride, 1976), and mixed-orientation marriages as a "cure" for SSA were frequently recommended by LDS Church leaders and church-affiliated mental health professionals (O'Donovan, 2004).

The LDS Church has evolved considerably over the past decade with regard to its position on SSA. For example, the LDS Church no longer denounces SSA as sinful (only same-sex behavior is considered sinful today) nor recommends heterosexual marriage as a cure for SSA (Church of Jesus Christ of Latter-day Saints, 2012). Nonetheless, as of 2014 the LDS Church continues to: (a) teach that only "marriage between a man and woman is ordained of God" (Church of Jesus Christ of Latter-day Saints, 1995), (b) publish statements by top church leaders indicating that SSA change is possible (Church of Jesus Christ of Latter-day Saints, 2012; Condie, 1993; Faust, 1995; Packer, 2003; Pyrah, 2010), (c) both officially and unofficially sponsor organizations that promote SOCE, celibacy, and mixed-orientation marriages as options for same-sex attracted church members (e.g., Evergreen International, LDS Family Services, North Star), (d) actively oppose the legalization of same-sex marriage (Church of Jesus Christ of Latter-day Saints, 2008), (e) prohibit legally same-sex married individuals from full fellowship

in the church, and (f) excommunicate members who either engage in same-sex sexual behavior, or who enter into legal same-sex marriages (Church of Jesus Christ of Latter-day Saints, 2010).

Questions for This Study

Because up to 80% of U.S. citizens report some religious affiliation (Pew Forum on Religion and Public Life, 2013) and up to 11% of Americans acknowledge at least some same-sex sexual attraction (Gates, 2011), it is reasonable to conclude that millions of individuals across the globe are struggling to reconcile their religiosity and their sexuality. To this day, a sampling of the most common recommendations made by religious institutions for their LGBT members include: (a) increased religious devotion and commitment, (b) increased efforts to manage or change their sexual orientation, (c) working towards the goal of entering into a mixed-orientation marriage, and (d) living a life of celibacy (where mixed-orientation marriages are not possible). Conversely, those who decide to pursue same-sex relationships often face discipline and/or excommunication from their respective churches.

While all of these options have received considerable discussion to date, relatively little research has been conducted regarding the prevalence rates and psychosocial impact of these various religiously-associated options for LGBT individuals (APA Task Force, 2009). Consequently, the following questions will be explored in this dissertation.

1. What is the prevalence of SOCE amongst current and former LDS Church members? What are the most common SOCE methods, and to what extent are they effective, ineffective, or damaging?

2. How do LDS individuals navigate the identity conflict that arises between their sexuality and their religiosity, and what are the psychosocial implications of these choices?

3. What are the psychosocial health implications of the various lifestyles options available to LDS LGBT individuals including increased religiosity, mixed-orientation marriage, celibacy, and same-sex relationships?

While these questions will be explored within a sample of 1,612 current and former members of the LDS Church who have experienced SSA, we are hopeful that the results will be relevant and useful to LGBT individuals within other conservative religious contexts. We are also hopeful that this information will prove useful to family members, friends, allies, religious leaders, mental health professionals, and policy makers interested in LGBT-related concerns.

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CHAPTER 2

SEXUAL ORIENTATION CHANGE EFFORTS AMONG CURRENT OR FORMER LDS CHURCH MEMBERS[1]

Abstract

This study examined sexual orientation change efforts (SOCE) by 1,612 individuals who are current or former members of The Church of Jesus Christ of Latter-day Saints (LDS). Data were obtained through a comprehensive online survey from both quantitative items and open-ended written responses. A minimum of 73% of men and 43% of women in this sample attempted sexual orientation change, usually through multiple methods and across many years (on average). Developmental factors associated with attempts at sexual orientation change included higher levels of early religious orthodoxy (for all) and less supportive families and communities (for men only). Among women, those who identified as lesbian and who reported higher Kinsey attraction scores were more likely to have sought change. Of the nine different methods surveyed, private and religious change methods (compared to therapist-led or group-based efforts) were the most common, started earlier, exercised for longer periods, and reported to be the most damaging and least effective. When sexual orientation change was identified as a goal, reported effectiveness was lower for almost all of the methods. While some beneficial SOCE outcomes (such as acceptance of same-sex attractions and reduction in depression

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and anxiety) were reported, the overall results support the conclusion that sexual orientation is highly resistant to explicit attempts at change, and that SOCE are overwhelmingly reported to be either ineffective or damaging by participants.

Introduction

Many 21st century, traditional world religions continue to denounce both same-sex attractions (SSA) and same-sex sexual activity as immoral, despite a growing social and professional consensus that views both as positive variants of human sexuality (Fontenot, 2013). As a result of this conflict, many traditional religious individuals who experience SSA engage in sexual orientation change efforts (SOCE) in an attempt to conform to religious teachings and social pressure (Beckstead, 2012; Jones & Yarhouse, 2011; Maccio, 2010). Despite a recent increase in public discourse regarding SSA, SOCE studies have been limited in quantity, scope, and methodology, and ultimately have failed to demonstrate either the effectiveness or benefit/harm of SOCE (American Psychological Association Task Force [APA Task Force], 2009). Even with the APA's extensive report and recommendations regarding SOCE (APA Task Force, 2009), considerable questions remain regarding SOCE demographics, prevalence, and intervention types. Consequently, the purpose of this study is to document and evaluate the prevalence, variety, duration, demographics, effectiveness, benefits, and harm of sexual orientation change efforts within one particular faith tradition—The Church of Jesus Christ of Latter-day Saints (LDS, Mormon). We build upon the APA Task Force (2009) recommendations for improving SOCE research by using (a) more representative sampling methods, (b) more precise measures of sexual orientation and identity, (c)

references to life histories and mental health concerns, and (d) increased inquiry regarding efficacy and safety.

Brief History of SOCE Research

Some early studies purported to demonstrate SOCE effectiveness (e.g., Birk, Huddleston, Miller, & Cohler, 1971; James, 1978; McConaghy, Armstrong, & Blaszczynski, 1981; Tanner, 1975). While not claiming the elimination of a same-sex orientation, some of these authors reported limited success in decreasing same-sex attraction and behavior, usually without a reciprocal increase in opposite-sex attraction or sexual behavior (cf., APA Task Force, 2009). However, this work suffered from major methodological flaws, including the absence of control groups, biased samples, very small treatment groups (< 15 subjects per treatment group), and internally inconsistent methods of data collection. Many recent studies have attempted to gain a deeper understanding of SOCE through surveys, case studies, clinical observations, and descriptive reports with convenience-sampled populations from religiously affiliated organizations, where conflict and distress remain high despite increasing social acceptance of LGBTQ individuals (e.g., Nicolosi, Byrd, & Potts, 2000; Schaeffer, Hyde, Kroencke, McCormick, & Nottebaum, 2000; Silverstein, 2003; Spitzer, 2003). A recent review of this literature by an APA Task Force (2009) on sexual orientation change efforts showed that individuals reported varied rationale for SOCE (see also Morrow & Beckstead, 2004). For example, telephone interviews with 200 self-selected individuals claiming success in sexual orientation change cited personal, emotional, religious, and/or marriage-related issues as reasons for seeking change (Spitzer, 2003).

The APA Task Force (2009) also reported widely varied SOCE strategies. A survey of 206 licensed mental health professionals who practice sexual orientation change therapy reported providing individual psychotherapy, psychiatry, group therapy, or a combination of individual and group therapies to address desires to change sexual orientation (Nicolosi et al., 2000). Many attempted sexual orientation change with the help of non-professional individuals or organizations, which are often religiously or politically motivated (e.g., Evergreen International, Exodus International, Focus on the Family, Jews Offering New Alternatives for Healing; cf., Besen, 2012; Drescher, 2009). Such efforts range from one-on-one pastoral counseling to group conferences or retreats and can include such practices as confession, repentance, self-control, as well as cognitive-behavioral approaches (Ponticelli, 1999). Individuals may also engage in personal efforts to change sexual orientation. One recent qualitative study of sexual and religious identity conflict among late adolescents and young adults reported heightened efforts to be faithful, bargains with God, prayer, fasting, and increased church involvement as common self-reported individual efforts to "overcome" SSA (Dahl & Galliher, 2012). The outcomes of these private and religious efforts, however, remain almost completely unstudied.

Finally, qualitative reports suggest that individuals who engaged in SOCE reported a variety of perceived benefits and harms (Beckstead & Morrow, 2004; Nicolosi et al., 2000; Shidlo & Schroeder, 2002). Based on a comprehensive review of this work, the APA Task Force (2009) task force concluded that no study to date has demonstrated adequate scientific rigor to provide a clear picture of the prevalence or frequency of either beneficial or harmful outcomes. More recent studies claiming benefits and/or harm have

done little to ameliorate this concern (e.g., Jones & Yarhouse, 2011; Karten & Wade, 2010).

Limitations of Previous Work

Experimental, quasi-experimental, correlational, and qualitative SOCE studies are limited in scope, methodological rigor, and comprehensiveness (APA Task Force, 2009). Previous studies have employed problematic sampling procedures, including biased subjects, small samples sizes, and a lack of female participants (e.g., McCrady, 1973; Mintz, 1966; Nicolosi et al., 2000; Spitzer, 2003). Virtually all studies to date have relied on convenience sampling, without any attempt to draw from non-biased sources (Silverstein, 2003). Many researchers have drawn directly from those who were previously enrolled in therapeutic-religious programs intended to change sexual orientation—participants who may be under cultural, religious, or personal pressure to make a positive self-report (e.g., Maccio, 2011; Nicolosi et al., 2000; Spitzer, 2003). Furthermore, previous studies lack consistency in the definitions of sexual orientation and sexual orientation change, making it difficult to compare across studies (Savin-Williams, 2006).

The frequency and rate of SOCE in SSA populations remains unknown (see Morrow & Beckstead, 2004, for a discussion). No known study to date has drawn from a representative sample of sufficient size to draw conclusions about the experience of those that attempted SOCE. Furthermore, no known study to date has provided a comprehensive assessment of basic demographic information, psychosocial well-being, and religiosity, which would be required to understand the effectiveness, benefits, and/or

harm caused by SOCE. Most studies have focused on the outcome of interventions led by licensed mental health professionals, while neglecting to directly assess the effectiveness and/or potential harm of self-help, religious, and/or nonlicensed efforts to change, understand, and/or accept sexual orientation. Finally, in spite of the APA's Task Force (2009) report on SOCE, considerable debate continues about the meaning of the report (cf., Hancock, Gock, & Haldeman, 2012; Rosik, Jones, & Byrd, 2012), focusing specifically around the lack of more conclusive SOCE-related outcome research.

The LDS Church and Same-Sex Attraction

The LDS Church is a U.S.-based Christian religious denomination claiming over 14 million members worldwide (Church of Jesus Christ of Latter-day Saints, 2013a). The LDS Church claims the *Holy Bible* as scripture and through traditional Biblical interpretations has historically both condemned same-sex sexuality as sinful (cf., Kimball, 1969; O'Donovan, 1994), and explicitly encouraged its LGBTQ members to attempt sexual orientation change (Byrd, 1999; Faust, 1995; Packer, 2003; Pyrah, 2010). While the LDS Church has somewhat softened its stance toward LGBTQ individuals in recent years (Church of Jesus Christ of Latter-day Saints, 2013b), it continues to communicate to its LGBTQ members that sexual orientation change is possible through various means including prayer, personal righteousness, faith in Jesus Christ, psychotherapy, group therapy, and group retreats (Holland, 2007; Mansfield, 2011). In these respects, the LDS Church's approach to SSA has closely paralleled other religious traditions including Orthodox Judaism, Evangelical Christianity, and Roman Catholicism (Michaelson, 2012).

The Present Study

The current study aims to build on previous work to present a comprehensive analysis of the **(**a) prevalence of SOCE in a sample of same-sex attracted Mormons, (b) most commonly pursued SOCE methods, (c) demographic and developmental factors associated with increased likelihood to engage in SOCE, (d) effectiveness of SOCE, and (e) extent to which SOCE have led to reported positive or iatrogenic effects. Our sample includes sufficient numbers of men and women so that gender can be included as a factor in analyses, allowing for a more nuanced assessment of gendered SOCE processes. We seek to overcome many of the limitations of previous work by reporting from a large, international, demographically diverse sample, and by employing a large battery of qualitative and quantitative measures of demographic information, psychosocial well-being, mental health, sexuality, and religiosity. We also believe that the LDS Church's longstanding opposition to same-sex sexuality, along with its continued support of SOCE in various forms, make the LDS SSA population ideal for a deeper study of these issues—one that could also inform our understanding of SOCE within other religious traditions.

Methods

Research Team

Given the controversial nature of SOCE research, we feel it is important to engage transparently in our research dissemination. All authors self-identify as LGBTQ allies, and also affirm the APA position on the importance of affirming and supporting religious

beliefs and practices. All authors have been active in supporting the LGBTQ community through campus, community, online, and national/ international engagement. Four of the five authors were raised LDS, and two remain active LDS Church participants. All authors work closely with LGBTQ Mormons in their professional and/or personal roles.

Participants

Participants were recruited for a web-based survey entitled, "Exploration of Experiences of and Resources for Same-sex Attracted Latter-day Saints" (Appendix B). Inclusion criteria were as follows: (a) 18 years of age or older, (b) having experienced SSA at some point in their life, (c) having been baptized a member of the LDS Church, and (d) completion of at least a majority of survey items (i.e., the basic demographics, relevant sexual history, and psychosocial measures sections).

Data management. The online survey software (Limesurvey) marked 1,588 responses as "completed." Of these responses, 40 were excluded for not meeting participation criteria in the following ways: underaged (n = 8), no indication of LDS membership (n = 3), no indication of ever experiencing same-sex attraction (n = 17), and leaving the majority of the survey blank (i.e., nothing beyond the demographic information, n = 12). Data for one participant was lost during downloading and data cleaning. Of the records designated as "not completed" by Limesurvey, 65 were included because they met the aforementioned inclusion criteria. This process left 1,612 respondents in the final dataset.

Demographic information. Seventy-six percent of the sample reported to be biologically male and 24% reported to be biologically female. Regarding gender, the

following was reported: “male” (74.5%), “female” (22.2%), “female to male” (0.3%), “male to female” (0.6%), “neither male nor female” (0.5%), and “both male and female” (1.9%). The mean sample age was 36.9 (*SD* =12.58). Approximately 94% reported residing in the U.S., with 6% residing in one of 22 other countries (Canada being the next most common at 2.8%). Of those residing in the U.S., 44.7% reported residing in Utah, with the remainder residing across 47 other states and the District of Columbia. Regarding race/ethnicity, 91.1% identified as exclusively “White/Caucasian,” 4.5% as multi-racial, 2.2% as “Latino(a),” and the remainder as either “Asian,” “Black,” “Native American,” “Pacific Islander,” or “Other.”

Regarding educational status, 97.2% reported at least some college education, with 63.7% reporting to be college graduates. Sexual orientation self-labeling indicated that 75.5% identified as gay or lesbian, 14.5% as bisexual, 4.9% as heterosexual, with the remaining 5.1% identifying as queer, pansexual, asexual, same-sex or same-gender attracted, or other. Relationship status was reported as 40.8% single, 22.7% unmarried but committed to same-sex partners, 16.9% married or committed to heterosexual relationships, 12.6% in a marriage, civil union, or domestic partnership with a same-sex partner, and 5.8% divorced, separated, or widowed. Regarding LDS Church affiliation, participants described themselves as follows: 28.8% as “active” (i.e., attend the LDS Church at least once per month), 36.3% as “inactive” (i.e., attend the LDS Church less than once per month), 25.2% as having resigned their LDS Church membership, 6.7% as having been excommunicated from the LDS Church, and 3.0% as having been disfellowshipped (i.e., placed on probationary status) from the LDS Church.

Measures

The survey included items developed specifically for this study, and a number of pre-existing measures assessing psychosocial health and sexual identity development. Major survey sections included demographics; sexual identity development history; measures of psychosocial functioning; an exploration of various methods to accept, cope with, or change sexual orientation; and religiosity. The larger study yielded data for a number of research questions; only measures relevant for the current study are described below. Specifically, measures for this study focus on methods related to SOCE, and on a number of outcome variables related to sexual identity development (i.e., sexual identity distress) and positive psychosocial functioning (self-esteem and quality of life) that allow us to assess SOCE correlates related to general well-being.

Sexual orientation identity, history, and religiosity. Participants answered several questions about their sexual orientation identity, history, sexual development milestones, disclosure experiences, and religiosity. Participants rated levels of family and community support for LGBTQ identities via a 6-point Likert-type scale from 0 (closed or nonsupportive) to 5 (very open or supportive). Participants rated their sexual behavior/ experience, feelings of sexual attraction, and self-declared sexual identity on a 7-point Likert-type scale (modeled after the one-item Kinsey scale), ranging from 0 (exclusively opposite sex) to 6 (exclusively same sex), with the additional option of *asexual* also provided (Kinsey, Pomeroy, & Martin, 1948). Participants rated early and current religious orthodoxy on a 6-point Likert-type scale from 0 (orthodox—a traditional, conservative believer) to 5 (unorthodox - more liberal and questioning).

Attempts to cope with same-sex attraction. Participants were asked which of

several activities they had engaged in to "understand, cope with, or change" their sexual orientation. Options included: (a) individual effort (e.g., introspection, private study, mental suppression, dating the opposite sex, viewing opposite-sex pornography); (b) personal righteousness (e.g., fasting, prayer, scripture study); (c) psychotherapy; (d) psychiatry (medication for depression, anxiety, sleep problems, somatic complaints, etc.); (e) group therapy; (f) group retreats; (g) support groups; (h) church counseling (e.g., LDS bishops); and (i) family therapy. These options were developed by the research team based on several sources, including direct clinical practice with LDS LGBTQ individuals, familiarity with LDS culture/practice and doctrine (Holland, 2007; Mansfield, 2011), and the psychology LGBTQ literature (APA Task Force, 2009). For each option, participants were asked to provide their ages when the effort began, the duration (in years), and a rating of the perceived effectiveness of each method (effort; 1 = highly effective, 2 = moderately effective, 3 = not effective, 4 = moderately harmful, 5 = severely harmful). These variables were later reverse scored to ease interpretation, such that 1= severely harmful, 2 = moderately harmful, 3 = not effective, 4 = moderately effective, 5 = highly effective. Participants were also provided with an open-ended field to describe each effort in their own words.

Participants were asked to indicate their original goals for each effort, along with what was actually worked on (e.g., "desire to change same-sex attraction," "desire to accept same-sex attraction"). Participants were grouped into two categories: "SOCE Reported" and "SOCE Not Reported." "SOCE Reported" consisted of those who checked the "desire to change same-sex attraction" box for at least one method, or who responded affirmatively to one of the following two questions: (a) "My therapist(s) actively worked

with me to reconsider my same-sex sexual behavior and thought patterns in order to alter or change my same-sex attraction," and/or (b) "My therapist(s) used aversive conditioning approaches (i.e., exposure to same-sex romantic or sexual material while simultaneously being subjected to some form of discomfort) in attempts to alter my attraction to members of my same-sex." All other participants were categorized as "SOCE not reported."

Sexual Identity Distress Scale. The Sexual Identity Distress Scale (SID; Wright & Perry, 2006) is a 7-item measure assessing sexual orientation-related identity distress. SID scores are obtained by reverse scoring the negative items and summing the scores. Higher scores indicate greater identity distress. According to its authors, the SID demonstrated high internal consistency ($\alpha = .83$), test-retest reliability, and strong criterion validity (Wright & Perry, 2006). Cronbach's alpha for the current sample was $\alpha = .91$.

Rosenberg Self-Esteem Scale. The Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965) is a 10-item measure of self-esteem developed for adolescents, but 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 demonstrated test-retest reliability of .85 and has demonstrated good validity. Cronbach's alpha for the current sample was $\alpha = .92$. Total scores are calculated as the average across items.

Quality of Life Scale (QOLS). The QOLS (Burckhardt, Woods, Schultz, & Ziebarth, 1989) is a 16-item instrument measuring six 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. The average total score for "healthy populations" is about 90. Average scores for various disease groups range between Israeli patients with posttraumatic stress disorder (61) and young adults with juvenile rheumatoid arthritis (92). Evaluations from various studies indicate that the QOLS has demonstrated internal consistency (α = .82 to .92) and high test-retest reliability (r = 0.78 to r = 0.84; Anderson, 1995; Wahl, Burckhardt, Wiklund, & Hanestad, 1998). Cronbach's alpha for the current sample was α = .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 (Appendix A) and confirmation that the respondents had only completed the survey once. Participants were given the option of providing their names, email addresses, and phone numbers in order to receive study results and/or be contacted for future studies; approximately 70% of the respondents voluntarily provided this information.

Since past SOCE outcome studies have been criticized for either small or biased samples, considerable efforts were made to obtain a large and diverse sample, especially with regard to ideological positions toward SOCE. 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*, ReligionDispatches.org, *Salt Lake Tribune*, *San Francisco Chronicle*, *Houston Chronicle*, *Q-Salt Lake*, and KSL.com. 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 major LDS-affiliated, LGBTQ support groups were also contacted and asked to advertise this study within their respective organizations (e.g., Affirmation, Cor Invictus, Disciples, Evergreen International, LDS Family Fellowship, Gay Mormon Fathers, North Star, Understanding Same-Gender Attraction). In total, 21% of respondents indicated learning about the survey from one of these groups. Careful attention was paid to include all known groups, and to ensure inclusion across the spectrum of varying LDS belief and orthodoxy (to avoid claims of selection/recruitment bias). Special emphasis was made to reach out directly and in multiple ways to conservative LDS LGBTQ support groups such as Evergreen and North Star. Only Evergreen International refused to advertise, although many among our respondents acknowledged either current or past Evergreen affiliation.

Nonreligiously affiliated LGBTQ support organizations (e.g., Equality Utah, Salt Lake City Pride Center) were also helpful in promoting awareness about this survey. In total, 5% of respondents indicated learning about the survey from one of these sources. Once the survey was promoted through the previously described venues, a sizable portion of survey respondents (47%) indicated learning about the survey through word of mouth, including email, Facebook, blogs, online forums, or other web sites.

Missing data. An analysis of missing data for the variables hypothesized to be associated with SOCE (family and community support, early religious orthodoxy, Kinsey scores, and the SID, RSES, and QOLS measures) revealed that 373 of the 1,612 cases (23.1%) contained at least some missing data across these variables, with 693 of the

62,175 fields overall (1.1%) being left blank. To account for potential bias in our statistical analyses arising from these missing data, a multiple imputation analysis using IBM SPSS Statistics Version 20 was conducted to test the robustness of our findings with respect to the group comparisons using these measures. In SPSS the imputation method was set to "automatic" and the number of imputations was set to five. When comparing the pooled imputed results with the original analyses, significance levels remained unchanged (with one exception noted below), and *t* values changed minimally. Consequently, all statistical analyses reported below are based on the original, non-imputed data.

Results

SOCE Prevalence, Methods, and Effectiveness

SOCE prevalence. Overall, 73% of men (n = 894) and 43% of women (n = 166) reported engaging in at least one form of SOCE, $\chi^2(1, N = 1{,}610) = 120.81$, $\Phi = .274$, $p < .001$. Of those who did attempt sexual orientation change, participants averaged 2.62 (SD = 1.60) different SOCE methods (max. = 8, min. = 1). Men reported utilizing a higher number of different SOCE types (M = 2.76, SD = 1.63) than did women (M = 1.93, SD = 1.22, t (adjusted df = 286) = -7.58, $p < .001$, d = .58).

Most common SOCE methods. Personal righteousness was reported by both men and women as the most commonly used SOCE method with the longest average duration, followed by individual effort, church counseling, and psychotherapy. Some of the most common personal righteousness methods mentioned included increased prayer, fasting, scripture study, focus on improving relationship with Jesus Christ, and temple

attendance. Some of the most common individual effort methods mentioned included cognitive efforts (e.g., introspection, personal study, journaling), avoidance (e.g., suppression, self-punishment), seeking advice from others, seeking to eliminate or reverse same-sex erotic feelings (e.g., date the opposite sex, view opposite-sex pornography, emphasize gender-conforming appearance or behavior), and exploration in the LGBTQ community. A full list of prevalence rates, average durations, and effectiveness ratings for the nine SOCE methods is provided in Table 2.1. As a group, religious and private efforts (personal righteousness, ecclesiastical counseling, and individual efforts) were by far the most commonly used change methods (exceeding 85% of those attempting change), with therapist-led (40.4%) and group-involved (20.8%) change efforts trailing significantly in prevalence. Finally, 31.1% of participants reported engaging exclusively in private forms of SOCE, not indicating any effort that involved external support.

Method effectiveness/harm ratings. As detailed in Table 2.1, when sexual orientation change was not reported as a method objective, participants rated all but one of the methods as at least moderately effective (scores between 3.0 and 4.0), with a few methods (support groups, group therapy, group retreats, psychotherapy, psychiatry, individual effort) approaching or exceeding highly effective status (4.0 and above). Conversely, when sexual orientation change was reported as a method objective, in almost all cases reported method effectiveness was significantly lower (i.e., more harmful), with medium to large Cohen's *d* effect sizes (see Table 2.1 for exact effect sizes). Several SOCE methods including personal righteousness, individual effort, church counseling, and family therapy received average effectiveness ratings below 3.0 (more

Table 2.1

SOCE Method Prevalence, Starting Age, Duration, and Effectiveness Ratings by Sex

	Count/% w/in sex		Age began SOCE method (years)		Method duration (years)		SOCE method effectiveness		Method effectiveness w/out SOCE			*ES*
SOCE method	*n*	%	*M*	*SD*	*M*	*SD*	*M*	*SD*	*n*	*M*	*SD*	*d*
Personal righteousness												
Men	688	77	16.65	6.91	12.40	9.73	2.57	1.21	218	3.39	1.26	0.66
Women	114	68.7	17.55	6.75	8.18	8.14	2.37	1.09	91	3.33	1.15	-0.86
Individual effort												
Men	520	58.2	17.45	6.78	11.24	9.25	2.88	1.18	376	3.93	0.98	-0.97
Women	62	37.3	19.28	6.33	8.07	6.88	2.97	1.12	176	4.09	0.93	-1.09
Church counseling												
Men	448	50.1	21.10	7.86	7.34	8.65	2.58	1.15	161	3.06	1.22	-0.41
Women	54	32.5	21.61	7.25	6.34	6.89	2.59	1.11	33	2.45	1.20	0.12
Psychotherapy												
Men	330	36.9	24.29	9.06	4.70	5.76	3.23	1.20	335	3.96	0.91	-0.68
Women	37	22.3	23.11	6.75	6.27	6.79	3.22	1.16	155	4.11	0.82	-0.89
Support groups												
Men	138	15.4	28.34	10.16	3.61	4.65	3.24	1.06	202	4.22	0.81	-1.04
Women	7	4.2	26.29	6.55	4.86	6.50	3.71	0.95	50	4.14	0.97	-0.45
Group therapy												
Men	126	14.1	27.93	10.44	2.71	3.38	3.16	1.18	111	4.04	0.85	-0.85
Women	6	3.6	32.00	9.10	1.58	0.80	3.00	1.79	31	3.90	0.98	-0.62
Group retreats												
Men	56	6.3	29.88	11.18	2.45	3.84	3.45	1.24	53	4.36	0.83	-0.86
Women	3	1.8	26.33	3.51	0.70	0.52	2.67	1.53	4	4.50	1.00	-1.42
Psychiatry												
Men	33	3.7	25.52	10.73	8.38	9.42	3.06	1.30	276	3.91	0.90	-0.76
Women	2	1.2	25.50	3.54	17.00	5.66	4.50	0.71	115	3.95	0.98	0.64
Family therapy												
Men	34	3.8	24.42	9.21	4.37	6.40	2.88	1.07	65	3.65	1.02	-0.74
Women	1	0.6	21.00	N/A	0.25	N/A	N/A	N/A	12	3.58	0.67	N/A

Note. The "%" column represents the percentage of those attempting change for each method divided by the total number who attempted change (by sex). Method effectiveness ratings: 1 = severely harmful, 2 = moderately harmful, 3 = not effective, 4 = moderately effective, 5 = highly effective. The "Method Effectiveness w/out SOCE" columns represent those who engaged in the respective method without attempting to change their sexual orientation. Regarding comparisons of method effectiveness with and without SOCE, *t* values ranged from -.5 to 14.5, *p* values ranged from 0.59 to <.001; *ES* (*d*) reflects differences between SOCE-focused methods and non-SOCE-focused methods.

harmful than helpful). As shown in Figure 2.1, the SOCE methods most frequently rated as either ineffective or harmful were individual effort, church counseling, personal righteousness, and family therapy. The SOCE methods most frequently rated as effective were support groups, group retreats, psychotherapy, psychiatry, and group therapy. Ironically, methods most frequently rated as "effective" tended to be used the least and for the shortest duration, while methods rated most often as "ineffective" or "harmful" tended to be used most frequently, and for the longest duration.

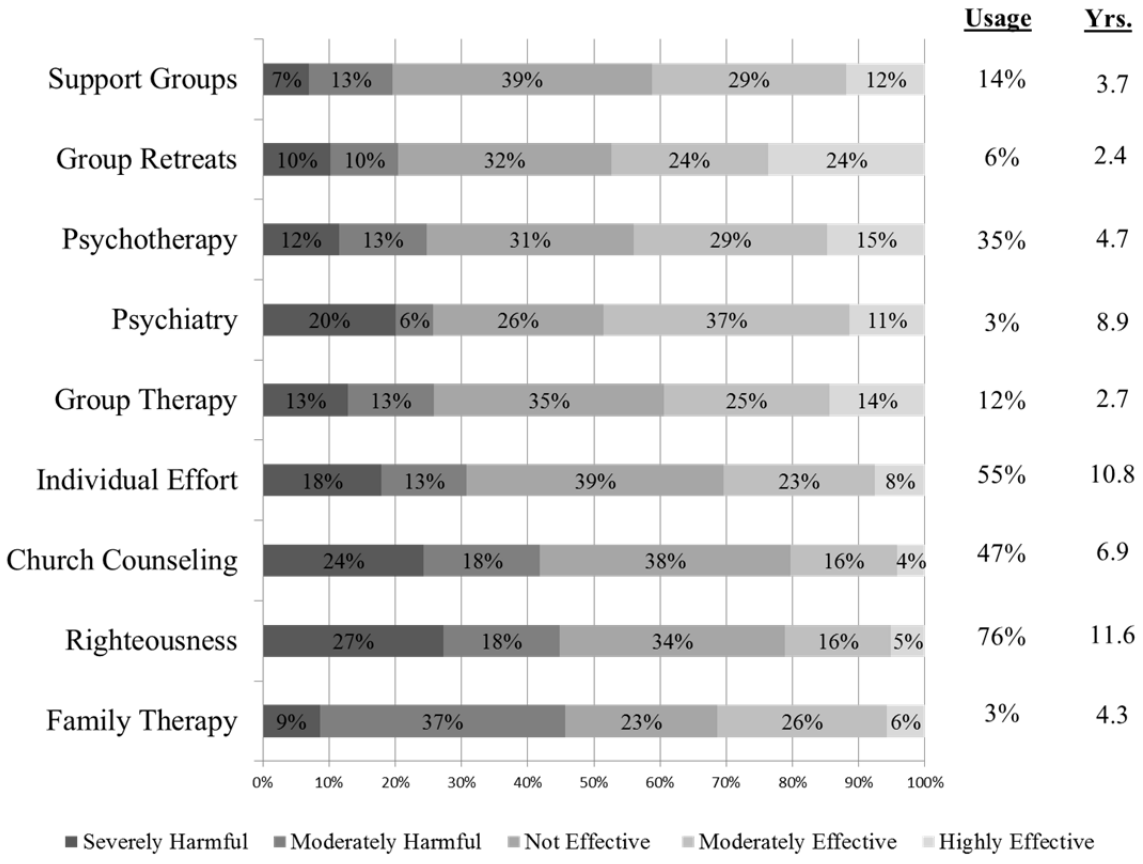


Figure 2.1. Sexual orientation change effort methods, effectiveness/harm ratings, usage, and duration.

Developmental Factors Linked to SOCE

As reported in Table 2.2, some developmental factors that appear to be associated with SOCE included less family and community support for LGBTQ identities (for men only), and high levels of religious orthodoxy prior to acknowledging SSA (for both men and women; highly significant with a Bonferroni corrected $\alpha = .008$). Those who reported growing up in a rural community were more likely to engage in SOCE (71.0%) than those who reported growing up in an urban (63.0%) or a suburban (64.4%) community, $\chi^2(2, n = 1{,}565) = 6.95, \Phi = .067, p = .03$.

Effectiveness of Change Efforts

Reported changes in sexual identity. With regard to self-reported sexual attraction and identity ratings, only one participant out of 1,019 (.1 %) who engaged in SOCE reported both a heterosexual identity label and a Kinsey attraction score of zero (exclusively attracted to the opposite sex). As shown in Table 2.2, the mean Kinsey attraction, behavior, and identity scores of those reporting SOCE attempts were not statistically different from those who did not indicate an SOCE attempt. Multiple imputation procedures to account for missing data yielded only one significant change in outcome; the statistical difference in Kinsey attraction scores between women who reported engaging in SOCE vs. those who did not was found to be significant for the pooled imputation results at $t = -2.0$, $p = .045$ (vs. $t = -1.75$, $p = .08$ in the original analysis)—indicating that women who reported engaging in SOCE reported significantly higher Kinsey attraction scores than women who did not report engaging in SOCE.

Table 2.2

Developmental Factors, Kinsey Scores, and Psychosocial Health by SOCE Involvement

	SOCE reported			SOCE not reported						
Variables	*n*	*M*	*SD*	*n*	*M*	*SD*	*t*	*df*	*p*	*d*
Developmental factors by sex										
Men										
Family LGBTQ support	879	0.89	1.31	323	1.33	1.63	4.4	483 [a]	<.001	0.30
Community LGBTQ support	881	0.96	1.32	325	1.33	1.6	3.73	495 [a]	<.001	0.25
Religious orthodoxy before ack. SSA	874	1.22	1.61	293	2.46	1.94	9.89	435 [a]	<.001	0.70
Women										
Family supportive growing up	165	0.84	1.23	218	1.00	1.42	1.11	381	0.268	0.12
Community supportive growing up	164	1.09	1.41	221	1.23	1.43	0.95	383	0.343	0.10
Religious orthodoxy before ack. SSA	165	1.51	1.73	213	2.77	1.95	6.66	369 [a]	<.001	0.68
Kinsey scores by sex										
Men										
Feelings of sexual attraction	858	5.12	1.28	315	4.93	1.62	-1.88	466 [a]	0.061	0.13
Sexual behavior/experience	849	4.49	2.00	306	4.72	1.89	1.71	1153	0.088	0.12
Sexual identity	845	4.82	1.98	308	4.87	1.98	0.37	1151	0.709	0.03
Women										
Feelings of sexual attraction [b]	161	4.45	1.57	209	4.15	1.62	-1.75	368	0.08	0.19
Sexual behavior/experience	157	3.76	2.09	206	3.32	2.15	-1.97	361	0.05	0.21
Sexual identity	154	4.47	2.02	204	4.09	2.04	-1.76	356	0.08	0.19
Psychosocial health by sex										
Men										
Quality of life	894	82.28	14.3	326	82.48	14.74	0.21	1218	0.834	0.01
Sexual identity distress	894	10.16	7.61	325	7.01	6.23	-7.35	697 [a]	<.001	0.45
Self-esteem	894	3.15	0.64	328	3.29	0.61	3.38	1220	0.001	0.22
Women										
Quality of life	166	81.9	13.2	222	83.01	13.81	0.79	386	0.428	0.08
Sexual identity distress	166	9.49	7	221	7.04	5.91	-3.65	320 [a]	<.001	0.38
Self-esteem	166	3.13	0.64	222	3.21	0.66	1.22	386	0.220	0.12

[a] Corrected degrees of freedom.

[b] Multiple imputation analyses conducted to account for missing data found a statistical difference in Kinsey attraction scores between women who reported engaging in SOCE vs. those who did not at $t = -2.0$, $p = .045$. Also, those who self-rated as "Asexual" (i.e., "7") were not included in the Kinsey analyses so as to not alter the commonly-accepted interpretations of Kinsey scores.

With regard to sexual identity (Table 2.3), over 95% of both men and women who engaged in some form of SOCE identified as non-heterosexual. Men who did and did not report engaging in SOCE did not differ from each other statistically in terms of current sexual identity labels. Women who reported engaging in SOCE were significantly more likely to self-identify as lesbian than were those who did not engage in SOCE. SOCE participants currently self-identifying as heterosexual reported a mean Kinsey attraction score of $M = 3.02$ ($SD = 1.42$), which is commonly associated with bisexuality.

Reports and explanations of successful change. Participants were provided the option to describe their various change efforts in their own words. A review of these

Table 2.3

Current Sexual Identity Status Differences by Sex and by SOCE Involvement

	SOCE reported		SOCE not reported	
Variable	*n*	%	*n*	%
Men[a]				
Gay	717	80.30	267	81.40
Bisexual	96	10.80	37	11.30
Heterosexual	41	4.60	14	4.30
SSA or SGA	20	2.20	0	0.00
Other	19	2.10	10	3.00
Subtotal	893		328	
Women[b]				
Lesbian	109	65.70	109	49.10
Bisexual	32	19.30	69	31.10
Heterosexual	7	4.20	17	7.70
Other	18	10.80	27	12.20
Subtotal	166		222	

[a] Male differences are not statistically significant.

[b] Female differences are significant at $\chi 2(3, n = 388) = 11.68$, $\Phi = .174$, $p < .01$.

narratives yielded 32 participants (3.1% of those attempting change) who indicated some type of SSA change in their open-ended narratives. Of these 32 participants, 15 described a decrease in the frequency and/or intensity of their SSA, without mentioning a cessation of SSA. As an example, one participant wrote, "While the same-sex attraction is still stronger than heterosexual attractions, the frequency and intensity and duration of those attractions have lessened." Twelve of the 32 narratives did not mention attraction at all, but instead mentioned either a decrease or a cessation of same-sex sexual behavior, as exemplified in this narrative, "I feel like I have been forgiven for my sexual behavior. I think of a same sex relationship every day but I don't act on it." Five of the narratives reported an increase in other-sex attractions, two of the narratives reported a reduction in anxiety about the SSA, and five indicated some sort of change that was unclear or vague (e.g., "I have felt so much strength from God to control myself"). Finally, it should be noted that some participants fit into more than one of these categories, and that none of the 32 participants indicated an elimination of SSA.

Perceived Benefits and Harm Associated with SOCE

Perceived benefits. Open-ended narratives were also reviewed to provide further insight into the perceived effectiveness summarized in Table 2.1 and Figure 2.1. Based on this review, methods rated as "Effective" did not appear to generally reflect any changes in sexual orientation, but instead referred to several other benefits, such as ultimate acceptance of sexual orientation, a decrease in depressive or anxiety symptoms, and improved family relationships. One such example from the Personal Righteousness narratives illustrates: "…instead of meeting original goals, the direction of the goals

changed as I learned to accept and love myself as I am--as God created me." Another participant who attempted SOCE through a psychotherapist added:

> My therapist wanted to treat what he called the underlying factors that could lead to my same gender attraction. He wanted to help with depression and other things he was qualified to do. It did help and the therapy helped with coping but did not really treat the underlying cause. In fact, because of talking I resolved to accept it.

Perceived harm. As shown in Table 2.2, comparisons of psychosocial health were made between those who reported SOCE attempts and those who did not. Overall, no significant difference (Bonferroni corrected $\alpha = .008$) in quality of life for men or women was found between the two groups, though participants who reported engaging in SOCE had significantly higher sexual identity distress (men and women) and lower self-esteem (men only).

A similar review of the open-ended narratives also provides additional insight into the "harmful" ratings assigned to the various methods. Reportedly damaging aspects of SOCE included decreased self-esteem, increased self-shame, increased depression and anxiety, the wasting of time and money, increased distance from God and the church, worsening of family relationships, and increased suicidality. One example from the Personal Righteousness narratives illustrates:

> Therapy, meeting with the bishop, meeting with stake president, praying, fasting, etc. Nothing worked. I felt that God wasn't listening, or wanted me to suffer. I felt horrible until I changed my outlook.

A narrative from the Ecclesiastical Counseling narratives further illustrates:

> After first being told to go on a mission to be cleansed of these feelings (resulting in relationships that intensified my same-sex activity) and then being told to get married and have children and the feelings would go away—I buried myself emotionally and spiritually.

Another wrote, "My Bishop gave me a blessing promising me that I could change. Every

day I didn't change, I thought I was more a failure, more of a monster."

Discussion

The purpose of this study was to better understand the demographics, prevalence, variety, perceived effectiveness, and potential benefit/harm of SOCE among current and former LDS Church members through the recruitment of a large, demographically diverse sample. Our findings suggest that the majority of participants engaged in SOCE via multiple avenues for over a decade (on average). Almost no evidence of SSA being eliminated via SOCE could be found in this sample, and minimal evidence supported successful change in sexual orientation. SOCE participants in this sample showed no differences in quality of life from those who had not engaged in SOCE, but psychosocial function was lower in those who had engaged in SOCE. Participants reported a number of positive and negative outcomes of change efforts; perceived effectiveness ratings varied substantially depending on the particular method and the reported goals.

The Nature of SOCE

LDS SOCE demographics. Highly religious LDS men from unsupportive families and communities reported to be most likely to engage in SOCE, while LDS women reported to be somewhat less likely to do so. These findings confirm previous research that SOCE efforts most often arise from religious and/or social pressure (APA Task Force, 2009). The finding that same-sex attracted LDS women were less likely to engage in SOCE seems noteworthy, though the exact reasons for this are still unknown. Same-sex attracted LDS women may feel less pressure to engage in SOCE because of the

greater sexual fluidity afforded women within the constraints of socialized gender roles (Diamond, 2009); U.S. male culture tends to stigmatize male homosexuality more than female homosexuality or bisexuality (Herek, 2002). The role of LDS cultural factors, such as the church's historical emphasis on missionary service for 19-year-old men with an accompanying requirement for sexual worthiness also warrants investigation.

Prevalence of SOCE types. Although the psychology literature to date has focused almost exclusively on therapist-led SOCE (APA Task Force, 2009), religious and private forms of SOCE were far more prevalent in our sample. To illustrate, while over 85% of SOCE participants reported engaging in either religious or individual SOCE efforts, only 44% reported some form of therapist or group-led SOCE. Personal righteousness (e.g., prayer, fasting, scripture study, improved relationship with Jesus Christ) as a form of SOCE was reported by our sample to be (a) by far the most prevalent method used to change sexual orientation (more than twice as common as psychotherapy), (b) initiated at the earliest average ages (16-18 years), and (c) utilized for the longest average duration of any SOCE method (over 12 years on average for men and 8 years for women). Church counseling (e.g., with LDS bishops) and individual efforts also yielded significantly higher prevalence and duration rates than most other SOCE forms. These findings generally held true for both men and women, though LDS women reported engaging in church counseling, individual-based, and group-based SOCE at considerably lower rates than LDS men.

We recognize, from the age of onset and duration of effort data, that many of our participants were still actively engaged in efforts to understand, cope with, or change their orientation, and that the efforts have been carried out across varying developmental

stages and historical contexts (i.e., our participants ranged in age from 18-70 years). Thus, while our "snapshot in time" yields important information about the experiences of SOCE at a broad and comprehensive level, we look forward to more detailed assessment of the ways that SOCE are developmentally, historically, and culturally contextualized.

Effectiveness/Harm Rates of SOCE

The evidence from this study—based on multiple criteria including Kinsey-style self-ratings of attraction, sexual identity self-labels, method effectiveness ratings, and open-ended responses—suggests that for this sample, sexual orientation was minimally amenable to explicit change attempts. The literature supports these findings (APA Task Force, 2009; Beckstead, 2012). It is notable that zero open-ended narratives could be found indicating complete elimination of SSA via SOCE, and that only a small percentage of our sample (3.2%) indicated even slight changes in sexual orientation. When survey participants did report experiencing sexual orientation change, the most common descriptions involved slight to moderate decreases in SSA, slight to moderate increases in other-sex attraction, and/or a reduction in same-sex sexual activity. As Beckstead noted, it is unclear if this decreased frequency and intensity of SSA is due to a reduction of sexual attraction or due to avoidance behaviors and/or a decrease of intense feelings, such as anxiety and shame, associated with SSA. Instead of fundamental changes in core sexual orientation, accommodation and acceptance of one's SSA were the most common themes. While these findings seem consistent with the larger literature and broad professional consensus, we are compelled by the fact that we have observed these patterns within a population that may be among the most likely to embrace and

support change efforts.

We note that all nine methods utilized by participants to understand, cope with, or change SSA (with the exception of church counseling for women) were rated as effective (on average) when sexual orientation change was not listed as a goal. However, when sexual orientation change was listed as a goal, a majority of methods decreased in reported effectiveness—often with large effect sizes. Personal righteousness was rated as the most "severely harmful" of all SOCE methods for our sample, particularly noteworthy given that it was also rated as the most commonly used SOCE method (76%) for the longest average duration (12 years for men, 8 for women). Church counseling and individual efforts were rated as the next most "severely damaging" SOCE methods for our sample, with church counseling being rated as only slightly less damaging than personal righteousness. Significantly higher sexual identity distress (in men and women) and lower self-esteem (in men) were associated with prior participation in SOCE, although we do not know distress and self-esteem levels prior to SOCE participation, and thus cannot determine causality.

Additional study is warranted to better understand why religious methods were simultaneously used so frequently, yet rated as most ineffective/harmful. We theorize that the high prevalence of religious SOCE is due in large part to the LDS Church's continued emphasis on prayer, fasting, scripture study, improved relationship with Jesus Christ, and consulting with church leaders (e.g., bishops) as primary ways to deal with SSA (Holland, 2007; Kimball, 1969; Mansfield, 2011). We also speculate that highly religious individuals in our sample were more likely to keep their SSA private due to social stigma, and thus more likely to favor/trust religious or private efforts over secular ones. In

addition, most licensed therapists are likely to refuse to engage in SOCE—all of which could explain the increased prevalence of private and religious forms of SOCE in this sample.

Based on our review of the open-ended responses, we also speculate that when religious SOCE did not result in the desired outcomes, it may have damaged many of our participants' faith and confidence in God, prayer, the church, and its leaders. Consequently, failed SOCE often led to high levels of self-shame, feelings of unworthiness, rejection and abandonment by God, and self-loathing, as well as "spiritual struggles" for many of our respondents (Bradshaw, Dehlin, Galliher, Crowell, & Bradshaw, 2013; Dahl & Galliher, 2012; McConnell, Pargament, Ellison, & Flannelly, 2006). This pattern of findings does emphasize the importance of ensuring that LDS Church leaders are adequately trained to deal with LGBTQ issues, and addressing culturally-inherited leadership beliefs and practices that might be contributing to these deleterious effects.

In terms of effectiveness, group-related and therapist-led methods tended to be rated by participants as the most effective and least damaging. While therapist-led SOCE were reportedly used less frequently than individual and religious methods, they were surprisingly common given the general denunciation of SOCE by all of the major mental health professional organizations. A review of the open-ended descriptions for the various methods indicated that for the majority of participants, a rating of "effective" for therapist-led methods did not signify successful change in sexual orientation, but instead indicated other outcomes such as acceptance of sexual orientation (even when change was an original goal), a decrease in anxiety or depression, and/or improvements in family

relationships. These findings appear to align with APA Task Force (2009) conclusions that the secondary benefits found in SOCE can be found in other approaches that do not attempt to change sexual orientation.

Implications for Counseling

Our results present several possible implications for therapist-led and church-affiliated LGBTQ counseling. First and most obvious, these findings lend additional support to the strong positions already taken by most mental health professional organizations that therapist-led SOCE are not likely to be successful—although our data indicate that such interventions are ongoing amongst the LDS population. Consequently, LDS-affiliated therapists, support group/retreat leaders, and ecclesiastical leaders who encourage or facilitate SOCE (whether therapist-led, religious, or group-based) might consider amending their approaches in light of these findings. LDS therapists, group, and ecclesiastical leaders might also consider providing evidence-based psychoeducation about reported SOCE effectiveness rates to their LDS LGBTQ clients, family, and fellow congregants.

Given the high prevalence and reported ineffectiveness/harm rates of religious SOCE in particular, counselors who work with LDS LGBTQ populations might consider explicitly assessing for, and exploring histories of religious SOCE with LDS LGBTQ clients. In addition, group-based methods such as support groups, group therapy, and group retreats (that do not encourage SOCE) should potentially be recommended with increased frequency, along with psychiatry (where depression/anxiety is particularly notable)—based on their reported relative effectiveness when compared to other

methods. Finally, as noted in Bradshaw and colleagues (2013), LDS-affiliated therapists should duly consider the finding that acceptance-based forms of therapy are likely to be rated as significantly more effective and less harmful by LDS LGBTQ individuals than are change-based forms of therapy. Ultimately, these suggestions align well with the therapeutic recommendations offered by the APA Task Force (2009).

Summary and Limitations

The major findings from this study are as follows: (a) the majority of same-sex attracted current and former LDS Church members reported engaging in SOCE for mean durations as long as 10-15 years, (b) religious and private SOCE were reported to be by far the most commonly used SOCE methods for the longest average durations, and were rated as the most ineffective/damaging of all SOCE methods, and (c) most LDS SOCE participants reported little to no sexual orientation change as a result of these efforts, and instead reported considerable harm.

Our reliance on convenience sampling limits our ability to generalize our findings to the entire population of same-sex attracted current and former LDS Church members. For example, our sample almost certainly overrepresents men, Whites, and U.S. residents, along with those who are more highly educated, affluent, and who either read the newspaper or are Internet-connected. Because of the highly distressing, stigmatizing, and/or controversial nature of being both same-sex attracted and LDS, it is probable that a significant number of both highly devout and highly disaffected current and former LDS Church members did not become aware of, or feel comfortable participating in this study.

The extent to which these findings generalize to the broader, non-LDS LGBTQ religious population is uncertain. While we acknowledge that the LDS Church is distinctive in many ways from other more LGBTQ-affirming religious institutions (e.g., Reform and Reconstructionist Judaism, Unitarian Universalism, Episcopalian), there is some evidence to suggest that the societal and theological pressures experienced by LDS LGBTQ individuals are similar to those in other conservative religious traditions (e.g., Orthodox Judaism, Catholicism, Evangelical Christianity, Islam; APA Task Force, 2009; Michaelson, 2012). Though no known research has been conducted to compare SOCE experiences across religious denominations, the APA's report on SOCE seems to acknowledge several commonalities in LGBTQ/SOCE experiences between LDS Church members and those of other religious traditions, which include: (a) church-based doctrinal and administrative opposition towards same-sex sexuality, (b) no known role for same-sex relationships within church structure, (c) the possible threat of expulsion for assuming an open LGBTQ identity, (d) considerable church-related familial and social pressure to eschew an LGBTQ identity and to engage in SOCE, (e) ostracizing of LGBTQ individuals at church/temple/synagogue/mosque, and (f) considerable psychological distress for religious LGBTQ individuals due to identity conflict. In addition, several studies which draw their samples from Christian reparative therapy conferences (e.g., Exodus International) explicitly noted the participation of LDS Church members, suggesting possible similarities between LDS LGBTQ experiences and those of other religious traditions (Beckstead & Morrow, 2004; Morrow & Beckstead, 2004). We are hopeful that additional research will be conducted to further assess similarities and differences in SOCE experiences between religious traditions.

Because our survey relied heavily on both self-report and participant memory, responses are likely to be impacted accordingly. Also, while we are able to provide some correlational data relative to findings such as factors associated with the likelihood of SOCE participation, average Kinsey scores of those who did and did not engage in SOCE, and a relationship between SOCE and well-being—it is not possible to determine causality and directionality of these relationships without the use of methodologies such as randomized clinical trials or longitudinal studies. For example, regarding our finding that women who have engaged in SOCE were more likely to identify as lesbian than those who did not engage in SOCE, it is difficult to ascertain from our data whether women who are more likely to identify as lesbian are also more likely to engage in SOCE, or if the process of engaging in SOCE might make one's non-heterosexual identity more salient. Finally, it should be noted that participants were not always consistent and coherent in their reports. For example, a number of participants described SOCE in their open-ended responses, even though they had not indicated "change" as either a goal or as something worked on during the methods earlier in the survey. In order to retain a more parsimonious set of classification criteria, we elected to use more conservative inclusion criteria, and did not include participants in the "SOCE Reported" group based on open-ended responses only. Consequently, it is likely that SOCE rates are underreported in our sample.

In summary, this study contributes to the literature by demonstrating significantly greater prevalence of religious and private SOCE vs. therapist-led SOCE, no meaningful evidence of reported SOCE effectiveness, and considerable evidence of SOCE-related harm—all via a large, diverse sample. Despite our results being limited to one particular

faith tradition, the observed motivations, correlates, and outcomes of SOCE are likely relevant in other conservative religious contexts and we look forward to additional research on this topic.

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CHAPTER 3

NAVIGATING SEXUAL AND RELIGIOUS IDENTITY CONFLICT: A MORMON PERSPECTIVE[2]

Abstract

This study examined navigation of sexual and religious identity conflict among 1,493 same-sex attracted current or former members of The Church of Jesus Christ of Latter-day Saints. Participants were classified into four groups: (a) rejected a lesbian, gay, or bisexual identity (5.5%), (b) rejected religious identity (53%), (c) compartmentalized both identities (37.2%), and (d) integrated their identities (4.4%). Systematic differences emerged among the groups in sexual identity development histories, developmental milestones, relationship experiences, religious engagement, and psychosocial health. Findings suggest that rejection or compartmentalization of sexual identity may be difficult to sustain over time and likely comes at a significant psychosocial cost. Integration of identities may be equally difficult to achieve, and appears to be associated with optimal outcomes.

Introduction

Sexuality is viewed as a central, healthy, and largely irrepressible component of the human experience (Kauth, 2006; Symons 1979); in addition, the American

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Psychological Association (APA) has indicated that "same-sex sexual and romantic attractions, feelings, and behaviors are normal and positive variations of human sexuality regardless of sexual orientation identity" (APA Task Force, 2009, p. v). Religiosity and church activity are also viewed by the APA as important influences for the well-being of many (Anton, 2008). In the U.S., over 80% identify with a religious group (Pew Forum on Religion & Public Life, 2013); 88% report attending a religious service with at least some frequency, with 54% attending at least once or twice per month (Pew Forum on Religion & Public Life, 2008). Many religions, however, condemn same-sex sexuality, or the assumption of a lesbian, gay, bisexual, transgender, or queer (LGBTQ) identity (Swidler, 1993). In addition, some research indicates that many religious sexual minorities describe their church environments as oppressive (Oswald, 2001; Yip, 1999). These factors can lead to significant identity conflict amongst same-sex attracted (SSA) religious individuals (e.g., Beckstead & Morrow, 2004; Schuck & Liddle, 2001).

Theoretical Framework for Identity Conflict

Two particularly useful frameworks developed to help better conceptualize the navigation of conflicting religious and sexual identities are those of Pitt (2010) and Anderton, Pender, and Asner-Self (2011). Based on the work of Troiden (1989) and Rodriguez and Ouellette (2000), Pitt detailed four common strategies that highly religious gay black men employ to manage conflict between their religious and sexual identities: (a) rejecting their "homosexual" or LGBTQ identity (RLI), (b) compartmentalizing the two identities (COMP), (c) rejecting their religious identity (RRI), and (d) integrating the two identities (INT). For the purposes of this paper, each strategy will be referred to by

its acronym (e.g., RLI = rejecting one's LGBTQ identity), and those who engage in the strategy will be referred to in plural form (e.g., RLIs).

According to Pitt (2010), RLI involves both eschewing a "homosexual" or LGBTQ self-identity, and actively seeking to inhibit thoughts and feelings of same-sex attraction. This stage can involve various behaviors, ranging from praying to God to eliminate same-sex thoughts, feelings, or attraction, to more drastic measures such as reparative therapy (APA Task Force, 2009). While this stage often involves staying closeted about one's SSA, individuals might disclose to others with the intention of seeking help to change their sexual orientation.

Pitt (2010) described the COMP identity as living a "double life," wherein participants attempt to hide their sexual minority status while at church, and to (often) hide their religious status while socializing with LGBT individuals. Pitt reported that many find this strategy to be difficult to maintain, as each world tends to bleed (over time) into the other.

RRI, according to Pitt (2010), primarily involves leaving one's previously held religious identity—often in an attempt to legitimize one's LGBT identity, enhance positive self-image, and neutralize feelings of guilt related to previously held religious beliefs. In some cases, this may lead to hostility towards one's faith of origin, and can lead to the wholesale rejection of all religion, as exemplified by Singer and Deschamps' (1994) finding that more than 60% of lesbians and gays no longer view religion as important in their lives. Pitt noted that rejecting one's religious identity can also involve converting to more LGBT-affirming religious traditions.

Finally, INT most often involves assuming the synthesized identity of an LGBT

religious person (e.g., "gay Christian"), wherein individuals come to perceive both their religiosity and their sexuality as valid parts of their total sense of self. When describing this final strategy, Pitt noted that while most in this stage remain single (62%), they nonetheless make increasing attempts to comply with traditional religious behavioral standards (e.g., sexual chastity, monogamy). For many, entering into a committed same-sex relationship often becomes an important part of attempting to integrate their gay and religious identities.

Anderton and colleagues (2011) utilized cognitive dissonance theory (Festinger, 1957) to conceptualize ways in which religious LGBT individuals manage conflicting identities, defining cognitive dissonance as "…the existence of non-fitting relations among cognitions that becomes a motivating factor in its own right. It is an incongruity or inconsistency occurring between any 'knowledge, opinion, [or] belief about the environment, about oneself, or about one's behavior'" (p. 263). Anderton and colleagues offered several ways in which cognitive dissonance is managed for religious LGBT individuals—strategies which harmonize with Pitt (2010): (a) disaffiliating from nonaffirming churches, (b) seeking out LGBT-affirming religions, (c) compartmentalizing disparate identities, and (d) abandoning religion and spirituality altogether. In addition, Anderton and colleagues explored in greater depth the varying ways in which individuals attempt to eliminate or harmonize their identity conflict, which can include: (e) behavior strategies such as increasing religious practice, decreasing same-sex sexual behavior, and engaging in sexual orientation change efforts (SOCE), and (f) adding their own cognitive elements including altering scriptural interpretations, changing religious beliefs, and seeking divine confirmation of their sexual orientation.

When taken together, these two frameworks provide a foundation upon which to understand the navigation of religious and sexual minority identity conflict.

SSA and the LDS Church

Founded by Joseph Smith in 1830, The Church of Jesus Christ of Latter-day Saints (LDS, a.k.a. The Mormons) claims over 15 million members worldwide (Church of Jesus Christ of Latter-day Saints, 2013) and is one of the largest churches in the United States (Pew Forum on Religion & Public Life, 2008). As Christians, the LDS Church accepts the *Holy Bible* as scripture, but also accepts an additional set of scriptural texts including *The Book of Mormon*, which purports to be a partial religious history of pre-Columbian America.

Although the LDS Church is well known for its participation in nontraditional marriage in the 19th century (i.e., polygamy, polyandry), it has maintained a conservative position regarding same-sex sexuality in the 20th and 21st centuries—consistent with many other U.S. churches. Statements made by LDS Church leaders between the 1950s and 1980s were frequently condemnatory (e.g., Kimball, 1971; Wilkinson, 1965). During this period, LDS Church leaders commonly recommended celibacy, various forms of SOCE (including limited experimentation with electro-shock therapy; McBride, 1976), and heterosexual marriage as "solutions" to SSA (O'Donovan, 1994).

The LDS Church has evolved considerably over the past decade with regard to its position on SSA—no longer denouncing SSA as inherently sinful, nor recommending heterosexual marriage as a "cure" (Church of Jesus Christ of Latter-day Saints, 2012). Nonetheless, as of 2013 the LDS Church continues to: (a) teach that only marriage

between a man and woman is acceptable to God (Church of Jesus Christ of Latter-day Saints, 1995), (b) publish statements indicating that SSA change is possible (e.g., Church of Jesus Christ of Latter-day Saints, 2012; Condie, 1993; Pyrah, 2010), (c) both officially and unofficially sponsor organizations that promote increased personal righteousness, celibacy, SOCE, and mixed-orientation marriages as viable options for same-sex attracted church members (SSA-LDS; LDS Family Services, Evergreen International, North Star), (d) oppose the legalization of same-sex marriage (Church of Jesus Christ of Latter-day Saints, 2008), (e) prohibit same-sex married individuals from full fellowship, and (f) excommunicate members who either engage in same-sex sexual behavior, or who enter into same-sex marriages (Church of Jesus Christ of Latter-day Saints, 2010). These restrictive approaches to same-sex sexuality lead to considerable identity conflict amongst SSA-LDS (Beckstead, 2001).

SSA-Religious Identity Research

A handful of studies identify the SSA-religious population as particularly prone to attempting reparative therapy as a way to deal with identity conflict (e.g., APA Task Force, 2009; Beckstead, 2001; Beckstead & Morrow, 2004; see also Chapter 2). Dehlin and colleagues found that 66% of SSA-LDS attempted on average three different forms of SOCE for a duration of over 10 years. Overall, these studies suggest that: (a) religious beliefs were usually the primary motivator for engaging in reparative therapy, (b) that SSA rarely (if ever) "goes away," and (c) that many participants reported experiencing harm as a result of these efforts. Instead, important steps identified as helpful in achieving overall well-being for SSA-Religious include: self-acceptance, positive self-

identification, identity and values congruence, increased authenticity, openness with family and friends, and increased self-determination. These studies explicitly call for more research and discussion regarding religious identity management for SSA individuals, expressing the need for more integrative solutions that eschew having to choose between sexual and religious identities (Beckstead & Morrow, 2004).

Dahl and Galliher have published four articles relating to SSA-religious identity navigation and conflict (2009, 2010, 2012a, 2012b). In their 2009 study of 105 lesbian, gay, bisexual, queer, or questioning (LGBQQ) youth raised in religious contexts, they found low levels of sexual and religious identity integration, and that self-acceptance and increased knowledge were instrumental for those who reported successful integration. Subsequently, Dahl and Galliher (2012a) found eight themes across a qualitative analysis of religious and sexual identity development among 19 youth and young adults, the majority of whom were raised LDS. Negative outcomes included feelings of inadequacy, religious-related guilt, depressive symptoms, and social strain. Positive outcomes included increased sense of self, acceptance of others, incorporation of religious values, and social support. Dahl and Galliher (2012b) found in the same sample that many of the participants questioned their faith, and that some responded by disconnecting religiously, while others worked hard to maintain connection with their faith communities. Participants generally reported internal conflict often resulting in efforts to change their sexual orientation, and a majority of participants ended up disengaging from their childhood faiths, disclosing their sexual orientation to friends and family, and redefining their religious beliefs and values.

Current Study

This study attempted to more deeply understand the many ways in which SSA-LDS adults manage their identity conflict. Through the frameworks presented by Pitt (2010) and Anderton and colleagues (2011), the following research questions were addressed.

1. To what extent do SSA-LDS represent each of the following approaches: (a) rejecting their LGBTQ identity, (b) compartmentalizing the two identities, (c) rejecting their religious identity, and (d) integrating the two identities?

2. What demographic characteristics are associated with each of these approaches?

3. To what extent are various cognitive elements (e.g., changes in religious beliefs, changes in opinions about the origins of SSA, self-described attraction levels and identity) and/or behavioral strategies (e.g., SOCE, mixed-orientation marriages, celibacy, changes in religious behavior, seeking divine confirmation of God's acceptance of their SSA, "coming out") associated with each approach?

4. To what extent is psychosocial well-being (e.g., quality of life, sexual identity distress, depression, self-acceptance, self-esteem) associated with each of these approaches?

Methods

Participants

Participants were recruited to complete an Internet-based self-report survey

described in detail below. Inclusion criteria were: (a) 18 years of age or older, (b) baptism in the LDS Church (current activity or membership was not required), (c) the experience of SSA at some point, and (d) completion of a majority of the survey items. After filtering out 23 respondents who did not meet criteria, 1,612 were included in the initial data set. For additional details on recruitment, data selection, and sample characteristics, (see Chapter 2).

The 1,493 participants who met criteria for one of the four Pitt (2010) categories (described below) reported an average age of $M = 36.8$ ($SD = 12.59$); 76% were men ($n = 1,138$). While most respondents ($n = 1,402$) resided in the U.S. covering 48 states and the District of Columbia, 21 other countries were also represented. Regarding ethnicity, 92% ($n = 1,369$) identified as White/Caucasian. With regard to educational status, 67.5% reported to be college graduates, with 97.1% reporting at least some college education. Relationship status was reported as 42.1% single, 23.9% unmarried but committed to same-sex partners, 15.5% married or committed to heterosexual relationships, 12.9% in a marriage, civil union, or domestic partnership with a same-sex partner, and 5.6% divorced, separated, or widowed.

Measures

Participants completed a collection of measures for a larger study addressing sexual identity development, psychosocial health, and sexual orientation change efforts among LGBTQ Latter-day Saints (see Crowell, Galliher, Dehlin, & Bradshaw, 2015; see also Chapter 2). Measures relevant to the current study are described below.

Demographic information. Respondents answered several demographic

questions including biological sex, age, state and country of residence, marital history, current relationship status, current religious affiliation/activity, and parental status.

Sexuality and sexual identity. Participants were asked to identify their self-defined sexual orientation (e.g., gay, lesbian, bisexual), and were also asked to rate their: (a) sexual behavior/experience, (b) feelings of sexual attraction, and (c) self-declared sexual identity on a 7-point Likert-type scale (modeled after the Kinsey scale), ranging from 0 (exclusively opposite sex) to 6 (exclusively same sex), with the additional option of asexual (Kinsey, Pomeroy, & Martin, 1948). Four items evaluated participants' degree of disclosure to: (a) family members, (b) friends, (c) classmates/coworkers, and (d) people with whom [participants] are religiously affiliated—with a scale ranging from 1 = none to 5 = everyone (Dahl & Galliher, 2009). Participants were also asked about their opinions regarding the origins of SSA both generally and for themselves specifically.

Attempts to cope with same-sex attraction. Participants were asked which of several activities they had engaged in to "understand, cope with, or change" their sexual orientation. Options included: (a) individual efforts; (b) personal righteousness (e.g., fasting, prayer, scripture study, temple worship); (c) psychotherapy; (d) psychiatry; (e) group therapy; (f) group retreats; (g) support groups; (h) ecclesiastical counseling; (i) family therapy; and (j) other. Participants were also asked to indicate what was actually worked on with each of these activities (e.g., depression, anxiety, desire to change, accept, and/or explore/understand their same-sex attraction).

Sexual Identity Distress Scale. The Sexual Identity Distress scale (SID; Wright & Perry, 2006) is a 7-item measure assessing sexual orientation-related identity distress. Sample questions include, "For the most part, I enjoy being (gay/lesbian/bisexual)" and

"I worry a lot about what others think about my being (gay/lesbian/bisexual)." Response options are "strongly agree, agree, mixed feelings, disagree, and strongly disagree." SID total scores are obtained by reverse scoring the negative items and summing the scores; higher scores indicate greater identity distress. The SID is reported to have high internal consistency and test-retest reliability with a Cronbach's alpha of .83 and strong criterion validity (Wright & Perry, 2006). Cronbach's alpha for the current sample was $\alpha = .91$.

Quality of Life Scale. The QOLS (Burckhardt & Anderson, 2003) is a 16-item instrument measuring six domains: 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 from "terrible" (1) to "delighted" (7). Total scores are obtained by summing all items, with higher scores indicating higher quality of life. Average scores for various disease groups include: fibromyalgia (70), chronic obstructive pulmonary disease (82), systemic lupus (84), and young adults with juvenile rheumatoid arthritis (92). The average score for "healthy populations" is 90. The QOLS has demonstrated high internal consistency ($\alpha = .82$ to .92) and high test-retest reliability ($r = 0.78$ to $r = 0.84$; Burckhardt & Anderson, 2003). Cronbach's alpha for the current sample was $\alpha = .90$.

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

Lesbian, Gay, Bisexual Identity Scale. The LGBIS (Mohr & Fassinger, 2000) is a 27-item measure assessing various dimensions of lesbian, gay, and bisexual identity

including: internalized homonegativity, need for privacy or concealment, need for acceptance, identity confusion, and difficult process (difficulty coming to terms with and disclosing sexual identity or orientation). Subscales are calculated by reverse scoring several items and calculating an average across each subscale. High scores indicate greater identity development negativity. Reliability and validity information has not been published on this measure. However, the authors suggest that the measure demonstrates overall good internal consistency for its subscales (between $\alpha = .75$ and $\alpha = .81$) based on comparison with a revised version of this measure that has been recently published (Mohr & Kendra, 2011). Only the internalized homonegativity ($\alpha = .90$) and identity confusion ($\alpha = .86$) subscales were used in the current study.

CCAPS-34 (Counseling Center Assessment of Psychological Symptoms). The CCAPS-34 (Locke et al., 2012) is a 34-item instrument assessing psychological symptoms and distress. Items are scored on a 5-point scale (0 = not at all like me, and 4 = extremely like me), with higher scores indicating more severe symptoms. Subscales for the CCAPS-34 include: depression, eating concerns, alcohol use, generalized anxiety, hostility, and social anxiety. The author-reported CCAPS-34 test-retest reliability is between $\alpha = .71$ and $\alpha = .84$ (depending on subscale). Only the depression scale was used for the current study ($\alpha = .90$).

Religiosity questions. Questions related to religion included current status in the LDS Church (i.e., active, inactive, resigned, disfellowshipped, excommunicated) and beliefs in God, Jesus, Joseph Smith and *The Book of Mormon* both before and after acknowledging SSA. Participants were asked to indicate the extent to which they experienced some sort of spiritual experience with God showing either acceptance or

condemnation of their SSA, and to describe those experiences in their own words.

Procedures

Data collection and recruitment. This study was approved by the Institutional Review Board at Utah State University, and was released from July 12 through September 29, 2011. The survey required both informed consent and confirmation that the respondents had only completed the survey once. Journalists in the online and print media were contacted about this study after it was released, and because of feature coverage by the Associated Press, articles about this study appeared in over 100 online and print publications worldwide (e.g., *San Francisco Chronicle*, *Houston Chronicle*, *Salt Lake Tribune*, *Huffington Post*). In all, 21% of respondents indicated that they heard about the study directly through print or online media.

Leaders of over 20 LDS-themed LGBT support groups were asked to help advertise this study within their organizations, regardless of positions on SSA, SOCE, or the LDS Church. Extra attempts were made to reach out specifically to LDS faith-affirming organizations, such as Evergreen and North Star, to ensure the most representative sample as possible. Evergreen declined to advertise the study to their participants, though several survey participants noted Evergreen-based experiences. Overall, approximately 21% of respondents learned about the survey from these support groups.

Secular LGBT support organizations such as the Salt Lake City Pride Center and Equality Utah and were also asked to advertise this study. In total, 5% of respondents indicated learning about the survey from one of these sources. Finally, a large percentage

of survey respondents (47%) reported learning about the survey through some form of snowball sampling including email, word of mouth, blogs, Facebook, online forums, or other web sites.

Categorization. An attempt was made in this study to operationalize Pitt's four categories to group survey participants for further analysis. Inclusion criteria for categorization included a Kinsey attraction score of greater than zero, under the assumption that at least some level of SSA was required for religious/sexuality identity conflict. The "Rejecting LGBTQ Identity" category (RLI) was defined as participants who identified as something other than lesbian, gay, bisexual, queer, or pansexual (e.g., heterosexual, same-sex attracted), and who reported the LDS Church as their church most frequently attended. The "Compartmentalizing the Two Identities" category (COMP) included participants who endorsed an LGBTQ identity, reported the LDS Church as the church most frequently attended, and who reported a score of 3 or lower on the question regarding level of identity disclosure to people with whom they are religiously affiliated (indicating compartmentalization with respect to their sexual and religious identities). The "Rejecting Religious Identity" category (RRI) was defined as participants who did not report the LDS Church as their church most frequently attended. The "integrating the two identities" category (INT) was defined identically to the COMP category, except that it included participants who reported scores of 4 or 5 on the question regarding level of disclosure with religious associates. Finally, participants who did not complete the requisite questions for categorization purposes were omitted from the analyses (n = 119).

Results

All tables in this manuscript are organized by Pitt categories, with statistical comparisons between categories provided for each variable. Since statistically significant differences were detected for the majority of the variables (due, in part, to the large sample size), interpretation will focus on results with the largest effect sizes. As shown in Table 3.1, RRIs (53%) and COMPs (37%) were by far the largest categories comprising 90% of the total sample, with RLIs and INTs appearing with much less frequency (10% combined).

Demographic information. Table 3.1 provides basic demographic information (e.g., sex, relationship status, state residency, parental status) by Pitt category. While RRI was the most common category for both men (50%) and women (64%), women were more likely to reject their religion than men. Regarding age, RRIs (M = 38.38, SD = 12.63) were found to be older on average (p = <.001, F = 9.05, df = 3, 1481, η^2 = .018) than RLIs (M = 34.72, SD = 10.66), COMPs (M = 35.00, SD = 12.59), and INTs (M = 35.45, SD = 11.88), with small individual pair-wise effect sizes between RRIs and the others (ds between .24 to .31). "Single" was the largest relationship status overall at 42%, with highest prevalence in the COMP (49%) and INT (48%) categories. Across all groups, 31.2% reported ever having been heterosexually married. RLIs were most likely to be currently in heterosexual marriages, with no RLIs reporting to be in same-sex relationships. COMPs were also very unlikely to be in legal same-sex marriages, but a considerable percentage (16.2%) reported non-legal same-sex relationships. RRIs and INTs were both very unlikely to be in heterosexual marriages, and much more likely than

Table 3.1

Distribution of Identity Negotiation Categories by Demographic Variables

	RLI		COMP		RRI		INT		Totals	
Variables	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%
Identity categories	82	6	555	37	791	53	65	4	1,493	
Sex										
Women	13	16	106	19	225	28	10	15	354	24
Men	69	84	449	81	565	72	55	85	1138	76
Total	82		555		790		65		1,492	
Chi square: $df = 3, \chi 2 = 21.74, p < .001$										
Relationship status										
Single	28	35	261	49	287	38	30	48	606	42
Het. marriage	48	61	137	26	36	5	2	3	223	15
Legal SS	0	0	16	3	157	21	13	21	186	13
Non-legal SS	0	0	87	16	245	32	12	19	344	24
Div./Sep.	3	4	35	7	37	5	5	8	80	6
Total	79		536		762		62		1,439	
Chi square: $df = 12, \chi 2 = 359.13, p < .001$										
Utah resident										
Yes	44	54	268	48	333	42	21	32	666	45
No	38	46	287	52	458	58	44	68	827	55
Total	82		555		791		65		1,493	
Chi square: $df = 3, \chi 2 = 11.76, p = .008$										
Parent										
Yes	41	50	181	33	195	25	12	18	429	29
No	41	50	365	67	595	75	53	82	1054	71
Total	82		546		790		65		1,483	
Chi square: $df = 3, \chi 2 = 32.83, p < .001$										

to be in legal same-sex marriages. RLIs were most likely to be parents, and INTs least likely. While no differences were found between groups regarding U.S. versus non-U.S. residency, RLIs and COMPs were most likely to live in Utah, with INTs least likely. Other demographic variables that showed no statistical relationship to the Pitt identity categories included education level and race (i.e., Caucasian vs. non-Caucasian).

Sexuality. Results regarding sexuality can be found in Table 3.2. While an analysis of the relationship between Pitt category and sexual identity could not be performed for the full sample (since RLIs were defined by their nonendorsement of an LGBTQ identity), a direct comparison between the COMP, RRI, and INT categories determined that: (a) COMPs were more likely than any other group to identify as bisexual, (b) RRIs were more likely than any group identify as lesbian, and (c) INTs were more likely than any group to identify as gay. RLIs reported significantly lower Kinsey scores across the board (i.e., attraction, behavior, and identity), with identity being exceptionally so. Effect sizes of pair-wise comparisons between the RLI group and the other groups with respect to Kinsey scores were all large: attraction (d = 1.08 to 1.69), behavior (d = 1.21 to 2.03), and identity (d = 1.76 to 3.39). COMPs (like RLIs) reported significantly lower Kinsey scores than RRIs and INTs, with mostly medium effect sizes: attraction (d = 0.26 to 0.56), behavior (d = 0.47 to 0.58), and identity (d = 0.52 to 0.83). RLI is the only group wherein sexual behavior self-ratings were actually higher than sexual identity self-ratings, possibly suggesting the suppression of sexual identity. Regarding current sexual activity, RLIs were more likely than other groups to report being celibate by choice (33%), and least likely to report being either celibate due to lack

Table 3.2

Comparisons for Sexual Identity, Behaviors, and Attraction

	RLI				COMP				RRI				INT				One-way ANOVA				Totals	
Variables	*n*	*M*	*SD*	%	*n*	*M*	*SD*	%	*n*	*M*	*SD*	%	*n*	*M*	*SD*	%	*F*	*df**	*p*	η2	*n*	%
Kinsey self-ratings																						
Sexual identity	74	1.07	1.71		523	4.38	2.04		774	5.30	1.42		63	5.69	0.89		88.6	3, 1430	<.001	0.16		
Sexual behavior	82	1.49	1.96		555	3.96	2.11		791	4.85	1.66		65	5.03	1.50		60.9	3, 1489	<.001	0.11		
Sexual attraction	75	3.32	1.55		527	4.86	1.30		775	5.18	1.20		64	5.51	0.99		164.4	3, 1437	<.001	0.26		
Sexual identity[a]																						
Lesbian	0			0	59			11	131			17	9			14					199	14
Gay	0			0	346			62	529			67	53			82					928	66
Bisexual	0			0	141			25	80			10	2			4					223	16
Heterosexual	59			72	0			0	13			2	0			0					72	5
SSA or SGA	18			22	0			0	0			0	0			0					18	1
Other	5			6	0			2	38			5	1			2					53	4
Total	82				555				791				65								1,398	
Chi square: $df = 6, \chi2 = 76.98, p < .001, V = .166$																						
Sexual activity																						
Celibate by choice	*27*			32.9	140			25.4	26			3.3	7			10.8					200	13
Celibate—no partner	*6*			7.3	108			19.6	139			17.6	15			23.1					268	18
Sex. active—committed	*46*			56.1	217			39.4	456			57.7	27			41.5					746	50
Sex. active—not committed	*3*			3.7	86			15.6	169			21.4	16			24.6					274	18
Total	*82*				551				790				65								1,488	
Chi square: $df = 9, \chi2 = 190.28, p < .001, V = .206$																						

[a] Chi square analysis for sexual identity and Pitt group excluded the RLI category (since the RLI category was defined as a claiming a non-LGBT identity), as was the Heterosexual identity (since most heterosexual were operationally defined as RLI).

of partner (7%), or sexually active while not in a committed relationship (4%). RRIs were least likely to be celibate by choice (3%). Across all groups, 50% reported being in a committed sexual relationship.

Support and disclosure. Results regarding social support and disclosure can be found in Table 3.3. Significant but small differences in early family support for same-sex sexuality were found between groups, with INTs reporting the highest levels of early family support. INTs reported considerably greater current family support than all other categories, with small to large effect sizes (d = 0.23 to 0.84). INTs also reported higher levels of current school/work and neighborhood/community support than the other groups (d = 0.25 to 0.86).

Since the category of disclosure to "people with whom [participants] are religiously associated" was used as the primary distinguishing criteria between COMPs and INTs, statistical comparisons between COMPs and INTs are not useful. However, comparisons regarding disclosure to immediate family, friends, and coworkers/classmates can still be made. INTs reported the highest levels of disclosure in all the three non-religious disclosure contexts, followed in order by RRIs, COMPs, and RLIs. Differences between INTs and other groups in terms of disclosure were significant in all categories, often with large effect sizes (immediate family: d = 0.63 to 2.10; friends: d = 0.55 to 3.03; coworkers/classmates: d = 0.49 to 2.71).

Religiosity. Regarding participants' reported early religious beliefs, no differences were found in belief in God, but INTs were more likely, and RRIs less likely than other groups to believe in Christ, Joseph Smith (as a prophet), and *The Book of Mormon* prior to acknowledging their SSA (Table 3.4). For RRIs this suggests the

Table 3.3

Identity Negotiation Category Differences in Social Support and Disclosure

	RLI			COMP			RRI			INT			One-way ANOVA			
Variables	*n*	*M*	*SD*	*n*	*M*	*SD*	*n*	*M*	*SD*	*n*	*M*	*SD*	*F*	*df*	*p*	η2
Early support																
Family	78	1.08	1.39	543	0.87	1.26	788	0.99	1.43	63	1.63	1.63	6.14	3, 1468	<.001	0.01
Community	78	1.19	1.28	548	1.06	1.30	788	1.07	1.49	65	1.45	1.57	1.65	3, 1475	0.176	0.00
Current openness/support																
Parents/family	82	1.43	1.44	553	1.80	1.57	790	2.34	1.68	65	2.72	1.62	19.99	3, 1486	<.001	0.04
Work/school	81	2.77	1.88	551	2.63	1.77	787	3.57	1.51	64	3.91	1.17	42.48	3, 1479	<.001	0.08
Neighborhood/community	82	2.10	1.59	553	1.92	1.56	789	2.80	1.61	65	3.08	1.47	38.29	3, 1485	<.001	0.07
Disclosure																
Immediate family	77	2.44	1.53	552	2.71	1.51	786	4.17	1.35	65	4.80	0.44	151.30	3, 1476	<.001	0.24
Friends	77	2.14	1.11	553	2.71	1.21	785	4.26	1.06	65	4.71	0.46	279.37	3, 1476	<.001	0.36
Coworkers/classmates	77	1.52	1.05	552	2.01	1.22	783	3.67	1.38	65	4.26	0.97	233.11	3, 1473	<.001	0.32
Religious	78	1.99	0.95	555	1.81	0.69	747	3.10	1.62	65	4.42	0.50	162.02	3, 1441	<.001	0.25

Table 3.4

Identity Negotiation Category Differences in Religiosity

	RLI		COMP		RRI		INT		Totals		Chi square		
Variables	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%	*df*	$\chi 2$	*p*
Early beliefs													
Believe in God?	76	93	515	93	710	90	63	97	1,493		3	6.74	0.081
Believe in Jesus?	75	92	501	90	659	83	63	97	1,493		3	21.77	<.001
Believe in Joseph Smith?	74	90	468	84	590	75	60	92	1,493		3	32.27	<.001
Believe in *The Book of Mormon*?	73	89	468	84	589	75	61	94	1,493		3	33.28	<.001
Current beliefs													
Believe in God?	75	92	493	89	405	51	60	92	1,493		3	255.87	<.001
Believe in Jesus?	71	87	447	81	220	28	53	82	1,493		3	428.80	<.001
Believe in Joseph Smith?	68	83	368	66	81	10	41	63	1,493		3	538.34	<.001
Believe in *The Book of Mormon*?	69	84	366	66	81	10	38	59	1,493		3	532.89	<.001
Spiritual manifestations regarding SSA													
Spiritual manifestation of God's acceptance	21	27	275	50	357	46	42	65	1,476		3	22.92	<.001
Spiritual manifestation of God's condemnation	23	31	90	17	104	14	11	17	1,459		3	16.02	0.001

(*table continues*)

	RLI		COMP		RRI		INT		Totals		Chi square		
Variables	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%	*df*	χ2	*p*
Sources of alienation													
LDS religious doctrine	6	7	91	16	508	64	13	20	1,493		3	364.4	<.001
LDS policies about homosexuality	5	6	240	43	672	85	40	62	1,493		3	374.49	<.001
Member attitudes about homosexuality	8	10	248	45	619	78	37	57	1,493		3	252.26	<.001
Mistreatment from LDS people	3	4	87	16	291	37	10	15	1,493		3	103.17	<.001
Mistreatment from local LDS Church leaders	2	2	69	12	220	28	13	20	1,493		3	64.85	<.001
Loss of faith in God	4	5	38	7	262	33	2	3	1,493		3	165.22	<.001
Current LDS Church status													
Active (attend church at least 1x/month)	73	91	325	61	0	0	23	37	421	29			
Inactive (attend church less than 1x/month)	4	5	166	31	316	42	24	38	510	36			
Disfellowshipped	3	4	16	3	20	3	3	5	42	3			
Excommunicated	0	0	12	2	75	10	6	10	93	7			
Resigned	0	0	13	2	344	46	7	11	364	25			
Total	80		532		755		63		1,430		12	832.12	<.001

possibility of deviation from the LDS norm for doctrinal reasons unrelated to sexual orientation. Regarding current beliefs, RLIs reportedly significantly higher, and RRIs significantly lower beliefs than all the other groups. While current belief in God and Christ remained above 80% for RLIs, COMPs, and INTs, reported belief in Joseph Smith and *The Book of Mormon* for COMPs and INTs ranged between 59% and 66%.

Regarding self-reported LDS Church status, activity rates declined sharply between groups in the following order: RLIs (91%), COMPs (61%), INTs (37%), and RRIs (0%). Over half of RRIs reported to no longer be members of the LDS Church, either through membership resignation or excommunication. When asked the church attended most frequently, 75.5% of RRIs reported to be either agnostic (14.2%), atheist (13.3%) or "None" (48%). Across all groups, 60% remain religiously affiliated to some degree. In response to the question about receiving a spiritual manifestation regarding God's acceptance or condemnation of participant SSA, INTs were significantly more likely, and RLIs significantly less likely, to report an affirming manifestation from God. Conversely, RLIs were significantly more likely, and RRIs considerably less likely, to receive a condemnatory manifestation from God. For RRIs, COMPs, and INTs, the largest sources of alienation from the LDS Church were policies and member attitudes about homosexuality. Reports of mistreatment from LDS people or leaders as the cause of alienation were relatively low. Except for RRIs (33%), loss of faith in God as a source of alienation is extremely low.

Attempts to cope with, accept, and change SSA. Results related to coping with SSA can be found in Table 3.5. Regarding beliefs about the causes of SSA, RLIs were significantly less likely than the other groups to ascribe a biological origin to SSA, and

Table 3.5

Identity Negotiation Category Differences in Coping

	RLI		COMP		RRI		INT		Chi Square			
Variables	*n*	%	*n*	%	*n*	%	*n*	%	*df*	*n*	$\chi 2$	*p*
Beliefs about general causes of SSA												
Dysfunctional parent-child relationship	53	65	180	32	63	8	11	17	3	1,493	222.76	<.001
Victim of sexual abuse	51	62	164	30	73	9	5	8	3	1,493	188.93	<.001
Early SS sexual experiences	46	56	190	34	88	11	10	15	3	1,493	158.12	<.001
Biology	52	63	426	77	690	87	54	83	3	1,493	43.93	<.001
Spiritual failure/weakness/Satan	15	18	41	7	7	1	2	3	3	1,493	73.64	<.001
Personal choice	24	29	58	11	68	9	5	8	3	1,493	34.66	<.001
Past efforts to cope with, accept, or change												
Individual effort	63	77	416	75	554	70	50	77	3	1,493	5.495	0.139
Personal righteousness	71	87	455	82	497	63	57	88	3	1,493	77.490	<.001
Psychotherapy	47	57	296	53	449	57	45	69	3	1,493	6.460	0.091
Church counseling	53	65	292	53	309	39	45	69	3	1,493	50.150	<.001
Past attempt at sexual orientation change												
Yes	63	77	409	74	466	59	46	71		984	66%	
No	19	23	146	26	325	41	19	29		509	34%	
Total	82		555		791		65		3	1,493	37.24	<.001

(*table continues*)

	RLI		COMP		RRI		INT		Chi Square			
Variables	*n*	%	*n*	%	*n*	%	*n*	%	*df*	*n*	$\chi 2$	*p*
Current efforts to cope with, accept, or change												
Individual effort	38	46	137	25	83	10	10	15	3	1,493	91.12	<.001
Personal righteousness	42	51	147	26	18	2	9	14	3	1,493	249.33	<.001
Psychotherapy	9	11	67	12	49	6	6	9	3	1,493	14.63	0.002
Church counseling	13	16	67	12	6	1	6	9	3	1,493	87.84	<.001
Currently engaged in SOCE												
Individual effort	22	27	73	13	12	2	7	11	3	1,493	92.12	<.001
Personal righteousness	30	37	94	17	10	1	8	12	3	1,493	249.33	<.001
Psychotherapy	6	7	29	5	13	2	2	3	3	1,493	14.63	0.002
Church counseling	9	11	44	8	5	1	4	6	3	1,493	87.84	<.001

considerably more likely to attribute SSA to factors (dysfunctional parenting, sexual abuse, early same-sex sexual experiences, spiritual failure/weakness/Satan, and personal choice) suggesting the possibility of orientation change. Around 91% of participants reported engaging in at least one type of effort to cope with, accept, or change their sexual orientation throughout their lifetime (e.g., personal righteousness, church counseling, psychotherapy). Statistical differences between groups in terms of past usage of various efforts were only found for three of the nine general interventions—personal righteousness, ecclesiastical counseling, and group retreats. Overall, RRIs were much less likely to have utilized religious SOCE. RLIs were considerably more likely to have engaged in group retreats (usually sponsored by LDS-affirming organizations) than the other categories. Approximately 66% of the total sample reported engaging in at least one sexual orientation change effort (SOCE), with small percentages indicating current engagement in SOCE: personal righteousness (10%), individual effort (8%), church counseling (4%), and psychotherapy (3%). RLIs were most likely (over 37%) to be currently engaged in SOCE, while RRIs were least likely.

Psychosocial health. Psychosocial health results can be found in Table 3.6. Statistically significant differences in psychosocial health were found between every category, with eta squared effect sizes ranging from .01 to .35. RLIs and COMPs reported consistently poorer scores on internalized homophobia (IH), identity confusion (IC), sexual identity distress (SID), and depression than RRIs and INTs; RLIs scored significantly worse than COMPs on the first three measures (no difference with depression). Effect size ranges when comparing RLI with the other groups were as follows: IH (d = 1.09 to 2.80), IC (d = 0.28 to 1.01), SID (d = 0.51 to 1.80), and

Table 3.6

Identity Negotiation Category Differences in Psychosocial Health

	RLI			COMP			RRI			INT			One-way ANOVA			
Variable	*n*	*M*	*SD*	*n*	*M*	*SD*	*n*	*M*	*SD*	*n*	*M*	*SD*	*F*	*df*	*p*	η2
Internalized homophobia	81	5.61	1.31	554	3.89	1.80	789	2.08	1.20	65	2.36	1.23	264.33	3, 1485	<.001	0.35
Identity confusion	79	2.87	1.50	552	2.44	1.55	788	1.56	1.06	65	1.60	1.03	66.24	3, 1480	<.001	0.12
Depression	82	2.28	1.15	554	2.32	1.03	790	1.97	0.94	65	1.78	0.79	17.17	3, 1487	<.001	0.03
Quality of life	82	81.78	15.02	554	79.90	14.01	790	83.71	13.53	65	88.00	13.62	12.08	3, 1487	<.001	0.02
Sexual identity distress	81	16.30	6.81	555	12.86	6.80	789	5.94	5.71	65	5.85	4.59	181.25	3, 1486	<.001	0.27
Self-esteem	82	3.03	0.68	555	3.04	0.65	791	3.29	0.59	65	3.35	0.61	20.93	3, 1489	<.001	0.04

depression (d = 0.51 for INTs only). COMPs also scored significantly poorer on IH than RRIs and INTs (d = .99 to 1.19). INTs and RRIs reported higher quality of life and self-esteem scores, with INTs having the highest overall QOL scores, and statistically significant differences from both COMPs and RLIs (d = 0.43 to 0.59).

Discussion

The overwhelming majority of participants in this study reported either rejecting their LDS identity, or living double lives through compartmentalizing their religious and sexual identities. Conversely, very few participants reported either rejecting their LGBT identities, or openly integrating their religious and sexual identities. These findings likely reflect the relative centrality of sexuality in the human experience, and the perceived difficulty of active church participation for open LGBT Mormons. Overall, psychosocial health and quality of life scores were significantly better for those who either integrated their sexual and religious identities, or who rejected their LDS religious identities altogether. Those who rejected their LGBT identities or compartmentalized their religious and sexual identities reported significantly lower psychosocial health and quality of life scores. Prior research seems to predict this outcome (Cass, 1979; Dahl & Galliher 2012a, 2012b; Pitt, 2010).

Rejecters of LGBT Identity

RLIs were relatively rare (6%). Factors that appear to be associated with rejecting an LGBT identity included being a man, in a heterosexual marriage, a parent, bisexual Kinsey ratings for same-sex attraction, higher levels of religious belief, and lower levels

of family support for LGBT identities. In spite of bisexual Kinsey ratings, RLIs were most likely to identify as heterosexual. RLIs were less likely to disclose their SSA to family, friends, and work associates. RLIs were least likely to be sexually active outside of committed relationships, and most likely to be celibate by choice (if single). RLIs were least likely to endorse biological origins of same-sex attraction, most likely to endorse environmental, social, or experiential causes, and most likely to have engaged in SOCE both in the past and in the present. RLIs were the least likely to report a spiritual manifestation of God's acceptance of their SSA, and most likely to endorse a spiritual manifestation of God's condemnation of their SSA. Regarding psychosocial health, RLIs in general reported the highest levels of internalized homophobia, identity confusion, depression, and sexual identity distress, and the lowest levels of self-esteem and quality of life.

These findings match well with Pitt's (2010) description of those who reject their homosexual identity as experiencing "identity confusion," and also align with Cass's (1979) Stage 1 of homosexual identity formation. The smaller RLI group size in this study, along with the high levels of reported sexual identity distress and confusion, suggest that this identity might be difficult to maintain for many. Related findings regarding the relatively high failure rates of LDS mixed-orientation marriages also support this possibility (see Chapter 4).

Compartmentalizers

COMPs were similar to RLIs in several respects: (a) heavy familial, social, geographical, and religious pressures to eschew a public LGBT identity, (b) low levels of

LGBT disclosure, (c) comparable levels of LDS Church activity and belief, (d) lower involvement in committed same-sex relationships, (e) considerable SOCE participation, and (f) high psychosocial costs associated with these choices. COMPs were different from RLIs in that they are far more prevalent, and because they reported: (a) higher Kinsey attraction scores, (b) a willingness to identify (at least internally) as LGBT, (c) slightly lower levels of belief in fundamental LDS truth claims, (d) higher levels of LDS alienation, (e) higher levels of celibacy due to lack of partner, and (f) relatively high levels of same-sex sexual behavior (in the context of clear prohibition of same-sex behavior in their faith community). COMPs were also significantly more likely to identify as bisexual than any other group.

Since COMPs and RLIs seem to share several attributes (e.g., age, religious beliefs and participation, family dynamics, SOCE participation) we theorize that higher Kinsey attraction scores for COMPs, along with lower heterosexual marriage and parenting rates, might explain a significant portion of these differences (e.g., COMP willingness to assume an LGBT identity, higher COMP levels of same-sex sexual behavior, increased LDS alienation for COMPs). It is possible that many COMPs were simply unable to marry heterosexually (due to very strong same-sex and weak other-sex attraction), but were still trying to maintain their religious identities. Pitt (2010) noted that COMPs often experience considerable identity conflict via their church participation, both because of the lack of social events geared towards their sexual orientation and because of dissonance between church teachings/beliefs and their sexual identity/behavior. These sources of dissonance could help to explain the four to six-fold

increases in LDS alienation rates for COMPs.

Rejecters of Religious Identity

RRIs were the most common category, comprising over half of the total sample. Factors associated with religious identity rejection included: being a woman, being in a committed same-sex relationship, not being a parent, non-Utah residency, increased age, and high Kinsey scores. Over 90% of RRIs identified as LGBT, with very few identifying as heterosexual or SSA/SGA. RRIs were the least likely group to report celibacy. RRIs showed high levels of LGBT identity disclosure to family, friends, and coworkers, and relatively high levels of support from these groups. RRIs reported very low levels of current religious belief or participation (LDS or otherwise), and very high levels of alienation from the LDS Church—mostly due to LDS policies, doctrine, and member attitudes regarding LGBT issues. RRIs were most likely to embrace biological explanations for SSA, and least likely to have attempted sexual orientation change or to be currently engaged in such efforts. Finally, RRIs reported relatively low levels of internalized homophobia, identity confusion, depression and sexual identity distress, and relatively high levels of quality of life and self-esteem (when compared with RLIs and COMPs).

The finding that over half (53%) of the participants in this study rejected their LDS identity aligns well with the high levels of LDS religious disaffection found by Dahl and Galliher (2012a, 2012b). Further investigation is warranted to understand the extent to which the slightly lower reports of religious belief for RRIs prior to acknowledging their SSA is related to their eventual LDS Church disaffection. While Pitt (2010) noted

that many LGBT individuals turn to more LGBT-affirming churches upon rejecting their own religious identity, this study indicates that within the Mormon LGBT population, such re-affiliation is much less common than complete religious disaffiliation. Finally, as RRIs report significantly higher psychosocial functioning and quality of life scores than RLIs and COMPs, we theorize that high levels of LGBT identity disclosure, engaging in identity-congruent romantic and sexual relationships, and distance from non-affirming religious contexts are important components to overall health and well-being.

Integrators

INTs were the rarest of all categories (at 4%). Demographic factors associated with INTs included being a man, not being in a heterosexual marriage or a parent, and living outside of Utah. INTs reported the highest Kinsey scores, and were most likely to identify as gay. INTs were more likely to be sexually active in a same-sex relationship. Regarding support, INTs reported the highest levels of both early and current family, community, and work/school support, along with the highest levels of LGBT disclosure. Approximately 40% of INTs reported "active" LDS Church status (i.e., attending church at least once a month). INTs report moderately high levels of current religious beliefs, with a little less than 2/3rds maintaining traditional LDS beliefs. INTs were the most likely to report a spiritual manifestation of God's acceptance of their SSA but reported moderate levels of alienation from the LDS Church. Across the board, INTs were the most likely to have engaged in efforts to either cope with or accept their sexual orientation. Finally, in general, INTs reported comparably equivalent levels of internalized homophobia, identity confusion, depression, sexual identity distress and self-

esteem when compared with RRIs, but reported the highest levels of overall quality of life.

According to theorists such as Cass (1979), Pitt (2010), and Troiden (1989), this stage of "identity synthesis" allows INTs to simultaneously live authentically and congruently with their sexual identity, and to maintain the protective benefits of religious identity and engagement. While INTs appear to have the "best of both worlds," further investigation is warranted to understand what factors allow INTs to experience LDS Church participation as less deleterious, and to understand how sustainable this identity is over the long term (given its low average age relative to RRIs). Further study is also warranted to understand the relationship between the INT category, and higher levels of LGBT identity disclosure and family support.

Limitations

There are several limitations to this study, including the reliance on convenience sampling for recruiting purposes, and self-report for data collection. It is almost certain that women, racial minorities, and non-U.S. residents are highly underrepresented in this sample, even as this sample represents the largest number of SSA-LDS ever studied. Even though conservative statistical approaches were used to compare across the Pitt groups (i.e., never assuming homogeneity of variance), the large differences in group size were certain to have impacted the statistical analyses. Identity differences in men vs. women were not analyzed in this study, and are likely meaningful. In addition, it is almost certain that the two largest groups (RRIs and COMPs) are heterogeneous in nature, and merit more detailed analysis to flesh out meaningful sub-group variability.

Finally, it is difficult to determine causality in the absence of longitudinal data.

Summary

The findings from this study suggest that rejecting one's religious identity is the most common path for LDS LGBT individuals. This option appears to be associated with greater psychosocial health and quality of life than either rejecting one's LGBT identity, or compartmentalizing one's religious and sexual identities. The following factors are worth investigating more deeply as positive correlates with overall positive psychosocial well-being and quality of life for religious and formerly-religious LGBT Mormons: (a) accepting one's LGBT identity, (b) coming out as LGBT to family, friends, religious, and work associates, (c) eschewing both single/celibate status and heterosexual marriage, and instead pursuing committed, same-sex relationships, (d) a reduction in LDS activity, along with seeking to obtain spiritual confirmation from God accepting one's SSA, (e) eschewing sexual orientation change efforts, and (f) living outside of Utah. Finally, while rejecting one's religious (LDS) identity appears to be associated with better psychosocial health and quality of life (when compared with either rejecting one's LGBT identity or compartmentalizing their religious and sexual identities), evidence from this study suggests that integrating one's religious beliefs into their open sexuality could be the healthiest of all scenarios, though this approach appears to be very rare, and merits further study.

Finally, an analysis of the relative significance of these variables leads to an explanatory model whose central feature is likely the outcome of intense orientation change efforts (see Chapter 2). For those on the same-sex end of the Kinsey scale

continuum for attraction (5-6), the failure to alter core erotic feeling can have highly negative consequences for feelings of identity, self-esteem, and the maintenance of religious faith. Relief from this internal conflict is often achieved through disassociation from the LDS Church. Those who identify as bisexual (or are near the heterosexual end of the scale) feel less need to seek affirmation from deity, and find a greater range of options for accommodation, including heterosexual marriage. Closeted in various degrees, some of the latter suffer a decline in psychosocial health. Some, in an effort to align most closely with LDS norms, eschew a homosexual identity and support explanations (like dysfunctional parenting) most likely to yield to change therapy. While this latter situation may be difficult to maintain, others find a more satisfactory and stable resolution through achieving compatibility between their sexual and religious lives. Overall, our data show that across all four groups, 66% have sought orientation change, 30% have entered heterosexual marriage, 60% have retained some religious affiliation, and 6% are reluctant to apply standard LGBTQ identity designations. Further investigation is warranted to determine if LDS are somewhat unique among highly religious non-heterosexuals in these respects.

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CHAPTER 4

PSYCHOSOCIAL CORRELATES OF RELIGIOUS APPROACHES TO SAME-SEX ATTRACTION: A MORMON PERSPECTIVE[3]

Abstract

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%.

Introduction

Approximately 83% of U.S. adults self-identify as religious (Pew Forum on Religion & Public Life, 2008), with 11% (25.6 million) acknowledging at least some

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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 Task Force, 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 Task Force, 2009; Bradshaw, Dehlin, Crowell, Galliher, & Bradshaw, 2014; see also Chapters 2 and 3 in this dissertation).

To assist 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, Chivers, & Bailey, 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 Task Force, 2009; Beckstead & Morrow, 2004; Bradshaw et al., 2014; Jones & Yarhouse, 2007; Nicolosi, Byrd, & Potts, 2000;

Throckmorton & Welton, 2005; see also Chapters 2 and 3 in this dissertation). 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 Task Force, 2009).

Beliefs about the Etiology of Same-Sex Attraction

Considerable evidence implicates various biological influences on same-sex sexuality including genetics, neeurohormonal 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 (Church of Jesus Christ of Latter-day Saints, 2010; Dobson, 2013; Jews Offering New Alternatives of Homosexuality [JONAH], 2001). A number of studies over the past 10 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, Pfeffer, Jayaratne, Feldbaum, & Petty, 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 and colleagues (see Chapter 3) found higher prevalence rates of psychosocially-based beliefs about SSA etiology amongst 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 Task Force, 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 Task Force, 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., 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, Ellison, & Larson, 2002; Smith, McCullough, & Poll, 2003). George and colleagues 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, Antoni, Ironson, & Kling, 1999), and that personal religious devotion amongst 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: (a) feelings of inadequacy and religious-related guilt, often persisting even after disaffiliation from their religion, (b) depression related to coming out, and (c) 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 and colleagues (see Chapter 2) 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, Christopher, Walter, Mourad, & Marek, 2006; Ryan, Russell, Huebner, Diaz, & Sanchez, 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 et al., 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; Sobo & Bell, 2001). However, as Sipe (2008) wrote, "Most religious commentators…are loath to address the more practical realities and difficulties of becoming celibate and maintaining the practice" (p. 548). Sipe continued, "The separation or disregard of the natural foundations of celibate asceticism is a serious flaw in its achievement" (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 Task Force, 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, 2002; 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), "[M]arriage 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 10-20% of gay men in the U.S. 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 MOMs (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). Unfortunately, MOMs are often characterized by a considerable array of negative dynamics including sexual and emotional dissonance, disorientation, despair, spiritual turmoil, insecurity, resentment, pain, and infidelity (Hernandnez, Schwenkie & Wilson, 2011). Most significantly, estimates put the divorce rate of MOMs somewhere between 50% and 85% (Buxton, 1994, 2001; Wolkomir, 2004).

The Present Study

The present study attempted to understand and explore the prevalence and psychosocial correlates of religion- and nonreligion-based approaches to same-sex sexuality, based on a large survey of current and former Mormons who experience SSA. Specific religious approaches to be examined include: psychosocial (vs. biological) beliefs about the etiology of SSA, religious 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 explored in this study included the following.

1. What are the psychosocial implications for LGBT individuals who espouse a biological versus psychosocial view of SSA etiology?

2. What are the mental health implications and effectiveness rates for the various religion-based recommendations for dealing with SSA, including: (a) increased church activity, (b) celibacy, and (c) mixed-orientation marriages.

3. 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 4.1. The mean age for respondents was 36.9 (SD = 12.58). Approximately 95% of participants lived in the U.S. (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).

Table 4.1

Demographic Counts of Participants

Variable	*n*	%	Variable	*n*	%
Biological sex			Sexual orientation		
Female	388	24.1	Gay	995	61.8
Male	1,222	75.9	Lesbian	221	13.7
			Bisexual	234	14.5
Race/ethnicity			Heterosexual	79	4.9
White/Caucasian	1,466	90.9	SSA or SGA	20	1.2
Multi-racial	72	4.5	Other	62	3.8
Latino(a)	35	2.2			
Other	36	2.2	Ever married heterosexually?	500	31.3
			Currently a parent?	462	28.9
Age cohort					
Teens (18-19)	39	2.4	Relationship status		
20s	530	32.9	Single	657	42.4
30s	422	26.2	Heterosexual marriage	240	15.5
40s	312	19.4	Legal SS relationship	202	13.0
50s	216	13.4	Non-Legal SS relationship	366	23.6
60s	76	4.7	Divorced/separated	83	5.4
70s	9	0.6			
			Current LDS Church status		
Highest education completed			Active	444	28.8
Elementary school	1	0.1	Inactive	559	36.3
High school degree	42	2.7	Disfellowshipped	46	3.0
Technical or trade school	63	4.0	Excommunicated	103	6.7
Some college	469	29.7	Resigned	388	25.2
College graduate	537	34.0			
Professional or graduate degree	467	29.6	Church attended most frequently		
			LDS	745	46.9
Annual income			None/Agnostic/Atheist	634	39.9
$24,000 or less	493	30.9	Episcopalian	30	1.9
$25-000 - $49,000	420	26.3	Unitarian Universalist	29	1.8
$50,000 - $74,999	294	18.4	Buddhist	21	1.3
$75,000 - $99,999	162	10.2	Other	131	8.2
$100,000 and above	225	14.1			
			Sexual activity		
Country of residence			Celibate by choice	224	14.0
U.S.A.	1,515	94.5	Celibate due to no partner	290	18.1
Other	89	5.5	Sex. active comm. rel.	801	49.9
			Sex. active no comm. rel.	290	18.1
Utah State Residence	720	44.7			

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 (married, committed relationship, single, divorced, etc.), 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: (a) sexual behavior/experience, (b) feelings of sexual attraction, and (c) self-declared sexual identity on a 7-point Likert-type scale (modeled after the Kinsey scale; Kinsey, Pomeroy, & Martin, 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 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 et al., 1989). The QOLS has demonstrated internal consistency (α = .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 α = .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 α = .85 and has demonstrated good validity. Cronbach's alpha for the current sample was α = .92.

Sexual Identity Distress Scale. The 7-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 α = .83. Cronbach's alpha for the current sample was α = .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 (see Chapter 2), 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 like 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 versus 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 (3 of 12 significant associations) and the lack of diversity in the sample necessitated collapsing all ethnic minority participants in to one group. Educational status was significantly related to several other study variables (7 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 non-biological 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 (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 4.2, not endorsing a biological etiology for SSA was associated with higher levels of internalized homophobia 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 4.3, those reporting an "active" LDS Church status reported the poorest scores of all the church-related groups across all five psychosocial measures. One-way ANOVAs for LDS Church status showed significant

Table 4.2

Mental Health Associations for Varying Beliefs about the Causes of Same-Sex Sexuality

	Selected			Not selected						
Variables	*n*	*M*	*SD*	*n*	*M*	*SD*	*F*	*df*	*p*	η2
Biological causes										
Internalized homophobia	1,292	2.78	1.68	298	3.69	2.06	67.82	1,1585	<.001	.041
Sexual identity distress	1,293	8.41	6.70	298	11.68	8.61	55.50	1,1586	<.001	.034
Depression	1,295	2.09	0.99	298	2.12	1.03	0.33	1,1588	0.568	.000
Self-esteem	1,296	3.20	0.63	299	3.10	0.69	7.31	1,1590	0.007	.005
Quality of life	1,296	82.65	13.7	297	81.1	16.1	3.66	1,1588	0.056	.002
Spiritual failure or weakness to Satan's temptation										
Internalized homophobia	69	5.59	1.41	1,521	2.83	1.71	168	1,1585	<.001	.096
Sexual identity distress	69	18.04	6.13	1,522	8.61	6.98	118	1,586	<.001	.069
Depression	69	2.65	1.13	1,524	2.07	0.99	21.9	1,1588	<.001	.014
Self-esteem	69	2.71	0.68	1,526	3.21	0.63	39.3	1,1590	<.001	.024
Quality of life	69	75.84	16.19	1,524	82.65	14.0	15.1	1,1588	<.001	.009
Dysfunctional parent-child relationship in the home										
Internalized homophobia	327	4.44	1.84	1,263	2.57	1.56	326	1,1585	<.001	.171
Sexual identity distress	327	13.97	6.67	1,264	7.74	6.78	207	1,1586	<.001	.116
Depression	327	2.45	1.03	1,266	2.01	0.97	49.1	1,1588	<.001	.030
Self-esteem	327	2.94	0.63	1,268	3.25	0.63	56.0	1,1590	<.001	.034
Quality of life	327	78.32	14.36	1,266	83.40	13.95	31.3	1,1588	<.001	.019
Being a victim of sexual abuse										
Internalized homophobia	315	4.37	1.85	1,275	2.60	1.60	291	1,1585	<.001	.155
Sexual identity distress	315	13.74	7.09	1,276	7.86	6.75	184	1,1586	<.001	.104
Depression	315	2.41	1.06	1,278	2.02	0.97	36.1	1,1588	<.001	.022
Self-esteem	315	2.98	0.65	1,280	3.23	0.63	34.9	1,1590	<.001	.022
Quality of life	315	78.65	14.24	1,278	83.27	14.02	24.5	1,1588	<.001	.015

Table 4.3

Psychosocial Health Associations with Level of LDS Church Participation

	Active (*n* = 435-437)		Inactive (*n* = 554-555)		Disfellowshipped (*n* = 46)		Resigned (*n* = 381-383)		Excommunicated (*n* = 102)		One-way ANOVA			
Variable	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F*	*df*	*p*	η2
Internalized homophobia	4.41	1.82	2.65	1.49	3.09	1.71	1.92	1.10	2.21	1.37	152.95	4, 1510	<.001	.288
Sexual identity distress	14.11	6.92	8.25	6.37	9.76	7.43	5.11	5.47	5.69	5.56	111.27	4, 1511	<.001	.228
Depression	2.33	1.02	2.12	1.03	1.88	0.85	1.91	0.91	1.76	0.83	11.51	4, 1513	<.001	.030
Self-esteem	3.02	0.64	3.16	0.67	3.13	0.69	3.36	0.55	3.39	0.52	15.37	4, 1515	<.001	.039
Quality of Life	80.18	13.89	81.13	14.32	82.91	14.60	85.51	13.42	86.77	12.27	9.82	4, 1513	<.001	.025

differences among groups on all five psychosocial measures ($p < .001$), with large between-group differences for internalized homophobia and sexual identity (η^2 of .29 and .23, respectively), and small between-group differences on depression, self-esteem, and quality of life (η^2 of between .03 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 to 1.66), and small to medium effects size differences on depression and self-esteem (d = .17 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, nonlegal 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 4.4 (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.

Table 4.4

Psychosocial Health Associations with Relationship Status

	Single (n = 650)		Heterosexual marriage (n = 235-237)		Nonlegal SS relationships (n = 362)		Legal SS relationships (n = 198-199)		One-way ANOVA			
Variable	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F*	*df*	*p*	η2
Internalized homophobia	3.17	1.82	4.34	1.86	2.24	1.30	1.89	0.98	111.32	3,1438	<.001	.188
Sexual identity distress	9.99	7.28	14.12	7.22	6.61	5.76	4.46	4.43	96.95	3,1439	<.001	.168
Depression	2.33	1.01	2.28	1.08	1.87	0.92	1.61	0.73	35.90	3,1440	<.001	.070
Self-esteem	3.05	0.64	3.09	0.68	3.32	0.61	3.47	0.49	25.74	3,1442	<.001	.051
Quality of Life	78.34	14.45	81.36	14.30	86.31	13.33	88.83	11.59	39.54	3,1440	<.001	.076

Note. Those self-identifying as "divorced/separated" (n = 83) were not included in this analysis.

ANOVAs 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 (η^2 of .19 and .17, respectively), and small to medium between-group differences on depression, self-esteem, and quality of life (η^2 between .05 and .08). Pairwise comparisons between the LSSR group and the "Single" group revealed large differences across all of the measures (d = .74 to .92). Differences between the LSSR and "heterosexual marriage" groups were medium to large (d = .59 to 1.66). Differences between the LSSR and NLSSR groups were small to medium (d = .21 to .42). Differences between the single and heterosexually married groups for internalized homophobia and sexual identity distress were medium (d = .58 to .65), small for quality of life (d = .21), and nonsignificant for depression and self-esteem.

Regarding success/divorce rates of MOMs, 31% (n = 500) of survey respondents reported entering into a 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 multi-generational 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 4.5, 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.

ANOVAs 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 (η^2 of .10 and .08, respectively), and smaller between-group differences on depression, self-esteem, and quality of life (η^2 of between .04 and .08). Pairwise comparisons between the SAC group and the "celibacy by choice" group revealed medium to large differences (d = .53 to .95). Differences between the SAC and "celibacy no partner" groups were small to medium (d = .21 to .73). Differences between the SAC and SANC groups were either nonsignificant (internalized homophobia and sexual identity distress) or small (d = .22 to .39). Differences between the celibacy by choice and celibacy due to lack of partners groups were nonsignificant for depression, self-esteem, and quality of life, medium for

Table 4.5

Psychosocial Health Associations with Reported Sexual Activity Status

	Celibate – Choice (n = 220)		Celibate - no partner (n = 288)		Sexually active - No committed relationship (n = 287)		Sexually active - Committed relationship (n = 788-793)		One-way ANOVA			
Variables	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F*	*df*	*p*	η2
Internalized homophobia	4.36	1.83	2.92	1.61	2.66	1.66	2.67	1.71	58.68	3,1576	<.001	.100
Sexual identity distress	14.15	6.97	9.26	6.97	8.14	6.83	7.78	6.85	47.88	3,1577	<.001	.083
Depression	2.39	1.02	2.46	1.03	2.12	0.98	1.88	0.92	31.54	3,1579	<.001	.057
Self-esteem	2.98	0.64	3.01	0.64	3.17	0.66	3.31	0.60	22.67	3,1581	<.001	.041
Quality of Life	78.04	14.36	76.51	13.94	81.02	14.71	86.21	12.85	44.30	3,1579	<.001	.078

sexual identity distress (d = .71), and large for internalize homophobia (d = .83).

Discussion

This study assessed the psychosocial health implications of observing church-recommended approaches towards same-sex attraction within one particular religious tradition (the LDS Church) 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 nonbiologically-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, 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 (Church of Jesus Christ of Latter-day Saints, 2010; Whitehead & Baker, 2012). One example from LDS apostle Dallin H. Oaks (Church of Jesus Christ of Latter-day Saints, 2006) illustrated:

> 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 non-legal, 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, 2012; Williams et al., 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 (Hernandnez et al., 2011), celibacy (Sipe, 2008), and family rejection of LGBT individuals (Ryan, Huebner, Diaz, & Sanchez, 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 in to 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 overrepresents 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 psychoeducation regarding the possible benefits of (a) biologically based views on LGBT etiology, (b) disaffiliation from non-LGBT-affirming churches, and (c) legal, same-sex committed relationships for LGBT religious individuals.

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CHAPTER 5

SUMMARY AND CONCLUSIONS

The purpose of this dissertation was to better understand the many ways in which LGBT individuals raised in conservative, non-LGBT-affirming religious traditions cope with the conflict between their sexuality and their religiosity, based on a sample of 1,612 current and former members of The Church of Jesus Christ of Latter-day Saints (LDS Church or Mormons). Three primary areas explored were the following: (a) sexual orientation change efforts (SOCE), (b) religious and sexual identity conflict management, and (c) the benefits and costs of various lifestyle choices commonly encouraged and/or condemned by conservative religious organizations, such as increased religious participation, celibacy, mixed-orientation marriage, and same-sex marriage.

Sexual Orientation Change Efforts

SOCE Prevalence

In spite of considerable evidence suggesting the potential harm of SOCE (APA Task Force, 2009), LDS Church leaders have historically either directly or indirectly encouraged various forms of SOCE as a means to cope with same-sex sexuality (O'Donovan, 1994). As would be expected, this study showed that an overwhelming majority of male respondents (73% at minimum) and a significant minority of female respondents (at least 43%) reported efforts to change their sexual orientation. Regarding the duration of these efforts, participants reported attempting sexual orientation change

for approximately ten years on average, using three different SOCE methods. The four most common methods of attempting change (in descending order) were personal righteousness (e.g., prayer, scripture study, fasting, temple attendance), individual efforts (e.g., introspection, private study, mental suppression, dating the opposite sex, viewing opposite-sex pornography), church counseling (e.g., bishops), and psychotherapy. Overall, religious and private efforts (exceeding 85%) were far more common than therapist-led (40%) or group-based (21%) change efforts.

SOCE Effectiveness and Harm

Overall, sexual orientation change efforts were reported to be overwhelmingly ineffective, and often harmful. Of the 1,019 participants who reported attempting sexual orientation change, 99.9% reported some combination of either continued same-sex attraction, continued same-sex sexual behavior, and/or an LGBT identity. Of the 5% who reported a non-LGBT identity (e.g., heterosexual, "same-sex attracted"), the average reported Kinsey attraction score of this group was $M = 3.02$—a score most commonly associated with bisexuality (not heterosexuality). Approximately 3% of SOCE participants did report some success in changing their sexual orientation—usually amounting to slight increases in other-sex sexual attraction, slight decreases in same-sex sexual attraction, or moderate decreases in same-sex sexual activity. Only one participant (out of 1,019) reported an elimination of all same-sex attraction.

When rated by participants for effectiveness and/or harm, all of the SOCE methods were more frequently rated as either harmful or ineffective than as effective.

Three of the four SOCE methods most frequently rated as harmful were religious and/or individual in nature (e.g., personal righteousness, individual effort, and church counseling). This means that in general, the most damaging SOCE methods were also the most commonly employed of all methods—usually for the longest average durations as well. A sampling of the reported harm associated with SOCE included increased anxiety and depression, decreased self-esteem, increased self-shame, increased distance from the church and God, increased suicidality, and the wasting of time and money. When participants did rate SOCE as effective, the most commonly reported benefits were acceptance of same-sex sexuality and reductions in depression and/or anxiety—not fundamental changes in sexual orientation. In general, group-based SOCE were rated more positively than all other SOCE forms, likely due to the social benefits of these groups (e.g., normalization of experiences, no longer feeling "alone," procurement of friendships, receiving advice and validation from others). Overall, these results support and strengthen previous findings in the LGBT literature that sexual orientation is highly resistant to explicit attempts at change, and that such efforts can often have damaging consequences (APA Task Force, 2009). These results also highlight a heretofore neglected area of SOCE research (e.g., religious and private SOCE)—which appear to be far more common and damaging than therapist-led SOCE.

Navigation of Identity Conflict

Historically, LDS Church leaders have often discouraged the assumption of an LGBT identity, instead referring to same-sex sexuality as a condition to be struggled

with, and overcome (Church of Jesus Christ of Latter-day Saints, 2006, 2010). Our participants reported that when faced with conflict between their religious (LDS) and LGBT identities, a majority (53%) rejected their LDS identities. Another 37% reported compartmentalization of these conflicted identities, while relatively few reported either rejecting their LGBT identities (6%) or integrating these identities in an open way (4%). Overall, those who reported either rejecting their LDS identities or integrating their identities in an open way also reported considerably superior psychosocial health and quality of life scores, when compared with those who reported either rejecting their LGBT identities, or compartmentalizing their identities. Some of the major factors that were likely associated with improved psychosocial health and quality of life included: (a) avoiding sexual orientation change efforts, (b) accepting one's sexual orientation, (c) "coming out" to family, friends, and religious/work/school associates, (d) pursuing same-sex relationships, and eschewing either single/celibate status or heterosexual marriage, and (e) reducing and/or eliminating LDS Church participation. The average age of those rejecting their LDS identity was significantly higher than all the other groups. This factor, combined with the fact that LDS-rejecters represented over half of all respondents—possibly suggests that the "rejecting LDS identity" group might be a final destination for many who start out in the other identity groups. Finally, while rejecting one's LDS identity was associated with significantly improved psychosocial health and quality of life (when compared with compartmentalization or rejection of LGBT identity), successfully integrating one's LDS identity with one's open LGBT identity appeared to be associated with the highest psychosocial health and quality of life scores—though this

option was quite rare, and merits further study.

Religion-Based Approaches to Same-Sex Sexuality

Historically, many LDS Church leaders and faithful authors have discouraged church members from believing that same-sex attraction has biological origins, and instead have encouraged the belief that same-sex sexuality is often a product of improper parenting, improper social development, and so forth (Byrd, 2008; Church of Jesus Christ of Latter-day Saints, 2006, 2010; Mansfield, 2011). These same leaders and authors have encouraged LGBT church members to view their same-sex sexuality as a "weakness" that can often be "fixed" through increased church devotion and righteousness—ultimately leading to either mixed-orientation marriage (where possible) or celibacy (where not possible; O'Donovan, 1994). Results from this study showed that the endorsement of non-biological causes for SSA, increased LDS Church activity, mixed-orientation marriages, and celibacy were all associated with significantly poorer psychosocial health and quality of life outcomes. Conversely, those who reported to have either resigned their LDS membership, or to have been excommunicated from the church reported the healthiest scores across the board.

Regarding relationship status, those reporting either a relationship status of "single," or to be in mixed-orientation marriages, reported the poorest scores (in general) across all measures—while those reporting to be in same-sex relationships reported the healthiest scores. Interestingly, those reporting to be in legal same-sex relationships (e.g., same-sex marriage) reported significantly healthier scores than even those in non-legal

same-sex relationships. The divorce rate for MOMs in our sample exceeded 50% at the time of the survey, with an estimated eventual divorce rate of 70% based on reported divorce trends from the sample. On average, those remaining in mixed-orientation marriages reported bisexual Kinsey attraction scores, while those reporting MOM divorces reported Kinsey attraction scores more commonly associated with exclusive same-sex attractions—suggesting bisexuality as a possibly key factor in successful MOMs. Finally, those who reported to be celibate reported the poorest psychosocial and quality of life scores across the board, while those who reported to be sexually active in committed relationships reported the healthiest scores—with generally large pairwise effect sizes.

Implications

Public Policy

The relatively high ineffectiveness and harm rates of sexual orientation change efforts found in this study provide additional support to the existing research base, which generally cautions against SOCE (APA Task Force, 2009). While SOCE have been denounced by virtually all major medical and mental health organizations, it appears to as though SOCE is still quite common within the LDS population, and further investigation is warranted to determine if SOCE are similarly common in other conservative, non-LGBT-affirming religious populations. Given the reported continued prevalence of SOCE, efforts to increase public health awareness regarding the ineffectiveness and potential harm of SOCE—both for the general public, and for mental health

professionals—should be considered. As states such as California and New Jersey have recently considered and/or passed legislation prohibiting SOCE (at least amongst minors), such legislation might be considered in other states as well. Although the number of U.S. states allowing same-sex marriage (SSM) continues to rise (17 U.S. states and the District of Columbia allow SSM at present), the majority of U.S. states (66%) still prohibit same-sex marriage. While further study is clearly warranted, the significant psychosocial and quality of life advantages associated with same-sex marriage in this study seem to provide additional justification for the expansion of same-sex marriage into the remaining 33 U.S. states.

Clinical

While therapist-led SOCE were reported to be much less common than religious or individual SOCE methods, they were still surprisingly common in this sample. Consequently, where relevant, it might be useful for professional mental health organizations to consider promoting greater awareness regarding the ineffectiveness and potential harm of SOCE amongst licensed mental health professionals who serve more conservative religious populations. In addition, since religious and personal SOCE methods were far more common (and damaging) than therapist-led SOCE, additional efforts to increase therapist awareness and sensitivity regarding the prevalence and risks of religious/private SOCE efforts could be useful.

For therapists who work with religious LGBT individuals, results from this study suggest the following factors as being positively correlated with psychosocial health and

quality of life: (a) acceptance of same-sex attraction and LGBT identity, (b) "coming out" as LGBT to family, friends, co-workers, and religious associates, (c) thoughtfully considering one's activity level with their church if the church is perceived to be non-LGBT-affirming, (d) seriously considering the negative health risks associated with celibacy and mixed-orientation marriages (MOMs), along with the high divorce rates of MOMs, before adopting those options, and (e) considering the positively associated benefits of committed, (and where possible) legal, same-sex relationships for those who are predominately same-sex attracted.

Religious

While the LDS Church has made considerable strides to become more LGBT-affirming in recent years (e.g., http://mormonsandgays.org), results from this study suggest that many LGBT LDS Church members continue to experience the LDS Church as either non-LGBT-affirming (at best) or deleterious (at worst). The very high rate of LDS Church disaffection (70%) by study participants supports this assertion. Based on this study, several recommendations might be offered to help the LDS Church (and other conservative churches) become more affirming for its LGBT members. Some suggestions might include: (a) ceasing to sell and/or distribute books, magazine articles, and talks/sermons that either pathologize same-sex sexuality, attribute the cause of same-sex sexuality to developmental factors, or promote SOCE in various forms (e.g., Byrd, 2008; Condie, 1993; Kimball, 1969; Mansfield, 2011), (b) provide improved, LGBT-affirming training and psychoeducation to church leaders (e.g., bishops), church-affiliated mental

health professionals (e.g., LDS family services), and the general church membership regarding the biological nature of same-sex sexuality, the ineffectiveness and potential harm of SOCE efforts (especially religious or private forms), the negative health risks associated with mixed-orientation marriages and celibacy, the benefits associated with both the acceptance of same-sex sexuality, and engagement in committed same-sex relationships, and (c) better educate church leaders, church members, and church-affiliated therapists on the very high health risks associated with family-based rejection of LGBT individuals (Ryan, Huebner, Diaz, & Sanchez, 2009), and the positive health benefits associated with family acceptance (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010).

Future Research

Several opportunities for future research emerge from this study. A few of the major questions include the following.

SOCE

Why is SOCE prevalence significantly greater for men than women in this population? Why are individual and religious forms of SOCE dramatically more prevalent and harmful than other SOCE types? Conversely, why are group-based SOCE methods rated as most effective, and least prevalent of all SOCE types?

Identity Conflict Management

What are the primary factors contributing to greater psychosocial health and

quality of life amongst those who either reject their LDS identities, or who are able to successfully integrate their religious and sexual identities? Why is this latter group so rare? To what extent are these identities developmental in nature—such that those who either reject their LGBT identity, compartmentalize their identities, or integrate their identities are likely to eventually reject their religious identities altogether (as the age differences between these groups might suggest)?

Religion-Based Lifestyle Recommendations

Given that religion is generally viewed as psychologically beneficial, why does religiosity fail to be a protective factor amongst LGBT LDS, and what, specifically, could be done organizationally to help the LDS Church (and other similar churches) become more LGBT-affirming? What are the specific reasons for the apparently negative psychosocial health and quality of life correlates of mixed-orientation marriages and celibacy? Finally, can the estimated 70% failure rate of LDS mixed-orientation marriages be supported by additional study?

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APPENDICES

Appendix A

Informed Consent

USU IRB Approved: April 12, 2011
Approval Terminates: 04/11/2012
Protocol Number: 2906
IRB Password Protected per IRB Administrator

2810 Old Main Hill
Logan UT 84322-2810
Telephone: (435) 797-1460
Fax: (435) 797-1448

Informed Consent
Exploration of Experiences of and Resources for Same-sex Attracted Latter Day Saints

Introduction/ Purpose: Dr. Renee Galliher in the Department of Psychology at Utah State University is conducting a study to understand the experiences of same-sex attracted Latter Day Saints. You do not have to identify as gay or lesbian in order to participate in this study, nor do you have to be currently active in the LDS church. Approximately 300 individuals who have experienced same-sex attraction and who have at some time been affiliated with the LDS church will participate in this study.

Procedures: If you agree to participate in this study, you will be asked to complete a 30 minute online survey at your convenience on a computer of your choice. The questions in this survey focus on how LDS people have experienced same-sex attraction through time, their beliefs about the nature of homosexuality, any experience they may have had in attempting to understand or alter their orientation, the current state of satisfaction with their lives and their feeling about and relationship with the Church.

Upon completion of the online survey, you will be given the option to submit your email address to volunteer to participate in a one hour follow up one-on-one interview exploring any formal (e.g., psychotherapy) or informal (e.g., personal exploration) efforts in which you have engaged related to understanding your same-sex attraction. Approximately ten survey participants will be invited to complete follow up interviews. Interviews will take place at a time and location selected by you, either by phone or in person.

Risks: There are minimal risks to this study. If you feel uncomfortable answering a question you may skip the question(s) and proceed with the questionnaire. There is minimal risk of being identified as a research participant via your email address.

Benefits: There may not be any direct benefits to you from participating in this study; however, you may benefit from the opportunity to reflect on your experience. The researchers hope this study may provide insights into the experiences of same-sex attracted Latter Day Saints, increasing the competence and sensitivity of the consumers of this research, who could potentially be psychologists, researchers, educators, and other service providers interacting with individuals who identify with these experiences.

Explanation & offer to answer questions: If you have any questions, concerns, complaints, or research-related problems, please contact Dr. Renee Galliher at (435) 797-3391 or by e-mail at renee.galliher@usu.edu

Payment/Compensation: To thank you for your participation in this research, you may choose to submit your email address to receive one of 10 randomly drawn $15 online Amazon gift certificate in compensation for your time. In addition, you may request to receive a summary of the results of this study by email. Email addresses will be held in a separate database, and survey responses will not be traceable to specific addresses.

Voluntary nature of participation and right to withdraw without consequence: Participation in research is entirely voluntary. You may refuse to participate or withdraw at any time without consequence.





USU IRB Approved: April 12, 2011
Approval Terminates: 04/11/2012
Protocol Number: 2906
IRB Password Protected per IRB Administrator

2810 Old Main Hill
Logan UT 84322-2810
Telephone: (435) 797-1460
Fax: (435) 797-1448

Informed Consent
Exploration of Experiences of and Resources for Same-sex Attracted Latter Day Saints

Confidentiality: All survey responses will be kept confidential, consistent with federal and state regulations. Only the investigators will have access to the data, which will be downloaded and stored on a password protected computer. Once the data are downloaded, email addresses will only be linked to survey responses until interested interview participants are identified. Email addresses will be separated from survey responses and stored in a separate file until the Amazon gift certificates and results of the study are disseminated. Upon completion of the study, all email addresses will be destroyed.

IRB Approval Statement: The Institutional Review Board (IRB) for the protection of human participants at USU has reviewed and approved this research study. If you have any questions or concerns about your rights or think the research may have harmed you, you may contact the IRB Administrator at (435) 797-0567 or email irb@usu.edu. If you have a concern or complaint about the research and you would like to contact someone other than the research team, you may contact the IRB Administrator to obtain information or to offer input.

Copy of Consent: Please print a copy of this informed consent for your files.

Renee V. Galliher, Ph.D., Principal Investigator

Participant Consent: If you have read and understand the above statements, please click on the "CONTINUE" button below. This indicates your consent to participate in this study.

Thank you very much for your participation! Your assistance is truly appreciated.

Appendix B

Survey

Exploration of Experiences of and Resources for Same-sex Attracted Latter-day Saints

This study is being conducted by Dr. Renee Galliher -- associate professor of psychology at Utah State University. The questions in this survey focus on how LDS (or previously LDS) people have experienced same-sex attraction through time, their beliefs about the nature of homosexuality, any experience they may have had in attempting to understand or alter their orientation, the current state of satisfaction with their lives and their feeling about and relationship with the Church. We believe that the overall impact of this study will be positive; that is, that the information obtained will be accurate, dispel myths, and promote understanding and good will.

Please be candid; answer as honestly and as completely as you can. Your responses are confidential and no individual will be identifiable in any report of the results of this study. It will require about 30-45 minutes of your time to complete this survey.

There are 149 questions in this survey

Informed Consent

Please read the following Informed Consent form and indicate your consent by clicking "yes" at the bottom of this page.

1 [IC]

Click "Yes" to continue: *
Please choose **only one** of the following:

- ○ Yes
- ○ No

Demographic Information

2 [Sex]What is your biological sex?
Only answer this question if the following conditions are met:
Please choose **only one** of the following:

- ○ Female
- ○ Male

3 [Gender]
How do you identify with respect to gender?
Only answer this question if the following conditions are met:
Please choose **only one** of the following:

- ○ Female
- ○ Male
- ○ Female to Male
- ○ Male to Female
- ○ Neither Male nor Female
- ○ Both Male and Female
- ○ If not described above, please specify:

4 [Country]
In which country do you presently reside?
Only answer this question if the following conditions are met:
Please choose **only one** of the following:

- ○ United States of America
- ○ If not described above, please specify:

5 [State]
In which state do you presently reside? (If in the United States)
Only answer this question if the following conditions are met:
Please choose **only one** of the following:

- ○ None
- ○ Alabama
- ○ Alaska
- ○ Arizona
- ○ Arkansas
- ○ California
- ○ Colorado
- ○ Connecticut
- ○ Delaware
- ○ District of Columbia
- ○ Florida
- ○ Georgia

- ○ Hawaii
- ○ Idaho
- ○ Illinois
- ○ Indiana
- ○ Iowa
- ○ Kansas
- ○ Kentucky
- ○ Louisiana
- ○ Maine
- ○ Maryland
- ○ Massachusetts
- ○ Michigan
- ○ Minnesota
- ○ Mississippi
- ○ Missouri
- ○ Montana
- ○ Nebraska
- ○ Nevada
- ○ New Hampshire
- ○ New Jersey
- ○ New Mexico
- ○ New York
- ○ North Carolina
- ○ North Dakota
- ○ Ohio
- ○ Oklahoma
- ○ Oregon
- ○ Pennsylvania
- ○ Rhode Island
- ○ South Carolina
- ○ South Dakota
- ○ Tennessee
- ○ Texas
- ○ Utah
- ○ Vermont
- ○ Virginia
- ○ Washington
- ○ West Virginia
- ○ Wisconsin
- ○ Wyoming

6 [Age]What is your age?
Only answer this question if the following conditions are met:
Please write your answer here:

7 [Race]
How do you identify with respect to race/ethnicity?
Only answer this question if the following conditions are met:
Please choose **all** that apply:

- ☐ Asian
- ☐ Black/African-American
- ☐ Latina(o)/Hispanic
- ☐ Middle Eastern
- ☐ Native American
- ☐ Native Hawaiian/Pacific Islander
- ☐ South Asian
- ☐ White/Caucasian
- ☐ If not described above, please specify::

8 [Income]Please indicate your present level of yearly income.
Only answer this question if the following conditions are met:
Please choose **only one** of the following:

- ○ $15,000 or less
- ○ $15,000 - $24,999
- ○ $25,000 - $34,999
- ○ $35,000 - $49,999
- ○ $50,000 - $74,999
- ○ $75,000 - $99,999
- ○ $100,000 - $149,999
- ○ $150,000 - $199,999
- ○ $200,000 - $299,999
- ○ $300,000 - $500,000
- ○ greater than $500,000.

9 [Community]
How would you describe the community you grew up in?
Only answer this question if the following conditions are met:
Please choose **only one** of the following:

- ○ Rural (country)
- ○ Urban (city)
- ○ Suburban (subdivisions)
- ○ If not described above, please specify:

10 [Education]
Highest level of education completed:
Only answer this question if the following conditions are met:
Please choose **only one** of the following:

- ○ Elementary school
- ○ High school degree
- ○ Some college
- ○ College graduate
- ○ Technical or trade school graduate
- ○ Professional or graduate degree
- ○ If not described above, please specify:

11 [Occupation]What is your occupation?
Please choose **only one** of the following:

- ○ (Architecture or Engineering) Architect
- ○ (Architecture or Engineering) Draftsman
- ○ (Architecture or Engineering) Engineer
- ○ (Architecture or Engineering) Surveyor
- ○ (Architecture or Engineering) Other architecture or engineering
- ○ (Arts, Design, Entertainment, and Media) Actor
- ○ (Arts, Design, Entertainment, and Media) Artist
- ○ (Arts, Design, Entertainment, and Media) Broadcaster, broadcast technician
- ○ (Arts, Design, Entertainment, and Media) Designer
- ○ (Arts, Design, Entertainment, and Media) Director, producer
- ○ (Arts, Design, Entertainment, and Media) Musician, singer
- ○ (Arts, Design, Entertainment, and Media) Photographer
- ○ (Arts, Design, Entertainment, and Media) Writer
- ○ (Arts, Design, Entertainment, and Media) Other arts, design, entertainment, and media
- ○ (Clerical or Office Worker) Administrative assistant/secretary
- ○ (Clerical or Office Worker) Bank clerk
- ○ (Clerical or Office Worker) Computer operator, data entry
- ○ (Clerical or Office Worker) Postal clerk
- ○ (Clerical or Office Worker) Telephone operator
- ○ (Clerical or Office Worker) Other clerical or office worker
- ○ (Community and Social Services) Clergy
- ○ (Community and Social Services) Mental health/substance abuse counselor
- ○ (Community and Social Services) Probation officer
- ○ (Community and Social Services) Social worker
- ○ (Community and Social Services) Therapist
- ○ (Community and Social Services) Other community and social services
- ○ (Computer and Mathematical) Actuary, mathematician, statistician
- ○ (Computer and Mathematical) Computer programmer

- ○ (Computer and Mathematical) Software engineer, database or network administrator
- ○ (Computer and Mathematical) Other computer or mathematical
- ○ (Construction or Mining Worker) Carpenter
- ○ (Construction or Mining Worker) Electrician
- ○ (Construction or Mining Worker) Miner
- ○ (Construction or Mining Worker) Plumber
- ○ (Construction or Mining Worker) Other construction or mining worker
- ○ (Education, Training, and Library) Librarian
- ○ (Education, Training, and Library) Professor
- ○ (Education, Training, and Library) Teacher (any level)
- ○ (Education, Training, and Library) Teacher's assistant
- ○ (Education, Training, and Library) Other education, training, and library
- ○ (Farming, Fishing, or Forestry Worker) Farmer, farm worker
- ○ (Farming, Fishing, or Forestry Worker) Fisherman, deck hand on fishing boat
- ○ (Farming, Fishing, or Forestry Worker) Lumberjack, forest management
- ○ (Farming, Fishing, or Forestry Worker) Other farming, fishing, or forestry worker
- ○ (Financial, Insurance, Real Estate, or Consulting) Accountant/CPA
- ○ (Financial, Insurance, Real Estate, or Consulting) Auditor
- ○ (Financial, Insurance, Real Estate, or Consulting) Consultant/analyst
- ○ (Financial, Insurance, Real Estate, or Consulting) Financial advisor
- ○ (Financial, Insurance, Real Estate, or Consulting) Insurance
- ○ (Financial, Insurance, Real Estate, or Consulting) Real estate/appraiser
- ○ (Financial, Insurance, Real Estate, or Consulting) Other financial, insurance, real estate, or consulting
- ○ (Healthcare) Medical assistant or aide
- ○ (Healthcare) Medical technician
- ○ (Healthcare) Nurse
- ○ (Healthcare) Physical therapist
- ○ (Healthcare) Physician
- ○ (Healthcare) Physician's assistant
- ○ (Healthcare) Veterinarian
- ○ (Healthcare) Other healthcare
- ○ (Installation, Maintenance, or Repair Worker) Garage mechanic
- ○ (Installation, Maintenance, or Repair Worker) Linesman
- ○ (Installation, Maintenance, or Repair Worker) Other installation, maintenance, or repair worker
- ○ (Legal) Court reporter
- ○ (Legal) Judge
- ○ (Legal) Law clerk
- ○ (Legal) Lawyer
- ○ (Legal) Title examiner

- ○ (Legal) Other legal
- ○ (Life, Physical , and Social Sciences) Biochemist, chemist
- ○ (Life, Physical , and Social Sciences) Geographer
- ○ (Life, Physical , and Social Sciences) Physicist
- ○ (Life, Physical , and Social Sciences) Political scientist
- ○ (Life, Physical , and Social Sciences) Scientist
- ○ (Life, Physical , and Social Sciences) Sociologist
- ○ (Life, Physical , and Social Sciences) Other life, physical, social sciences
- ○ (Manager, Executive, or Official) Manger, executive, or official for a business
- ○ (Manager, Executive, or Official) Manger, executive, or official for a government agency
- ○ (Manager, Executive, or Official) Other manager, executive, or official
- ○ (Manufacturing or Production Worker) Garment or furniture manufacturing
- ○ (Manufacturing or Production Worker) Non-restaurant food preparation (baker)
- ○ (Manufacturing or Production Worker) Printer, print shop worker
- ○ (Manufacturing or Production Worker) Worker in a factory
- ○ (Manufacturing or Production Worker) Other manufacturing or production
- ○ (Military) Military personnel
- ○ (Sales Worker) Clerk in a store
- ○ (Sales Worker) Door-to-door salesperson
- ○ (Sales Worker) Manufacturer's representative
- ○ (Sales Worker) Sales associate
- ○ (Sales Worker) Other sales worker
- ○ (Service Worker) Attendant
- ○ (Service Worker) Barber or beautician
- ○ (Service Worker) Fast-food worker
- ○ (Service Worker) Firefighter, police officer
- ○ (Service Worker) Janitorial
- ○ (Service Worker) Landscaping
- ○ (Service Worker) Maid or housekeeper
- ○ (Service Worker) Personal care worker
- ○ (Service Worker) Waiter or waitress
- ○ (Service Worker) Other service worker
- ○ (Small Business Owner) Small business owner
- ○ (Transportation Worker) Driver (bus, truck, taxi)
- ○ (Transportation Worker) Flight attendant
- ○ (Transportation Worker) Pilot
- ○ (Transportation Worker) Postal carrier
- ○ (Transportation Worker) Other transportation worker
- ○ (Other Job Category) Other occupation

12 [Religion]
Which (if any) of the following churches do you attend most frequently?
Only answer this question if the following conditions are met:
Please choose **only one** of the following:

- ○ Agnostic
- ○ Atheist
- ○ Baptist
- ○ Buddhist
- ○ Catholic
- ○ Episcopalian
- ○ Hindu
- ○ Jewish
- ○ LDS
- ○ Lutheran
- ○ Methodist
- ○ Metropolitan Community Church
- ○ Muslim
- ○ Unitarian Universalist
- ○ United Church of Christ
- ○ None
- ○ If not described above, please specify:

13 [SexualOrientation]
How do you identify with respect to sexual orientation?
Only answer this question if the following conditions are met:
Please choose **only one** of the following:

- ○ Lesbian
- ○ Gay
- ○ Bisexual
- ○ Queer
- ○ Heterosexual
- ○ Pansexual
- ○ Asexual
- ○ If not described above, please specify:

14 [SexOrientationIndexT]
We are interested in understanding your sexuality along three different dimensions: A) sexual behavior/experience, B) feelings of sexual attraction, and C) sexual identity. Please indicate for each of these where you position yourself along the 7-point scale from exclusively opposite sex oriented to exclusively same sex oriented (or, if applicable, asexual).
Please choose the appropriate response for each item:

	(A) Sexual behavior/experience	(B) Feelings of sexual attraction	(C) Self-declared sexual identity
0 - Exclusively opposite sex	○	○	○
1 - Predominantly opposite sex, only minimally same sex	○	○	○
2 - Predominantly opposite sex, but more than minimally same sex	○	○	○
3 - Equally opposite sex and same sex	○	○	○
4 - Predominantly same sex, but more than minimally opposite sex	○	○	○
5 - Predominantly same sex , only minimally opposite sex	○	○	○
6 - Exclusively same sex	○	○	○
Asexual	○	○	○

15 [Relationship]
What is your current relationship status?
Only answer this question if the following conditions are met:

Please choose **only one** of the following:

- ○ single
- ○ married heterosexual relationship
- ○ married same-sex relationship
- ○ civil union
- ○ domestic partnership
- ○ unmarried, but committed to opposite sex partner
- ○ unmarried, but committed to same-sex partner
- ○ divorced
- ○ widowed
- ○ If not described above, please specify:

16 [HeteroMarriage]Have you ever been married heterosexually?
Only answer this question if the following conditions are met:

Please choose **only one** of the following:
- ○ Yes
- ○ No

17 [HeteroMarriageLength]If Yes, what was the length in years of that marriage?
Only answer this question if the following conditions are met:

Please write your answer here:

18 [Parent]Are you a parent?
Only answer this question if the following conditions are met:

Please choose **only one** of the following:
- ○ Yes
- ○ No

19 [Children]If Yes, how many children?
Only answer this question if the following conditions are met:

Please write your answer(s) here:
- Biological?
- Adopted?
- Foster?

Sexual Orientation History

”GLBTQ” is a term used to describe those who identify as gay, lesbian, bisexual, transgender or questioning. For the purposes of this survey, it includes those who report some level of same-sex attractions or engage in same-sex sexual behavior.

20 [SSADifference]If applicable, what was the earliest age in years that you began to sense a difference (feeling, attitudes, behavior) between yourself and others of your same age and biological sex that you now recognize or attribute to your same-sex sexual orientation?
Only answer this question if the following conditions are met:

Please write your answer here:

-

21 [SSAAge]
If applicable, at what age in years did you first realize you were attracted romantically or sexually to persons of the same sex?
Only answer this question if the following conditions are met:

Please write your answer here:

-

22 [SSAExperience]With reference to your first experience of same-sex attraction (previous question) what event, relationship, or interaction led you to consider this?
Only answer this question if the following conditions are met:

Please write your answer here:

23 [SSARomantic]
How old were you when you experienced your first same-sex romantic or sexual experience?

(Leave blank if you have never had a same-sex romantic or sexual experience.)
Only answer this question if the following conditions are met:

Please write your answer here:

-

24 [Label]
How old were you when you first <u>labeled</u> yourself gay, lesbian, bisexual, transgendered, questioning, queer, or another personal label you have chosen for yourself?
(Leave blank if you do not use such a label for yourself.)

Only answer this question if the following conditions are met:

Please write your answer here:

-

25 [ToldSSA]How old were you when you first told someone of your same-sex attraction?

(Leave blank if you have not told anyone about your same-sex attraction.)
Only answer this question if the following conditions are met:

Please write your answer here:

-

26 [SexualActivity]
Are you:
Only answer this question if the following conditions are met:

Please choose **only one** of the following:

- ○ celibate by choice
- ○ celibate due to lack of partner
- ○ sexually active in a committed relationship
- ○ sexually active with others but not in a committed relationship

27 [Supportive]For the following questions, please select a number on a scale from 0 to 5, where 0 means closed or non-supportive, and 5 means very open or supportive.
Only answer this question if the following conditions are met:

Please choose the appropriate response for each item:

	0 - Closed or non-supportive	1	2	3	4	5 - Very open or supportive
How open/supportive are your parents and family, toward sexual and gender diversity in general?	○	○	○	○	○	○
How open/supportive is your school/work environment toward diversity, especially sexual and gender diversity?	○	○	○	○	○	○

	0 - Closed or non-supportive	1	2	3	4	5 - Very open or supportive
How open is your neighborhood/community toward diversity, especially sexual and gender diversity?	○	○	○	○	○	○
How supportive is (or was it growing up) it to be LGBTQ in your family?	○	○	○	○	○	○
How supportive is (or was it growing up) it to be LGBTQ in your community?	○	○	○	○	○	○

28 [Teachings]Please describe what was taught about homosexuality in your LDS community while you were growing up or at the time you joined the Church.
Only answer this question if the following conditions are met:

Please write your answer here:

29 [Teasing]
If applicable, please describe any negative reaction, teasing, ostracization, or violence you experienced because you were perceived by those in your LDS community as being homosexual?
Only answer this question if the following conditions are met:

Please write your answer here:

30 [Anti-GLBTQ]
If applicable, please describe any anti-GLBTQ behavior (teasing, etc.) that <u>you</u> engaged in as a member of an LDS community?
Only answer this question if the following conditions are met:

Please write your answer here:

31 [ComingOut]
If applicable, please describe the reactions of your parents, family members, church leaders, or ward members when you told them about your same-sex attractions/came out.

Only answer this question if the following conditions are met:

Please write your answer here:

32 [Disclosure]To what degree have you disclosed your sexual orientation (told others you were gay/lesbian/bisexual/questioning/etc.):
Only answer this question if the following conditions are met:

Please choose the appropriate response for each item:

	None	A Few	Some	A lot	Everyone
Immediate Family	○	○	○	○	○
Friends	○	○	○	○	○
Classmates/Coworkers	○	○	○	○	○
People with whom you are religiously affiliated	○	○	○	○	○

33 [Openness]
Overall, to what degree are you "out" regarding your sexual orientation:
Only answer this question if the following conditions are met:

Please choose **only one** of the following:
○ I have not told anyone about my sexual orientation
○ I have told only a few of the people I trust the most.
○ I have told less than half of the people about my sexual orientation
○ I have told more than half of the people about my sexual orientation
○ I have disclosed to most people in most settings (e.g., work, school, friends, family)
○ I am totally open about my sexual orientation

34 [GodsResponse]How did you view God's response to your sexual orientation growing up?
Only answer this question if the following conditions are met:

Please write your answer here:

35 [ChangedView]If your view has changed, when did it change? What helped it to change?
Only answer this question if the following conditions are met:

Please write your answer here:

36 [SSAManifestation]Have you experienced a spiritual manifestation through which you felt an <u>acceptance</u> of your same-sex sexual orientation from Deity?
Only answer this question if the following conditions are met:

Please choose **only one** of the following:
○ Yes
○ No

37 [SSAWitnessExplain]If yes, please briefly describe the experience.
Only answer this question if the following conditions are met:

Please write your answer here:

38 [SSACondemn]Have you experienced a spiritual manifestation through which you felt <u>condemnation</u> of your same-sex sexual orientation from Deity?
Only answer this question if the following conditions are met:

Please choose **only one** of the following:
○ Yes
○ No

39 [SSACondemnExplain]If yes, please briefly describe the experience.
Only answer this question if the following conditions are met:

Please write your answer here:

40 [SSACauses]
Which of the following, if any, best represents your *personal opinion* about what, as a general rule, causes or contributes to an individual experiencing same-sex attraction?
Only answer this question if the following conditions are met:

Please choose **all** that apply:
☐ A failure of normal gender development due to a dysfunctional parent-child relationship in the home (for example, a father being emotionally distant from his son)
☐ Being a victim of sexual abuse
☐ Same-sex sexual experiences in childhood or early adolescence
☐ Biological mechanisms (based in genetics and biochemistry) operating during prenatal and/or early postnatal development.
☐ A spiritual failure or weakness to Satan's temptation
☐ It is a personal choice.

41 [ExplainSSACauses]If the previous options do not adequately represent your opinion, please use this space to elaborate on your opinion or indicate some other cause not listed above.
Only answer this question if the following conditions are met:

Please write your answer here:

42 [PersonalCauses]
Which of the following, if any, best represents potential causes or contributing factors associated with *your own* non-heterosexual orientation?
Only answer this question if the following conditions are met:

Please choose **all** that apply:
☐ A failure of normal gender development due to a dysfunctional parent-child relationship in the home (for example, a father being emotionally distant from his son)
☐ Being a victim of sexual abuse
☐ Same-sex sexual experiences in childhood or early adolescence
☐ Biological mechanisms (based in genetics and biochemistry) operating during prenatal and/or early postnatal development.
☐ A spiritual failure or weakness to Satan's temptation
☐ It is a personal choice.

43 [PersonalCausesExp]Please use the space below to describe or elaborate on any previously listed or unlisted contributing factors or potential causes associated with your own same-sex attraction.
Only answer this question if the following conditions are met:

Please write your answer here:

44 [ParentTension]
In the instance where there was (or continues to be) emotional distance, tension, or conflict between a parent and her or his same-sex attracted child, do you believe this tension:
Only answer this question if the following conditions are met:

Please choose **all** that apply:
☐ *Causes* the child's development of same-sex attraction
☐ *Results* from parents' disappointment in their child's homosexuality and/or gender non-conformity
☐If not described above, please specify::

Abuse History

The items on this page inquire about experiences with emotional, physical or sexual abuse. We recognize the sensitive nature of these questions and again, assure you this information will be kept entirely confidentialand will be used exclusively for research purposes.

45 [Abuse1]Were you ever a victim of physical, sexual, or emotional abuse?
Please choose **only one** of the following:
○ Yes
○ No

46 [Abuse2age]If you were a victim of physical, sexual, or emotional abuse, at what age(s) did you experience the abuse?
Please write your answer here:

47 [Abuse3Perp]If you were a victim of physical, sexual, or emotional abuse, by whom were you abused? (We are not asking for the names of the abusers, just their relationship to you).
Please write your answer here:

48 [Abuse4order]
If you were a victim of physical, sexual, or emotional abuse, did the abuse occur before or after your realization of your LGBTQ identity?
Please choose **only one** of the following:
○ Before
○ After

49 [Abuse5sex]
If you were the victim of physical, sexual, or emotional abuse, was the abuse perpetrated by someone of the opposite sex or the same sex?
Please choose **all** that apply:
☐ Opposite sex
☐ Same sex

Psychosocial Measures

58: Rosenberg Self-Esteem Scale (Rosenberg, 1965)

Instructions: Below is a list of statements dealing with your general feelings about yourself. If you strongly agree, circle SA. If you agree with the statement, circle A. If you disagree, circle D. If you strongly disagree, circle SD.

1. On the whole, I am satisfied with myself. SA—A—D—SD

2. At times, I think I am no good at all. SA—A—D—SD

3. I feel that I have a number of good qualities. SA—A—D—SD

4. I am able to do things as well as most other people. SA—A—D—SD

5. I feel I do not have much to be proud of. SA—A—D—SD

6. I certainly feel useless at times. SA—A—D—SD

7. I feel that I'm a person of worth, at least on an equal plane with others.

SA—A—D—SD

8. I wish I could have more respect for myself. SA—A—D—SD

9. All in all, I am inclined to feel that I am a failure. SA—A—D—SD

10. I take a positive attitude toward myself. SA—A—D—SD

59-60: QUALITY OF LIFE SCALE (QOL)

Please read each item and circle the number that best describes how satisfied you are at this time. Please answer each item even if you do not currently participate in an activity or have a relationship. You can be satisfied or dissatisfied with not doing the activity or having the relationship.

Delighted (7) Pleased (6) Mostly Satisfied (5) Mixed (4) Mostly Dissatisfied (3) Unhappy (2) Terrible (1)

1 Material comforts home, food, conveniences, financial security
2 Health - being physically fit and vigorous
3 Relationships with parents, siblings & other relatives- communicating, visiting, helping
4 Having and rearing children
5 Close relationships with spouse or significant other
6 Close friends
7 Helping and encouraging others, volunteering, giving advice
8 Participating in organizations and public affairs
9 Learning- attending school, improving understanding, getting additional knowledge .
10 Understanding yourself - knowing your assets and limitations - knowing what life is about
11 Work - job or in home
12 Expressing yourself creatively
13 Socializing - meeting other people, doing things, parties, etc.
14 Reading, listening to music, or observing entertainment
15 Participating in active recreation
16 Independence, doing for yourself

61-63: Lesbian, Gay, and Bisexual Identity Scale (LGBIS)

For each of the following statements, mark the response that best indicates your experience as a lesbian, gay, or bisexual (LGB) person. Please be as honest as possible in your responses.

1----------2----------3----------4----------5----------6----------7
Disagree Strongly — Agree Strongly

1. _ I prefer to keep my same-sex romantic relationships rather private.
2. _ I will never be able to accept my sexual orientation until all of the people in my life have accepted me.
3. _ I would rather be straight if I could.
4. _ Coming out to my friends and family has been a very lengthy process.
5. _ I'm not totally sure what my sexual orientation is.
6. _ I keep careful control over who knows about my same-sex romantic relationships.
7. _ I often wonder whether others judge me for my sexual orientation.
8. _ I am glad to be an LGB person.
9. _ I look down on heterosexuals.
10. _ I keep changing my mind about my sexual orientation.
11. _ My private sexual behavior is nobody's business.
12. _ I can't feel comfortable knowing that others judge me negatively for my sexual orientation.
13. _ Homosexual lifestyles are not as fulfilling as heterosexual lifestyles.
14. _ Admitting to myself that I'm an LGB person has been a very painful process.
15. _ If you are not careful about whom you come out to, you can get very hurt.
16. _ Being an LGB person makes me feel insecure around straight people.
17. _ I'm proud to be part of the LGB community.
18. _ Developing as an LGB person has been a fairly natural process for me.
19. _ I can't decide whether I am bisexual or homosexual.
20. _ I think very carefully before coming out to someone.
21. _ I think a lot about how my sexual orientation affects the way people see me.
22. _ Admitting to myself that I'm an LGB person has been a very slow process.
23. _ Straight people have boring lives compared with LGB people.
24. _ My sexual orientation is a very personal and private matter.
25. _ I wish I were heterosexual.
26. _ I get very confused when I try to figure out my sexual orientation.
27. _ I have felt comfortable with my sexual identity just about from the start.

64: Sexual Identity Distress Scale (Wright & Perry, 2006)

We want to know more about how you think and feel about your sexual orientation. Please circle the answer that best describes how much you agree or disagree with each of the following statements. There are no right or wrong answers.

Only answer this question if the following conditions are met:

Strongly Agree, Agree, Mixed Feelings, Disagree, Strongly Disagree, Don't Know

1. I have a positive attitude about being gay, lesbian, or bisexual.

2. I feel uneasy around people who are very open in public about being gay, lesbian, or bisexual.

3. I often feel ashamed that I am gay, lesbian, or bisexual.

4. For the most part, I enjoy being gay, lesbian, or bisexual.

5. I worry a lot about what others think about my being gay, lesbian, or bisexual.

6. I feel proud that I am gay, lesbian, or bisexual.

7. I wish I weren't attracted to the same sex.

65-67: CCAPS

The following statements describe thoughts, feelings, and experiences that people may have. Please indicate how well each statement describes you, during the past two weeks, from "not at all like me" (0) to "extremely like me" (4), by marking the correct number. Read each statement carefully, select only one answer per statement, and please do not skip any questions.

Not at all like me …….. Extremely like me

1. I am shy around others
2. My heart races for no good reason
3. I feel out of control when I eat
4. I don't enjoy being around people as much as I used to
5. I feel isolated and alone
6. I think about food more than I would like to
7. I am anxious that I might have a panic attack while in public
8. I feel confident that I can succeed academically
9. I have sleep difficulties
10. My thoughts are racing
11. I feel worthless
12. I feel helpless
13. I eat too much
14. I drink alcohol frequently
15. I have spells of terror or panic
16. When I drink alcohol I can't remember what happened
17. I feel tense
18. I have difficulty controlling my temper
19. I make friends easily
20. I sometimes feel like breaking or smashing things
21. I feel sad all the time
22. I am concerned that other people do not like me
23. I get angry easily
24. I feel uncomfortable around people I don't know
25. I have thoughts of ending my life
26. I feel self-conscious around others
27. I drink more than I should
28. I am not able to concentrate as well as usual
29. I am afraid I may lose control and act violently
30. It's hard to stay motivated for my classes
31. I have done something I have regretted because of drinking
32. I frequently get into arguments
33. I am unable to keep up with my schoolwork
34. I have thoughts of hurting others

68-129: Efforts to understand, cope with, or change sexual orientation

68 [Assistance]
Which of the following activities (if any) have you engaged in, in an attempt to understand, cope with, or change your sexual orientation:

Note: For each box that you select you will be asked a set of corresponding questions.
Only answer this question if the following conditions are met:

Please choose **all** that apply:

- ☐ Individual Effort (Non-religious efforts)
- ☐ Personal Righteousness (Fasting, prayer, obedience to commandments and Church teachings)
- ☐ Psychotherapy (talk therapy with a licensed mental health professional)
- ☐ Psychiatry (medication for Depression, Anxiety, Sleep problems, Somatic complaints, etc.)
- ☐ Group Therapy
- ☐ Group Retreats
- ☐ Support Groups
- ☐ Ecclesiastical Counseling (bishops, branch presidents, stake presidents, etc.)
- ☐ Family therapy
- ☐ Other (please describe below)

69 [OtherExplain]Other effort(s):
Only answer this question if the following conditions are met:

Please write your answer here:

70-129: For each of the 10 items checked above, the following questions were asked:

On this page, please provide details regarding your ***(selected effort)*** to understand, cope with, or change your sexual orientation.

[Age] Age in years when you started this intervention

[Duration] Time in years during which you made that effort (i.e. 1.5 years).

[Goals] What was/were your original goal(s) or reason(s) for seeking help?

Please choose **all** that apply:

- ☐ Depression
- ☐ Anxiety
- ☐ Eating/Body Image Concerns
- ☐ Family Concerns
- ☐ Problems with Friends
- ☐ Problems with Romantic Partner
- ☐ Work/School Related Problems
- ☐ Anger/Aggression Problems
- ☐ Substance Use Concerns
- ☐ Desire to Change Same-Sex Attraction
- ☐ Desire to Accept Same-Sex Attraction
- ☐ Desire to Explore/Understand Same-Sex Attraction
- ☐ Other:

[IssuesWorkedOn]What issue(s) did you actually work on?

Please choose **all** that apply:

- ☐ Depression
- ☐ Anxiety
- ☐ Eating/Body Image Concerns
- ☐ Family Concerns
- ☐ Problems with Friends
- ☐ Problems with Romantic Partner
- ☐ Work/School Related Problems
- ☐ Anger/Aggression Problems
- ☐ Substance Use Concerns
- ☐ Desire to Change Same-Sex Attraction
- ☐ Desire to Accept Same-Sex Attraction
- ☐ Desire to Explore/Understand Same-Sex Attraction
- ☐ Other:

[Effective]How effective was this experience in meeting your goals?

Please choose **only one** of the following:

- ○ highly effective
- ○ moderately effective
- ○ not effective (goals were not met)
- ○ moderately harmful
- ○ severely harmful (I felt significantly worse about myself or emotionally damaged as a result of this experience)

[Description]Please describe your experiences with this effort in as much detail as you would like:

Please write your answer here:

Therapy Effectiveness

If you have participated in formal therapy or counseling, please identify any of following models of counseling (philosophy, ideology, conceptual framework) that was adopted by your counselor/s. Also, using the scale below, please also rate your experience of the model's overall effectiveness in meeting your therapy goals.

130 [TherapyEffectiveness]
Only answer this question if the following conditions are met:

Please choose the appropriate response for each item:

0 - Not applicable	1 - Highly effective	2 - Moderately effective	3 - Not at all effective	4 - Moderately harmful	5 - Severely harmful

- My therapist(s) actively worked with me to reconsider my same-sex sexual behavior and thought patterns in order to alter or change my same-sex attraction.
- My therapist(s) helped me to consider accepting my sexual orientation and begin to accept my same-sex attraction into my lifestyle as opposed to trying to change it.
- My therapist(s) did not attempt to influence my acceptance of my sexuality, and was genuinely open and supportive of whatever decision I chose to make regarding my sexuality.
- My therapist(s) used aversive conditioning approaches (i.e., exposure to same sex romantic or sexual material while simultaneously being subjected to some form of discomfort) in attempts to alter my attraction to members of my same-sex.

Religious Experiences and History

131 [LDSConnection] What was your initial connection with the LDS Church?
Only answer this question if the following conditions are met:

Please choose **only one** of the following:
○ Born into an LDS family
○ Convert to the church

132 [LDSLeadership]
Identify your past activity and leadership roles in the LDS Church
Only answer this question if the following conditions are met:

Please choose **all** that apply:
☐ Baptized
☐ YM quorum or YW group presidency
☐ Endowed
☐ Served a mission
☐ Quorum/Relief Society officer
☐ Ward auxiliary officer
☐ Bishop
☐ Bishopric
☐ Stake President
☐ Stake Presidency
☐ Stake Auxiliary
☐ Mission President
☐ If not described above, please specify::

133 [LDSActivity]
Identify your current activity and leadership roles in the LDS Church
Only answer this question if the following conditions are met:

Please choose **all** that apply:
☐ Member without calling
☐ Home or visiting teacher
☐ Quorum or auxiliary teacher
☐ Quorum/Relief Society officer
☐ Ward auxiliary officer
☐ Bishop
☐ Bishopric
☐ Stake President
☐ Stake Presidency
☐ Stake Auxiliary

☐ Mission President
☐ If not described above, please specify::

134 [LDSStatus]What is your current status in the LDS Church?
Only answer this question if the following conditions are met:

Please choose **only one** of the following:
○ Active (attend church at least 1x/month)
○ Inactive (attend church less than 1x/month)
○ Disfellowshipped
○ Excommunicated
○ Resigned

135 [OrthodoxBefore]
Using a scale of 0 to 5, where 0 indicates orthodox (a traditional, conservative believer) and 5 indicates unorthodox (more liberal and questioning), please indicate your commitment to LDS doctrines <u>before</u> acknowledging same-sex attraction.

Only answer this question if the following conditions are met:

Please choose **only one** of the following:
○ 0 -- Orthodox (a traditional, conservative believer)
○ 1
○ 2
○ 3
○ 4
○ 5 -- Unorthodox (more liberal and questioning)
○ 6 -- N/A I have not acknowledged same sex attraction

136 [OrthodoxAfter]
Using a scale of 0 to 5, where 0 indicates orthodox (a traditional, conservative believer) and 5 indicates unorthodox (more liberal and questioning), please indicate your commitment to LDS doctrines <u>after</u> acknowledging same-sex attraction.
Only answer this question if the following conditions are met:

Please choose **only one** of the following:
○ 0 -- Orthodox (a traditional, conservative believer)
○ 1
○ 2
○ 3
○ 4
○ 5 -- Unorthodox (less rigid)
○ 6 -- N/A I have not acknowledged same sex attraction

137 [BeliefBefore]Before acknowledging same-sex attraction did you:
Only answer this question if the following conditions are met:

Please choose **all** that apply:
☐ Believe in the existence of God?
☐ Believe in Jesus as the Christ, the Savior of the world?
☐ Believe that Joseph Smith was a prophet of God?
☐ Accept the authenticity of the Book of Mormon as scripture?

138 [BeliefAfter]Having acknowledged same-sex attraction do you now:
Only answer this question if the following conditions are met:

Please choose **all** that apply:
☐ Believe in the existence of God?
☐ Believe in Jesus as the Christ, the Savior of the world?
☐ Believe that Joseph Smith was a prophet of God?
☐ Accept the authenticity of the Book of Mormon as scripture?

139 [PresentLDSFeelings] How would you describe your present emotional/spiritual/attitudinal relationship to the LDS Church?
Only answer this question if the following conditions are met:

Please choose **all** that apply:
☐ Committed, supportive
☐ Angry, hostile
☐ Neutral
☐ Hurt, damaged
☐ Mistrusting
☐ Disappointed
☐ Sorrowful

140 [Elaborate] If you would like, please elaborate. How would you describe your present emotional/spiritual/attitudinal relationship to the LDS Church?
Only answer this question if the following conditions are met:

Please write your answer here:

141 [Unaffiliated]
To the extent that you are now unaffiliated or alienated from the LDS Church, please indicate which of the following are responsible for that alienation.
Only answer this question if the following conditions are met:

Please choose **all** that apply:
☐ I am not alienated from the Church.
☐ Basic LDS religious doctrine.
☐ Policies concerning homosexuality instituted by LDS general authorities.
☐ General attitudes of LDS people concerning homosexuality.
☐ Specific ways in which I've been mistreated by LDS people.
☐ Specific ways in which I've been mistreated by my local ecclesiastical leaders.
☐ My loss of faith in God.
☐If not described above, please specify::

142 [Miss]If disaffected, is there anything you miss about being an active church member?
Only answer this question if the following conditions are met:

Please write your answer here:

143 [ChangeLDS] If disaffected, what, if any, change in policy by the LDS Church would make it possible for you to re-affiliate?
Only answer this question if the following conditions are met:

Please write your answer here:

Final Survey Information

144 [SurveySource]
An invitation to participate in this survey may have come to you from several sources. Please indicate here the source from which you were made aware of this survey. If from multiple sources, please indicate the one group or organization with which you most closely identify.
Only answer this question if the following conditions are met:

Please choose **only one** of the following:
- ○ Affirmation
- ○ Cha-Cha Brotherhood
- ○ Cor Invictus
- ○ Disciples
- ○ Equality Utah
- ○ Evergreen
- ○ Family Fellowship
- ○ Gamofites
- ○ Mormon Stories, Mormon Matters, StayLDS
- ○ Northstar
- ○ Ohana News
- ○ Q-Saints
- ○ Reconciliation
- ○ Salt Lake City Pride Center
- ○ Spicy Dinner Group
- ○ USGA
- ○ Word of mouth, email, Facebook, etc.
- ○ Newspaper article
- ○ If not described above, please specify:

145 [Once]Please indicate here that you are responding only once. "I have responded a single time to this survey."
Only answer this question if the following conditions are met:

Please choose **only one** of the following:
- ○ Yes
- ○ No

146 [Contact]
****May we contact you for an additional follow-up study regarding your personal experiences associated with your same-sex attraction?**
(If you answer yes to this question, you will be taken to a form where you can provide us with your name and contact information).

Only answer this question if the following conditions are met:

Please choose **only one** of the following:
○ Yes
○ No

Contact Information
Thank you for your willingness to participate in the follow-up portion of this study. Since this survey is entirely confidential, we need to obtain some basic information in order to contact you in the future. Consequently, any information you provide for this survey will be temporarily associated with the answers you have given, but will be kept entirely confidential, and will be immediately destroyed once the second portion of this study is completed.

147 [Name]Name:
Please write your answer here:

148 [Phone]Personal telephone number:
Please write your answer here:

149 [Email]Email address:
Please write your answer here:

Thank you for your participation!

31.12.1969—17:00

Submit your survey.
Thank you for completing this survey.

Appendix C

Permission to Reprint Copyrighted Material and Manuscript Information



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Copyright and reusing your own work

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Chapter 2: Sexual Orientation Change Efforts Among Current Or Former LDS CHURCH Members

Authors: John P. Dehlin, Renee V. Galliher, William S. Bradshaw, Daniel Hyde, and Katherine A. Crowell

Journal Name: Journal of Counseling Psychology

Status of Manuscript:

___ Prepared for submission to a peer-reviewed journal

___ Officially submitted to a peer-reviewed journal

___ Accepted by a peer-reviewed journal

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Dehlin, J. P., Galliher, R. V., Bradshaw, W. S., Hyde, D. C., & Crowell, K. A. (2014). Sexual Orientation Change Efforts Among Current or Former LDS Church Members. *Journal Of Counseling Psychology*, doi:10.1037/cou0000011

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Chapter 3: Navigating Sexual and Religious Identity Conflict: A Mormon Perspective

Authors: John P. Dehlin, Renee V. Galliher, William S. Bradshaw, and Katherine A. Crowell

Journal Name: *Identity: An International Journal of Theory and Research*

Status of Manuscript:

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Chapter 4: Psychosocial Correlates of Religious Approaches to Same-Sex Attraction: A Mormon Perspective

Authors: John P. Dehlin, Renee V. Galliher, Katherine A. Crowell, and William S. Bradshaw,

Journal Name: Journal of Gay & Lesbian Mental Health

Status of Manuscript:

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Appendix D

Co-Author Release Letters

12/13/2013

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Dear Ms. Crowell:

I am preparing my dissertation in the Department of Psychology at Utah State University. As you are aware, my dissertation has been completed at part of a larger study that I worked collaboratively with you, Dr. Renee Galliher, Dr. Bill Bradshaw, and Dr. Daniel Hyde. As such, I am writing this letter requesting permission to report findings from our research, in which I am the primary author, in my final dissertation document. I will include an acknowledgment to all non-signatory authors on the first page of all relevant chapters. Additionally, permission information will be included in a special appendix. If you would like a different acknowledgment, please so indicate. Please indicate your approval of this request by signing in the space provided.

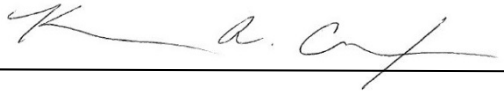
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Thank you for your assistance.

John P. Dehlin, M.S.

I hereby give permission to John P. Dehlin to use collaborative study findings for which he is first author, with the following acknowledgment to be included on the first page of all relevant chapters as well as a copy of this letter to be included in the appendix:

Non-signatory co-authors: William Bradshaw, Ph.D., Brigham Young University, Katie Crowell, Ed.S., Pacific Lutheran University, Daniel C. Hyde, Ph.D., University of Illinois at Urbana-Champaign

Signed  Date 12/13/2013

12/13/2013

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Dear Dr. Bradshaw:

I am preparing my dissertation in the Department of Psychology at Utah State University. As you are aware, my dissertation has been completed at part of a larger study that I worked collaboratively with you, Dr. Renee Galliher, Katie Crowell, and Dr. Daniel Hyde. As such, I am writing this letter requesting permission to report findings from our research, in which I am the primary author, in my final dissertation document. I will include an acknowledgment to all non-signatory authors on the first page of all relevant chapters. Additionally, permission information will be included in a special appendix. If you would like a different acknowledgment, please so indicate. Please indicate your approval of this request by signing in the space provided.

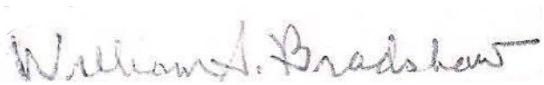
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Signed_____ Date 12/13/2013

12/13/2013

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Dear Dr. Hyde:

I am preparing my dissertation in the Department of Psychology at Utah State University. As you are aware, my dissertation has been completed at part of a larger study that I worked collaboratively with you, Dr. Renee Galliher, Dr. William Bradshaw, and Katie Corwell. As such, I am writing this letter requesting permission to report findings from our research, in which I am the primary author, in my final dissertation document. I will include an acknowledgment to all non-signatory authors on the first page of all relevant chapters. Additionally, permission information will be included in a special appendix. If you would like a different acknowledgment, please so indicate. Please indicate your approval of this request by signing in the space provided.

If you have any questions, please contact me at the phone number or email address provided above.

Thank you for your assistance.

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Education

Ph.D. 2015 — **Combined Clinical/Counseling/School Psychology (APA Accredited)**
Utah State University, Logan, UT
Dissertation: Sexual Orientation Change Efforts, Identity Conflict, and Psychosocial Health Amongst Same-Sex Attracted Latter-day Saints
Chair: Renee Galliher, Ph.D.

Thesis: Acceptance and Commitment Therapy as a Treatment for Scrupulosity in Obsessive Compulsive Disorder
Chair: Michael P. Twohig, Ph.D.

M.S. 2007 — **Instructional Technology**
Master's Project: The Instructional Use of Web 2.0 Technologies
Chair: David Wiley, Ph.D.
Utah State University, Logan, UT

B.A. 2003 — **Political Science**, *Summa Cum Laude*
Brigham Young University, Provo, UT

Clinical Experience

2014-2015 — **Psychology Intern (APA Accredited)**
Counseling and Psychological Services
Utah State University, Logan, UT

Responsibilities: Conducted consults, intakes, individual and group therapy, intellectual assessments (ADHD, learning disabilities), support groups, workshops, campus outreach, graduate student and peer supervision, treatment planning and coordination.

Supervisors: Luann Helms, Ph.D., David Bush, Ph.D., Eri Bentley, Ph.D.,

Charles Bentley, Ph.D., Amy Kleiner, Ph.D., Steven Lucero, Ph.D., Justin Barker, Psy.D., Mark A. Nafziger, Ph.D.

2013-2014 **Graduate Student Therapist**, Clinical Psychology Practicum
Center for Persons with Disabilities
Utah State University, Logan, UT
Responsibilities: Psychological assessments for individuals presenting with concerns about Autism Spectrum Disorder and learning and developmental disabilities.

Supervisor: Martin Toohill, Ph.D.

2011-2013 **Graduate Student Therapist and Graduate Assistant**
Counseling and Psychological Services
Utah State University, Logan, UT

Responsibilities: Conducted consults, intakes, individual and group therapy, support groups, workshops, campus outreach, peer supervision, treatment planning and coordination, and developed campus-wide podcast to increase center reach.

Supervisors: Luann Helms, Ph.D., David Bush, Ph.D., Eri Bentley, Ph.D., Mark A. Nafziger, Ph.D.

2010-2011 **Graduate Student Therapist**, Clinical/Counseling Psychology Practicum
Psychology Community Clinic
Utah State University, Logan, UT

Responsibilities: Provided individual and family-based psychological services at a university-based community clinic. Typical presenting problems included depression, anxiety, OCD, relationship distress, life transitions, couples issues, parent/child behavior training.

Supervisors: Susan Crowley, Ph.D., Kyle Hancock, Ph.D., Gretchen Peacock, Ph.D., Scott DeBarard, Ph.D.

2009-2011 **Graduate Assistant/Therapist**
Center for Clinical Research
Utah State University, Logan, UT

Responsibilities: Provided screening, assessments, individual and group psychological services, and reliability coding for several clinical studies involving Acceptance and Commitment Therapy, OCD, Scrupulosity,

problematic pornography viewing, Trichotillomania, and coping with LGBT/religious conflict.

Supervisors: Michael P. Twohig, Ph.D., Melanie Domenech Rodriguez, Ph.D.

Group Therapy Experience

2012 - 2015 **Understanding Self and Others Personal Process Groups**
Utah State University CAPS, Logan, UT

2012 - 2015 **Navigating a Religious Faith Crisis/Transition Groups**
Utah State University CAPS, Logan, UT

2015 **Skills Training Psycho-educational Group (based on DBT)**
Utah State University CAPS, Logan, UT

2012 **"LGBT Brown-Bag" Support Group**
USU Counseling and Psychological Services, Logan, UT

2010 **LGB Mormon University Students Experiencing Identity Conflict**
Support for Colleague Dissertation, Logan, UT
Tools and support for navigating sexual and religious identity conflict using Acceptance and Commitment Therapy.

Publications

Bradshaw, W. S., Heaton, T. B., Decoo, E., **Dehlin, J. P.**, Galliher, R. V., & Crowell, K. A. (In Press). *Religious Experience of GBTQ Mormon Males*. Journal for the Scientific Study of Religion.

Dehlin, J. P., Galliher, R. V., Bradshaw, W. S., & Crowell, K. A. (2015). Navigating Sexual and Religious Identity Conflict: A Mormon Perspective. *Identity: An International Journal of Theory and Research*, doi:10.1080/15283488.2014.989440

Crowell, K. A., Galliher, R. V., **Dehlin, J. P.**, & Bradshaw, W. S. (2015). Specific Aspects of Minority Stress Associated With Depression Among LDS Affiliated Non-Heterosexual Adults. *Journal of Homosexuality*. DOI: 10.1080/00918369.2014.969611

Dehlin, J. P., Galliher, R. V., Bradshaw, W. S., Crowell, K. A. (2014). Psychosocial Correlates of Religious Approaches to Same-Sex Attraction: A Mormon Perspective. *Journal of Gay & Lesbian Mental Health*. DOI:

10.1080/19359705.2014.912970.

Dehlin, J. P., Galliher, R. V., Bradshaw, W. S., Hyde, D. C., & Crowell, K. A. (2014). Sexual Orientation Change Efforts Among Current or Former LDS Church Members. *Journal of Counseling Psychology*, doi:10.1037/cou0000011.

Bradshaw, K., **Dehlin, J. P.**, Crowell, K. A., Galliher, R. V., Bradshaw, W. S. (2014). Sexual Orientation Change Efforts through Psychotherapy for LGBQ Individuals Affiliated with the Church of Jesus Christ of Latter-day Saints. *Journal of Sex & Marital Therapy*. DOI: 10.1080/0092623X.2014.915907

Fabricant, L. E., Abramowitz, J. S., **Dehlin**, J. P., & Twohig, M. P. (2013). A comparison of two brief interventions for obsessional thoughts: Exposure and acceptance. *Journal of Cognitive Psychotherapy*, *27*, 195-209.

Dehlin, J. P., Morrison, K. L., & Twohig, M. P. (2013). Acceptance and commitment therapy as a treatment for scrupulosity in obsessive compulsive disorder. *Behavior Modification*, *37*, 409-430. doi:10.1177/0145445512475134

Crosby, J. M., **Dehlin, J. P.**, Mitchell, P. R., & Twohig, M. P. (2012). Acceptance and commitment therapy and habit reversal training for the treatment of trichotillomania. *Cognitive and Behavioral Practice*, *19*, 595-605. doi:10.1016/j.cbpra.2012.02.002

Twohig M. P., & **Dehlin, J. P.** (2012). Skills training. In W. T. O'Donohue and J. E. Fisher (Eds.), *Cognitive behavior therapy: Core principles for practice* (pp. 37-74). Hoboken NY: John Wiley & Sons.

Manuscripts under review

Mattingly, M. S., Galliher, R. V., Dehlin, J. P., Crowell, K. A., Bradshaw, W. S. A Mixed Methods Analysis of the Family Support Experiences of GLBTQ Latter Day Saints.

Manuscripts in progress

Bradshaw, W.S., Norman, N., **Dehlin, J. P.** , Galliher, R. V., and Crowell, K. A. The Etiology of Sexual Orientation and Its Spiritual Ramifications: An LGBTQ Mormon Perspective.

Crowell, K. A., Galliher, R., **Dehlin, J. P.**, Bradshaw, W. S. *The Positive Aspects of Non-Heterosexuality: A Quantitative Assessment.* Manuscript in preparation.

Crowell, K. A., Galliher, R., **Dehlin, J. P.**, Bradshaw, W. S. *Out and Proud: Associations between Disclosure and Perceived Benefits of Being Non-heterosexual.* Manuscript in preparation.

Crowell, K. A., Galliher, R., **Dehlin, J. P.**, Bradshaw, W. S. *Out of the Closet and Outside the Box: Associations between Creativity and Mental Health Resilience Among Non-Heterosexuals*. Manuscript in preparation.

Presentations

Invited Presentations

Dehlin, J. P. (November, 2013). *The Ally Within*. Invited speaker at the 2013 Utah State University TEDx event, Logan, Utah. Link: https://www.youtube.com/watch?v=0MxCXjfAunk

Dehlin, J. P. (July, 2012*). Coming Out as an Ally: The Impact of Straight Mormons in Advancing LGBT Issues in the Church and Around the World.* Invited speaker at the 2012 Sunstone Symposium of Mormon Scholarship, Salt Lake City, Utah.

Dehlin, J. P. (March, 2012). *Why Mormons Leave, and How the Internet is Helping.* Invited speaker for Journeys of Faith on the Internet Symposium conducted at the 2012 Mormons and the Internet Conference at Utah Valley University, Orem, Utah.

National/International Conferences

Dehlin, J. P., Galliher, R. V., Bradshaw, W. S., Crowell, K. A., (October, 2014). *Psychosocial Correlates of Religious Approaches to Same-Sex At- traction: A Mormon Perspective*. In Knowlton, D. (Chair), *Psychological and Therapeutic Concerns on How Latter-day Saints Interact with Their Religious Society, the Church of Jesus Christ of Latter-day Saints.* Symposium conducted at the Society for the Scientific Study of Religion Annual Meeting, Indianapolis, Indiana.

Crowell, K. A., Galliher, R. V., **Dehlin, J. P.**, & Bradshaw, W. (March 2014). Out and Proud: Associations between Disclosure and Perceived Benefits of Being Non-heterosexual. Poster to be presented at the bi-annual meeting of the Society for Research on Adolescents, Austin, Tx.

Dehlin, J. P., Galliher, R. V., Bradshaw, W. S., & Crowell, K. A. (August, 2013). *The Quality of Life Advantages of Religious Disbelief and Disaffiliation for Same-Sex Attracted Members of the Church of Jesus Christ of Latter-day Saints*. In M. E. Brewster (Chair), *Current Advancements and New Directions in Atheism*

Research. Symposium conducted at the American Psychological Association Annual Convention, Honolulu, Hawaii.

Dehlin, J. P., Galliher, R.V., Bradshaw, W., & Crowell, K.A. (May, 2013). *Sexual Orientation Change Efforts Among Current or Former Members of The Church of Jesus Christ of Latter-Day Saints*. Presentation given at the Society for Research on Identity Formation, Saint Paul, Minnesota.

Crowell, K.A., Galliher, R.V., **Dehlin, J. P.**, & Bradshaw, W. (May, 2013). *A New Quantitative Assessment of The Positive Aspects of Non-Heterosexuality:Psychometrically Evaluated Among a Nationwide Sample of LDS Non-Heterosexual Adults*. Presentation given at the Society for Research on Identity Formation, Saint Paul, Minnesota.

Dehlin, J. P. & Twohig, M.P. (November, 2011). *Acceptance and Commitment Therapy for Scrupulosity: Results of a Multiple Baseline Across Participants Trial*. In **J. P. Dehlin** (Chair), *Understanding and Treating Religious and Sexual Obsessions*. Symposium conducted at the Association for Behavioral and Cognitive Therapies, Toronto, Canada.

Sherwood, J. A., Crosby, J. M., **Dehlin, J. P.**, & Twohig, M. P. (November 2011). *Acceptance Versus Distraction for Unwanted Sexual Thoughts*. Poster presentation at the annual convention of the Association for Behavioral and Cognitive Therapies in Toronto, ON.

Sherwood, J. A., Crosby, J. M., **Dehlin, J. P.**, & Twohig, M. P. (April 2011). *Distraction versus acceptance for unwanted sexual thoughts*. Poster presentation at the annual convention of the Rocky Mountain Psychological Association in Salt Lake City, UT.

Crosby, J. M., Twohig, M. P., **Dehlin, J. P.**, & Mitchell, P. R. (November 2010). *When and how to integrate Acceptance and Commitment Therapy and Habit Reversal in the treatment of trichotillomania*. Poster presentation at the annual convention of the Association for Behavioral and Cognitive Therapies in San Francisco, CA.

Regional Conferences

Dehlin, J. P. (October, 2014). *The Psychosocial Impact of Mixed-Orientation Marriage, Celibacy, Same-Sex Relationships, and Religious Participation for LGBTQ Mormons and Former Mormons*. Utah University and College Counseling Centers Conference, Park City, Utah.

Paramenter, J. G., Crowell, K.A., Galliher, R. V., **Dehlin, J. P.**, & Bradshaw, W. (April

2014). Opening the Closet Door to Creativity: Associations between Non-heterosexual Identity Development and Creativity. Poster to be presented at the annual meeting of the Western Psychological Association, Portland, OR.

Coddington, K. P., Crowell, K.A., Galliher, R. V., **Dehlin, J. P.**, & Bradshaw, W. (April 2014). Counselor Creativity and Therapy Effectiveness for Non-heterosexual Identifying Individuals. Poster to be presented at the annual meeting of the Western Psychological Association, Portland, OR.

Bradshaw, W. & **Dehlin, J. P.** (July, 2012). *Survey Says: Data Analysis of Sexual Orientation Change Efforts in Former and Current LDS Church Members*. 2012 Sunstone Symposium of Mormon Scholarship, Salt Lake City, Utah.

Outreach Activities

2011-2013 **Depression and Anxiety Screening**
USU Counseling and Psychological Services, Logan, UT
Provided depression and anxiety screening and psychoeducation for university students.

2013 **Impact of LDS Sexual Orientation Change Efforts**
USU Counseling and Psychological Services, Logan, UT
Presented educational seminar to CAPS clinical staff.

2013 **"Navigating a crisis of faith" workshop series**
USU Counseling and Psychological Services, Logan, UT
Developed and co-led ten 1.5 hour workshop sessions over a ten week period dealing with the difficulties of losing religious faith.

2013 **Helping Students with Internet Addictions and Other Issues**
Local LDS student ward bishops and stake president, Logan, UT

2012 **Building Psychological Resilience through Work-Life Balance**
Utah State University Air Force ROTC, Logan, UT

2012 **Sexual Orientation Change Efforts of Current and Former LDS Church Members: Results from an Online Survey of 1600 Respondents.**
Utah University & College Counseling Centers Conference, Park City, Utah.

2012 Invited presenter of ***"Can Mormons Change Their Sexual Orientation?"***
Parents, Families, and Friends of Lesbian and Gays (PFLAG), Logan, UT

2011 **Joy of Depression and Effective Coping workshops**
USU Counseling and Psychological Services, Logan, UT
Co-developed and co-led weekly workshops around depression and anxiety for a four-month period.

Professional Development and Training Activities

2013 **Supershrinks: Learning From the Field's Most Effective Practitioners with Scott D. Miller, Ph.D.**
USU CAPS Annual Conference, Logan, UT.

2013 **Internal Family Systems Therapy with Richard Schwartz, Ph.D.**
BYU CAPS Annual Conference, Provo, UT.

2012 **Utah University and College Counseling Centers' Annual Conference**
Park City, UT

2012 **Utah State University CAPS Annual Staff Retreat**
USU CAPS, Logan, UT.

2012 **The How, What and Why of Happiness with Sonya Lyubomirsky, Ph.D.**
USU CAPS Annual Conference, Logan, UT.

2009 **An Introduction to Acceptance and Commitment Therapy with Steven Hayes, Ph.D.**
USU CAPS Annual Conference, Logan, UT.

Grant Activity

Grants Awarded

2011 **Exploration of Experiences and Resources for Same-sex Attracted Latter-day Saints.**
Amount: $10,000
Funding Source: Private
Role: Co-Principal Investigator with Renee Galliher, Ph.D. (Co-PI)
Responsibilities: Developing the relationship with funders. Conducting the research.

2011 **Combining Acceptance and Commitment Therapy with Exposure and Response Prevention to Enhance the Treatment of OCD**
Amount: $50,344

Funding Source: International OCD Foundation
Role: Co-Investigator with Michael Twohig, Ph.D. (P.I) and Jon Abramowitz, Ph.D (Co-I)
Responsibilities: Co-authoring the grant application, budget design and analysis, grant submission.

2010 **Development of ACT-Based Treatments**
Amount: $25,000
Funding source: Private

Role: Co-Principal Investigator with Michael Twohig, Ph.D. (Co-PI)
Responsibilities: Co-authoring the grant application, budget design and analysis, grant submission, conducting the research.

Grants Not Awarded

2010 **Development and pilot test of an on-line dissemination platform for mental health professionals**
Amount: $20,000
Funding Source: Trichotillomania Learning Center
Role: Co-Investigator, Michael Twohig Ph.D. (PI)
Responsibilities: Overall project manager, editing of all documents, budget analysis, submission.

Research Experience

2011—Pres. **Graduate Student and Research Assistant**
Utah State University
Dr. Renee Galliher's Research Lab

2010—2011 **Technical Advisor and Web Site Consultant**
Association for Contextual and Behavioral Science (ACBS)
Founder and co-host of *ACT in Context Podcast*

2009—2011 **Graduate Student and Research Assistant**
Utah State University
Dr. Michael Twohig's Psychology Research Lab

Professional Experience

2013 **Technical Assistant**
USU Counseling and Psychological Services (CAPS), Logan, UT
Designed, developed and implemented campus-wide podcast to extend the center's reach and to provide an introduction to basic psychological services and most common issues.

2009 **Technical Advisor**
Carnegie Foundation for the Advancement of Teaching
Stanford University, Palo Alto, CA

2006—2009 **Director**
International OpenCourseWare Consortium
Massachusetts Institute of Technology, Cambridge, MA

2004-2006 **Director of Outreach**
Center for Open and Sustainable Learning, Logan UT
Utah State University

1998—2004 **Technical Marketing Director, Executive Speech Writer, Executive Business Manager**
Microsoft Corporation, Redmond, WA

1997-1998 **Computer Programmer**
Church of Jesus Christ of Latter-day Saints, Salt Lake City, UT

1995—1997 **Computer Programmer**
Parian Corporation, Chicago, IL

1994—1995 **Associate Consultant**
Arthur Andersen, Chicago, IL

1993—1994 **Associate Consultant**
Bain and Company, Boston, MA (Dallas, TX office)

Membership in Professional Associations

2012-2014 American Psychological Association, student affiliate
APA Division 44: Society for the Psychological Study of Lesbian, Gay, Bisexual and Transgender Issues
APA Division 36: Society for the Psychology of Religion and Spirituality

2013-2014 LGBTQ-Affirmative Therapist Guild of Utah, student affiliate

2013-2014	Society for Research in Identity Formation, student affiliate
2009-2011	Association for Contextual and Behavioral Sciences, student affiliate
2009-2011	Association for Behavioral and Cognitive Therapies, student affiliate

Awards and Honors

2009—2015	Peter Krantz USU Psychology Department Travel Awards
2010—2013	USU Psychology Department Student Travel Awards
2009—2013	Graduate Student Senate Travel Awards
2012	Affirmation LGBT Mormons *Ally Award*
2009	Presidential Fellowship, Utah State University, Logan, UT
2007	Instructional Technology Department Researcher of the Year Utah State University, Logan, UT
1991- 1993	Edwin S. Hinckley Scholarship Brigham Young University, Provo, UT
1987-1988, 1990-1991	Presidential Scholarship Brigham Young University, Provo, UT