SEXUAL MINORITIES WHO REJECT AN LGB IDENTITY

Sexual Minorities who Reject an LGB Identity: Who Are They and Why Does It Matter?

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Abstract

Although some persons with minority sexual orientations do not identify as lesbian, gay, or bisexual (LGB), Minority Stress Theory (Meyer, 2003) has largely been developed utilizing LGB-identified samples. We examined a sample (n = 274) of sexual minorities with diverse religious and sexual identity labels to determine if those rejecting versus adopting an LGB identity were different in terms of religious, sexual, relational, and health characteristics. Results suggested those who reject an LGB identity are more likely to be religiously active, full members of their church, and highly intrinsic and theologically conservative in their religious viewpoint. They further reported having slightly more lifetime heterosexual attractions, fantasies, and behaviors, greater internalized homonegativity, and being more interested in having children and a child-centered family life. They were also more likely to be single and celibate or in a heterosexual relationship. Contrary to expectations, these differences were not associated with health differences in depression, anxiety, and social flourishing. LGB-identified participants did report higher life satisfaction than those rejecting an LGB identity, but this difference was not interpretively meaningful when considered in reference to population norms. We conclude with a discussion of the potential implications of our findings for research, legal and professional advocacy, and clinical care.

Keywords: sexual identity, religion, health, LGBTQ, minority stress

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Although many sexual minorities adopt a lesbian, gay, bisexual (LGB) identity, some persons who experience same-sex attractions reject an LGB identity in favor of other descriptions for their sexuality, such as "same-sex attracted" or "mostly heterosexual" (Lefevor et al., 2020). Because research typically focuses on LGB-identified individuals, very little is known about those who reject an LGB identity. In this study, we seek to identify characteristics of this group and how these characteristics may distinguish them from sexual minorities who are LGB-identified. We also examine to what extent these groups differ on several health measures and close with a discussion about why our findings matter for this literature.

Implications of Minority Stress Theory for Rejecting an LGB Identity

Minority stress theory (MST) maintains that LGB persons experience stress associated with their stigmatized social status and this stress is responsible for their increased risk for psychological distress (Meyer, 2003). Meyer proposed a number of stress processes linked to LGB identity along a distal-proximal continuum. Distal stressors are defined as objective events, such as violence or overt acts of prejudice. Proximal stressors are defined as perceptions or appraisals of objective events, including hypervigilance or internalized stigma. The present study focuses on three core proximal stressors: expectations of rejection, concealment, and internalized homonegativity (IH). Research has indicated that each of these proximal stressors are associated with adverse mental health outcomes for sexual minorities in comparison to their heterosexual counterparts (Cohen et al., 2016; Newcomb & Mustanski, 2010; Pachankis et al., 2020). Each of these may also have implications for sexual minorities who do not identify as LGB.

Expectations of Rejection

Experiences of stigma and prejudice in one's interactions can result in anticipating future rejection and being sensitive and vigilant toward the interpersonal world (Feinstein et al., 2012). Following MST, sexual minorities may reject an LGB identity label to manage stigma and

expectations of rejection in their environment. Heteronormative religious settings are a common example of where such sexual identity rejection may occur.

Concealment

Concealment is an internal psychological-stress process whereby individuals hide their stigmatized minority sexual identity due to feelings of guilt and shame and/or out of fear its disclosure would cause them harm (Meyer, 2003; Pachankis et al., 2020). Within this framework, sexual minorities who reject an LGB identity may do so to evade detection and potential negative ramifications in non-affirming environments. Such consequences might include loss of a social network, loss of social status, expulsion from a private school, and/or loss of church membership.

Internalized Homonegativity

Sexual minorities coping with stigma and prejudice may also internalize these experiences and the accompanying negative beliefs, a stress-inducing process called internalized homonegativity (IH) (Puckett et al., 2017; Szymanski et al., 2008). This internalization of negative beliefs may lead sexual minorities to reject an LGB identity. Certain faith or political communities may, for example, impart beliefs that the experience of same-sex attractions makes one morally deficient or mentally ill.

Religious Exposure and Proximal Stressors

A significant body of research has found religion, and particularly conservative religion, to be associated with these proximal stressors. Generally, conservative or traditional religiosity has been related to more homonegative beliefs, greater sexual minority identity concealment, and higher levels of IH, all of which are in turn associated with poorer mental health outcomes (Crowell et al., 2015; Newcomb & Mustanski, 2010; Pachankis, et al. 2020; Sowe et al., 2014; Stern & Wright, 2017). However, this literature also largely relied upon LGB-identified samples and, as a consequence, may have limited validity for non-LGB-identified conservatively religious sexual minorities (Szymanski et al., 2008). For example, rejection of an LGB identity may limit exposure to proximal stressors

within conservative religious communities and promote access to social connection within these groups, both of which could reduce associations with negative health outcomes.

Although Meyer (2003) theorized sexual minorities who did not adopt an LGB identity would not be subject to proximal stressors, to our knowledge this has not been tested among sexual minorities who reject an LGB identity. From our perspective, individuals experiencing same-sex attractions in a conservative religious setting may not be concealing a sexual identity, but certainly are concealing the presence of sexual attractions whose behavioral enactment would be strictly prohibited. This could promote fears of rejection and internalized negativity. Our study thus presumes these stressors are real for sexual minorities who reject an LGB identity, though further research with such a focus is certainly desirable.

Possibly motivated and undergirded by religious norms, rejection of an LGB identity would also appear to signal a lack of identity integration and self-acceptance, which is viewed in many sexual minority developmental models and LGB-affirmative therapies as the culmination of the coming out process (e.g., McCormick & Baldridge, 2019; Fassinger & Miller, 1996). The minority stress processes resulting in a disruption of LGB identity formation would be expected to result in mental health disparities between sexual minorities who have integrated their LGB identity as compared to those who have rejected it.

Although MST has been helpful in understanding the experiences of many sexual minorities, it was ultimately developed to describe the experiences of LGB-identified sexual minorities. As such, it may have limited applicability to sexual minorities who reject an LGB identity, particularly those in conservative religious contexts. The present study examines sexual minorities who reject an LGB sexual identity label in comparison to those who are LGB identified. In light of the research on minority stress and mental health outcomes, we sought to (a) understand who rejects a sexual minority identity status and (b) determine if this rejection is associated with measures of mental health.

Method

Survey Design

Participants were asked to take part in a survey that was designed to identify important aspects of life and relationships for those who experience (or have experienced) same-sex attractions (SSA) and identify as LGB, heterosexual, other sexual identities, or who reject a label, and were involved in one of four relationship options (i.e., single and celibate; single and non-celibate; heterosexual, mixed-orientation relationship; same-sex relationship). Participants completed the survey through a website designed for the survey (4OptionsSurvey.com). A description of the survey can be found in (Lefevor et al., 2019).

Data Collection and Recruitment

We obtained approval from the Idaho State Institutional Review Board prior to commencing this study. Data collection occurred over a 10-month period from September, 2016 to June, 2017. This involved invitations through (a) news media in Utah; (b) email lists, Facebook groups, and conventions; (c) psychological associations and support networks; and (d) mental health providers. Organizations and networks utilized for recruitment ranged from those religiously and/or conservative oriented (e.g., North Star, Alliance for Therapeutic Choice and Scientific Integrity, People Can Change) to those formally LGB-affirming (e.g., American Psychological Association's Society for the Psychological Study of Sexual Orientation and Gender Diversity, the LGBTQ-affirmative Psychotherapist Guild of Utah, and the National Association for Social Work). Complete details about participant recruitment can be found in (Lefevor et al., 2019). The present study was conducted mostly by individuals who have experienced SSA or identify as LGB. In addition, some members of the research team hold leadership roles in conservative organizations such as North Star and The Alliance for Therapeutic Choice and Scientific Integity. This representation may have encouraged non-LGB-identified participants to believe their perspectives would be represented and

understood. Indeed, 120 (43.8%) participants reported rejecting an LGB identity and 79 (28.8%) participants identified as theologically conservative.

To be included in analyses, participants must have (a) been at least 18 years of age, (b) experienced SSA at some point in their life, (c) identified their relationship status, and (d) completed the first two sections of the survey, which took approximately one hour to complete. More details about recruitment and makeup of the full sample can be obtained from Lefevor et al. (2019).

Participants

A total of 1499 respondents completed all mandatory questions. Our focus for this study was on participants who had never identified as Mormon and rejected or adopted an LGB identity (n = 274) as Mormon participants have been analyzed elsewhere (Lefevor et al., 2020). The average age of these participants was 42.3 (*SD* = 14.8). In terms of gender, 62 participants identified as women, 209 as men, and 14 used other descriptors (e.g., transman, gender fluid, genderqueer). Our sample was primarily White (*n* = 227) and educated, with 75.2% (*n* = 206) earning at least a bachelor's degree.

Measures

The survey included both measures specifically created for this study as well as preexisting measures and was designed to provide data to inform several studies. The present research incorporated the variables described below. Differences in sample sizes for some of these variables occurred due to the exclusion of "not applicable" responses when it was inappropriate to incorporate these responses into the measure.

Demographics

We included single item measures of age, education (a 6-point Likert scale from "*Less than high school degree*" to "*Graduate degree*"), race (0 = White, 1 = All others), and gender (1 = Female, 2 = Male, 3 = Others). The LGB and non-LGB participants did not differ in level of education or racial distribution, but the non-LGB group was older (*M* = 44.98, *SD* = 14.64) than the

LGB group (M = 39.9, SD = 14.52) ($t(272) = 2.87$, $p < .01$, $d = .35$). In addition, the LGB-identified group contained more women (n = 39) than the non-LGB identified (n = 18) ($X^2(2) = 9.98$, $p < .007$, Cramer's $V = .19$).

Religiousness

We utilized four common indicators of religiousness. Church/religious activity was measured on a 5-point Likert scale from 1 = *More than once per week* to 5 = *Stopped attending/not applicable*. This variable was transformed so that higher scores would indicate greater religious activity. Current church/religious statuses examined were "full member," alienated from membership (e.g., probation, disfellowshipped, excommunicated, resigned), and "disinterested/not applicable." Many options for religious views were offered to participants, and categories employed were (a) "theologically conservative, traditional, or orthodox"; (b) "theological moderate"; (c) "theological liberal/progressive"; (d) "other religious views" (e.g., "theologically heterodox" and "spiritual but not religious"); and (e) "non-religious or anti-religious." Intrinsic Religiosity (IR) was measured by the statement, "My whole approach to life is based on my religion/spirituality" (Gorsuch & McPherson, 1989). This item utilized a 7-point Likert scale format from 1 = *Strongly disagree* to 7 = *Strongly agree*.

Relationships

We assessed relationship contexts using four measures. Participants indicated whether they were (a) single and celibate; (b) single and not celibate; (c) in a heterosexual, mixed-orientation relationship; or (d) in a same-sex relationship. Participants' history of heterosexual marriage was assessed with the question, "Have you ever been in a heterosexual marriage?", with response options of (a) currently in a heterosexual marriage, (b) divorced or separated, (c) widowed, (d) never, and (e) other. Due to low frequencies, widowed participants were included in the "other" category. Participants were also asked about the importance they place on having children and living a child-centered life now or in the future. Responses ranged from 1 = *Not important to me* to 4 = *Very*

important to me. Degree of social support was assessed with the question, "I meet my needs for connection, intimacy, and mutual understanding" rated on a 7-point Likert scale anchored by 1 = *Never* to 7 = *Always*.

Sexuality

Sexuality-related variables included Kinsey (Kinsey et al., 1948) lifetime ratings of sexual behaviors, attractions, and fantasies utilizing a 7-point Likert scale ranging from 1 = *Exclusively heterosexual with no homosexual* to 7 = *Exclusively homosexual with no heterosexual*. Two participants who reported no lifetime experience of same-sex attractions, behaviors, and fantasies and were removed from the sample before our analyses. IH was assessed using the three-item internalized homonegativity subscale from the Lesbian, Gay, and Bisexual Identity Scale (Mohr & Kendra, 2011). The authors report an internal consistency of .86 and a test-retest reliability of .92. Cronbach's alpha for the present study was .90. This scale is in line with the original conceptualization of IH (Puckett et al., 2017), including the item, "If it were possible, I would choose to be straight." Total scores could range from 3 to 21, with higher scores signaling greater IH. Participants also indicated the degree of conflict between religious and sexual identities with the single item, "I feel resolved about my sexuality and religious issues." IH and identity resolution were both measured on a 7-point Likert scale ranging from 1 = *Strongly disagree* to 7 = *Strongly agree*.

Sexual Identity Labeling

Participants were asked about their current sexual identity and given 28 options from which to choose. They also indicated their degree of rejection of an LGB identity or acceptance of it through the question, "I am open/out about my rejection of the gay/lesbian/bisexual identity (mark N/A if you identify as gay/lesbian/bisexual)." Degree of openness about LGB identity rejection ranged from 1 = *Never* to 7 = *Always*. Participants who indicated rejection of an LGB identity regardless of their degree of outness about it were grouped (n = 120) and compared with participants identifying as LGB (n = 154), resulting in a final sample of 274.

Not surprisingly, there were significant differences between the groups regarding their current sexual identity ($X^2(17) = 103.68$, $p < .001$, Cramer's $V = .62$. Despite indicating that they rejected an LGB identity, 17 participants also reported an LGB identity. After deliberation, we decided to include these individuals with those who rejected an LGB identity.

Health Indicators

Depression. Current depression was measured using the Patient Health Questionnaire (PHQ-9; Kroenke et al., 2001). The PHQ-9 has good concurrent validity with the Short Form-20 (SF-20) and diagnosis of major depressive disorder (Kroenke et al., 2001). Total scores could range from 4 to 36 with higher scores reflecting greater depression. Cronbach's alpha for the present study was .91.

Anxiety. Current anxiety was measured using the Generalized Anxiety Disorder 7-item (GAD-7) scale (Spitzer et al., 2006). The GAD-7 has good concurrent validity with the SF-20 and diagnosis of generalized anxiety disorder (Spitzer et al., 2006). Total scores could range from 4 to 28 with higher scores indicating greater anxiety. Cronbach's alpha for the present study was .91.

Flourishing. Psychosocial flourishing was measured using the Flourishing Scale (Diener et al., 2009), an 8-item measure of self-perceived success in areas such as relationships, purpose, and optimism rated on a 7-point Likert scale with anchors of 1 = *Strongly disagree* to 7 = *Strongly agree.* Total flourishing scores could range from 8 to 56 with higher scores indicating greater flourishing. The Flourishing Scale is psychometrically validated and is comparable to other measures of psychosocial well-being. Cronbach's alpha for this present study was .93.

Life Satisfaction. Life satisfaction was assessed with the five-item Satisfaction with Life Scale (SWLS; Diener et al., 1985). Participants indicated agreement with statements on a 7-point Likert scale ranging from 1 = *Strongly disagree* to 7 = *Strongly agree.* Total life satisfaction scores could range from 5 to 35 with higher scores signaling greater life satisfaction. Cronbach's alpha for the present study was .89.

Data Analysis

All analyses were conducted using SPSS Statistics 25. Univariate analyses supported the linearity and normality of all our continuous variables. All variables were within the acceptable range with skewness less than 2 and kurtosis less than 5 (West et al., 1995). These impressions were confirmed by examination of residuals. Independent-samples *t*-tests were used for group comparisons on continuous variables. Cohen's *d* was obtained as the effect size statistic and interpreted according to his recommendations (Cohen, 1992). Chi-square statistics were employed for analyses of comparisons for nominal variables. Due to the number of comparisons, we used an alpha of .01 to control for Type I error.

Results

Univariate statistics and participant characteristics for the full sample are presented in Table 1. Results for group comparisons between LGB-identified and LGB-rejecting participants are examined below.

Religion, Relationships, and Sexuality

Tables 2 and 3 display the significant findings for differences between participants who adopt versus reject an LGB identity as pertains to religiousness, relationships, and sexuality. Religiously, sexual minority individuals who rejected an LGB identity tended to be more active in and full members of their church as well as more highly intrinsic and conservative in their religious viewpoint than those who identified as LGB, with effect sizes in the medium to large range. In terms of the relationship variables, those rejecting an LGB identity tended to place a greater emphasis on having family and children and were more likely to be single and celibate than participants who identified as LGB, with effect sizes in the medium range. The groups did not differ in the degree they felt their needs for connection and intimacy were being met, though there was a trend in the direction of LGB participants ($M = 4.91$, $SD = 1.80$) feeling more connected than those who rejected an LGB identity ($M = 4.33$, $SD = 2.01$)($X^2(269) = 2.47$, $p = .013$, $d = .30$). There was not a significant difference in participants' history of involvement in a heterosexual marriage/relationship, although there was a

trend suggesting that those rejecting an LGB identity may be more likely to have been involved in a heterosexual marriage/relationship than LGB participants ($X^2(3) = 9.61$, $p < .05$, Cramer's $V = .19$).

Regarding sexuality, participants who rejected an LGB identity reported greater IH and lower Kinsey lifetime attraction ratings (i.e., more heterosexual attractions, fantasies, and behaviors) than the LGB participants, with effect sizes being large for IH and medium for the Kinsey ratings. In post hoc analyses, we noted within the LGB-identified group the association between IH and depression ($r(154) = .21$, $p = .01$) diminished slightly when controlling for religious activity ($r(154) = .18$, $p < .02$). However, among participants rejecting an LGB identity, the association between IH and depression ($r(120) = .33$, $p < .001$) *increased* when religious activity was controlled ($r(120) = .46$, $p < .001$), suggesting IH and religious activity may operate differently for these groups in relation to health outcomes. The Kinsey ratings indicate that participants who reject an LGB identity label reported on average somewhat more heterosexual attractions, though both groups described themselves as predominantly experiencing same-sex attractions (SSA).

Participants who reject an LGB identity ($M = 5.40$, $SD = 1.81$) did not differ from the LGB group ($M = 5.50$, $SD = 1.65$) in terms of the degree of resolution of conflict between their religious and sexual identities ($X^2(232) = .48$, $p = .63$, $d = .06$). On average, both groups reported moderate agreement with having resolved these issues.

Health Indicators

For the most part, health indicators were not different between sexual minorities who adopted or rejected an LGB identity. The LGB-identified participants and those rejecting an LGB identity label reported similar levels of depression ($M = 14.36$, $SD = 5.39$ vs. $M = 15.37$, $SD = 5.79$, respectively)($t(272) = -1.49$, $p = .14$, $d = .18$), anxiety ($M = 12.05$, $SD = 5.14$ vs. $M = 12.47$, $SD = 4.99$)($t(272) = -.67$, $p = .50$, $d = .08$), and flourishing ($M = 47.37$, $SD = 7.72$ vs $M = 46.13$, $SD = 8.75$)($t(272) = 1.25$, $p = .21$, $d = .15$). However, we did find that participants identifying as LGB reported greater life satisfaction than those rejecting an LGB identity, with a medium effect size.

As a check on our findings, we reran our analyses after removing the 17 participants who indicated an LGB identity earlier in the survey and later indicted rejecting such an identity. The removal of these individuals did not substantially alter our results. In fact, subsequent effect sizes increased modestly, although their strength did not change in terms of conventional interpretive guidelines. These may be individuals less dogmatic about their rejection of an LGB identity, but whatever the reasons for their manner of responding, their inclusion with other participants who reject an LGB identity appears empirically justifiable.

Discussion

We examined a theologically diverse sample of sexual minorities to determine how those who reject an LGB identity may differ from those who have adopted an LGB identity and how the two groups compare in terms of health indicators. Our findings are generally consistent with a recent study on Mormon sexual minorities (Lefevor et al., 2020) and suggest that significant differences exist between the two groups; however, these differences do not appear to translate into health disparities.

Who Rejects an LGB Identity?

Participants who rejected an LGB label were significantly more conservatively religious than LGB-identified participants. They were also more likely to be single and not sexually active or in a heterosexual relationship and place a greater emphasis on raising children than those identifying as LGB. These values and relational choices likely reflect the heteronormative environment of conservative religious communities. Participants who rejected an LGB label also reported more lifetime heterosexual attractions, fantasies, and behaviors than LGB-identified participants. These sexual experiences may undergird the difference between these groups in their involvement in and aspirations for heterosexual marriage and a child-centered family life. Nonetheless, we note that both groups indicated a primarily same-sex sexual orientation.

We found also that both groups reported feeling moderately resolved about any conflicts between their sexuality and religious issues. Both groups also reported similar degrees of social support and age. These findings contrast with expectations that those rejecting an LGB identity may be less developed in their sexual identity than LGB individuals and hence be expected to eventually adopt an LGB identity (Fassinger & Miller, 1996). Rather, it seems more probably likely that the rejection of an LGB identity by these sexual minorities reflects the congruence between their conservatively religious values, their sexual experiences, and their ability to meet needs for connection, intimacy, and mutual understanding within their conservatively religious community (Barringer & Gay, 2017).

In keeping with our view that religiously active sexual minorities who reject an LGB identity are still subject to the proximal stressors of Minority Stress Theory, we found IH to be significantly greater among participants who rejected an LGB identity than for those LGB identified. However, in contrast to our expectations, for the most part this was not associated with worse reported health (see also Barnes & Meyer, 2012). This may be due to the buffering effects on minority stress processes of social support and connection within religious communities (Barringer & Gay, 2017). Exposure to proximal stressors within conservative religious communities may additionally be mitigated by the rejection of an LGB identity, which in turn could reduce associations with negative health outcomes. Additionally, it is possible among some of those rejecting an LGB identity that our measure of IH, which prioritizes a heterosexual identity, may reflect principled religious conviction more than health-diminishing shame or self-loathing (Hallman et al., 2018).

We did not find that participants who rejected an LGB identity had significantly worse levels of depression, anxiety, and psychosocial flourishing than those who were LGB identified. Assuming sexual minorities who reject an LGB identity are indeed subject to proximal sexual minority stressors, this seems at odds with minority stress and sexual identity theories that assume adoption of an LGB identity is the healthiest pathway of sexual minority identity development. This plausibly

could be the result of the underrepresentation in research of sexual minorities who reject an LGB identity or are otherwise living within conservatively religious communities, a problem we discuss below. Nevertheless, these participants did report less life satisfaction than LGB-identified participants. This finding suggests that real stresses remain for sexual minorities who are active in conservative religious environments that may not be completely mitigated by the social capital available within these communities. No doubt leaders and members within these religious traditions can do more to promote emotional and relational thriving among sexual minorities in their communities.

It is also important to situate contextually the health findings within population norms. Means for both groups were in the moderately severe range (i.e., 15-20) for depression (Kronke et al., 2001) and in the moderate clinical range (i.e., 10-14) for anxiety (Spitzer et al., 2006). Despite these health findings, results for psychosocial flourishing indicated both groups were experiencing slightly above average levels of flourishing (Diener et al., 2009). Life satisfaction was slightly below the non-clinical sample average (i.e., 25; Diener et al., 1985) for participants rejecting an LGB identity, whereas the LGB-identified participants reported average life satisfaction levels. However, both groups are classifiable within the "slightly satisfied" range (Pavot & Diener, 1993); therefore, this difference may not be interpretively meaningful. These findings may suggest that, regardless of identity choice and although minority stress negatively impacts the emotional health of these sexual minorities, both groups find ways to live equally flourishing and satisfying lives within their respective religious or LGB communities. Minority stress processes not specific to conservatively religious environments may be dominant in the depression and anxiety findings; alternatively, sexual orientation minority stresses unique to LGB communities may be roughly as harmful to sexual minorities as minority stresses deriving from conservatively religious contexts. It is also possible non-sexual orientation related stress processes common to both groups are important in explaining the emotional distress of our sample. Further research is needed to clarify these important questions.

Implications for Research, Advocacy, and Clinical Care

Our findings have several implications for understanding sexual minorities who reject an LGB identity. We briefly address three intersecting areas of concern related to research and advocacy, clinical care, and the need for profession-wide ideological diversity.

Our findings for sexual minorities who reject an LGB identity seem to go against the scholarly consensus and conventional wisdom pertaining to those who experience SSA but remain in conservative religious faith communities. Contrary to expectations that severe minority stresses within heteronormative religious contexts and a concomitant arrested sexual identity development would be associated with greater adverse health, we found no significant or interpretively meaningful health differences between those rejecting or adopting an LGB identity. This may have been a function of sociopolitically diversifying our research team to gain the trust of and have access to conservative sexual minority networks that have large numbers of individuals who reject an LGB identity. We suspect our findings would not be so surprising if research in this area was regularly conducted outside the LGB networks and venues more easily accessed by researchers whose values and beliefs align with those they study. To put it another way, when studies utilize LGB self-identity as the sexual minority inclusion criterion, they exclude those sexual minorities rejecting an LGB identity by definition and render these individuals invisible.

This potentially serious limitation of the research literature has implications for legal and mental health advocacy, particularly where legislative and policy initiatives impact sexual minorities and their conservative religious communities (Rosik, 2017). Caution should be exercised not to assume theories and constructs derived from LGB samples can be easily generalized to sexual minorities who do not share such an identity (Lefevor et al., 2020). Similarly, using studies limited to or dominated by LGB-identified persons alienated from or uninterested in traditional faith communities (e.g., Dehlin et al., 2015; Hamilton & Gross, 2013; Ryan et al., 2020; Sowe, Brown et al., 2014; Sowe, Taylor et al., 2017) as a basis for laws or advocacy efforts that impact sexual

minorities in traditional religious settings may be a dubious practice (e.g., advocating the curtailment of religious freedoms to promote LGB well-being; Sowe, Taylor, et al., 2017). Legal opinions as well as official pronunciations and clinical guidance from professional associations in this arena need to be primarily grounded in population-based samples able to identify sexual minorities who reject LGB labels or samples purposefully recruiting sexual minorities not LGB identified. Furthermore, mental health professionals encountering sexual minority clients who are (or are not) embedded within conservative religious communities should not assume their rejection of an LGB identity label inhibits their ability to live healthy, meaningful, and satisfying lives.

At the broadest level, our findings highlight the value of ideological diversity for developing a more comprehensive understanding of sexual minorities. When legal and mental health associations become too tribal (Clark & Winegard, 2020), there is a risk certain groups and perspectives will be overlooked, as may have been the case with sexual minorities who reject an LGB identity. As Chambers et al. (2013) warned, "To the extent that social scientists operate under one set of assumptions and values, and fail to recognize important alternatives, their scientific conclusions and social-policy recommendations are likely to be tainted" (p. 148). We hope our experience with an ideologically diverse research team exemplifies the benefits of such an endeavor and encourages legal and mental health professionals to prioritize sociopolitical diversity as a diversity dimension in their research and advocacy.

Limitations

Some limitations of our study should be noted. The study's cross-sectional nature does not allow for a determination of causation in our findings. It is possible that participant characteristics between sexual minorities rejecting versus adopting an LGB identity promote well-being and do so in different ways. It is also possible preexisting levels of well-being lead to specific differences in certain participant characteristics (e.g., less depression enables greater

religious activity among those rejecting LGB identity and less religious activity among those who identify as LGB).

Many of our variables were single-item measures, which is common for exploratory research but precludes our ability to establish their psychometric properties. This limitation also suggests caution in interpreting our findings, although single-item measures are common in the sexual orientation literature and have not prevented other studies from being widely cited (e.g., Dehlin et al., 2015; Ryan et al., 2020).

Our sample consisted primarily of white men and hence may not generalize to women and racial minorities. Finally, we utilized theological identification to discern conservative faith communities among participants. Although this assumption is sensible, it is possible religious viewpoint may not be an exact indicator of the degree to which a participant's religious community is affirming or rejecting of an LGB identity.

Conclusion

We examined a sample of sexual minorities with diverse religious and sexual identity labels to determine if those rejecting versus adopting an LGB identity were different in terms of religious, sexual, relational, and health characteristics. Results suggested those who reject an LGB identity are more likely to be religiously active, hold full membership in their church, and be highly intrinsic and theologically conservative in their religious viewpoint. They further report slightly more heterosexual attractions and behaviors, greater internalized homonegativity, and more interest in raising children. They also were more likely to be single and celibate or in a heterosexual relationship. Contrary to our expectations from minority stress and sexual identity development theories, these differences were not associated with differences in experiences of depression, anxiety, and social flourishing, nor were they related to interpretively meaningful differences in life satisfaction. These findings seem to be at odds with conventional wisdom and underscore the

importance of pursuing sociopolitical diversity among researchers and the populations they study as well as its value for ensuring appropriate legal advocacy and clinical care.

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Table 1

Participant Characteristics

Characteristic	*M*	*SD*	Characteristic	*M*	*SD*
Age	42.11	14.72	Importance of Children	2.35	1.41
Education	4.89	1.24	Internalized Homonegativity	9.77	5.96
Religious Activity	1.91	1.78	Depression	14.80	5.58
Intrinsic Religiousness	5.22	1.96	Anxiety	12.22	5.05
Kinsey Lifetime Rating	5.50	1.52	Psychosocial Flourishing	46.82	8.20
Identity Resolution	5.45	1.72	Life Satisfaction	23.28	7.00

Characteristic	*n*	%	Characteristic	*n*	%
Religious Affiliation			Sexual Identity		
None/Unaffiliated	93	33.9	Lesbian or Gay	96	35.0
Catholic	40	14.6	Same-Sex/Gender Attracted	41	15.0
Evangelical Protestant	32	11.7	Heterosexual with SSA	30	10.9
Baptist	15	5.5	No Option/More than One Applies	23	8.4
Jehovah's Witness	12	4.4	Bisexual	13	4.7
Judaism	12	4.4	Homosexual	13	4.7
Methodist	11	4.0	Heterosexual/Straight Bisexual	12	4.4
Pentecostal	11	4.0	Do Not Use a Label	12	4.4
Exploring Options	11	4.0	Queer	8	2.9
Other	38	13.5	Other	26	9.5
Religious Viewpoint			Race		
Theology Conservative	79	28.8	White/Caucasian	227	82.8
Spiritual/Not Religious	36	13.1	Multi-Ethnic/None Apply	13	4.7
Theology Heterodox	28	10.2	Latina(o)/Hispanic/American	12	4.4
Atheist	25	9.1	Black/African-American	9	3.3
Theology Liberal	22	8.0	Middle Eastern/M.E. American	5	1.8
Theology Moderate	20	7.3	Asian/Asian American	4	1.5
Non-Religious	17	6.2	South Asian	3	1.1
Agnostic	15	5.5	Native American/American Indian	1	.4
Others	32	11.8			
Heterosexual Marriage Status			Relationship Status		
Never Married	194	70.8	Single and Celibate	83	30.3
Currently Married	47	17.2	Same-Sex Relationship/Marriage	78	28.5
Divorced/Separated	24	8.8	Single, Not Celibate	59	21.5
Other	5	1.8	Heterosexual Relation/Marriage	54	19.7
Widowed	4	1.5			
Current Church/Religious Status					
Full Member	133	48.5			
Not Applicable	63	23.0			
Disinterested	49	17.9			
Resigned	20	7.3			
Plan to Leave	4	1.5			
Formal Probation	3	1.1			
Excommunicated	2	.7			

Note. $N = 274$ except for Intrinsic Religiousness ($N = 233$), Kinsey Ratings ($N = 264$), Identity Resolution ($N = 235$), and Importance of Children ($N = 262$). Smaller N's due to *Not Applicable* responses being excluded.

Table 2

Significant Group Differences Between Participants Identifying as LGB and Those Rejecting an LGB Identity

	LGB			Reject LGB				
Variable	*n*	*M*	*SD*	*n*	*M*	*SD*	*t*	Cohen's *d*
Religious Activity	154	1.38	1.70	120	2.58	1.64	-5.88**	.72
Intrinsic Religiousness	116	4.68	2.04	106	5.80	1.70	-4.67**	.60
Children/Family Important	154	2.10	1.32	120	2.68	1.45	-3.40**	.42
Kinsey Lifetime Attraction	152	5.82	1.33	112	5.06	1.64	4.02**	.51
Internalized Homonegativity	154	7.58	5.05	120	12.58	5.87	-7.42**	.91
Life Satisfaction	154	24.29	6.94	120	21.98	6.89	2.75*	.33

Key: * $p < .01$. ** $p < .001$. Unequal variances not assumed for Intrinsic Religiousness, Children/Family Important, Kinsey Rating, and Internalized Homonegativity.

Table 3

Significant Frequency Differences Between Participants Identifying as LGB and Those Rejecting an LGB Identity

Variable	Category	% LGB	% Reject LGB	X^2	Cramer's *V*
Religious Viewpoint	Conservative	13.0%	49.2%	50.50*	.43
	Moderate	5.2%	10.0%		
	Liberal/Progressive	12.3%	5.0%		
	Other	40.3%	20.0%		
	Non- or Anti-Religious	31.2%	15.8%		
Church Status	Full Member	33.1%	68.3%	40.23*	.38
	Alienated from Church	16.0%	3.3%		
	Not Interested/Applicable	50.6%	28.3%		
Relationship Status	Single & Celibate	18.8%	45.0%	41.90*	.39
	Single Not Celibate	26.6%	15.0%		
	Mixed Orientation Relationship	14.3%	26.7%		
	Same-Sex Relationship	40.3%	13.3%		

Key: * $p < .001$.