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Article *in* Journal of GLBT Family Studies · July 2019

DOI: 10.1080/1550428X.2019.1629369

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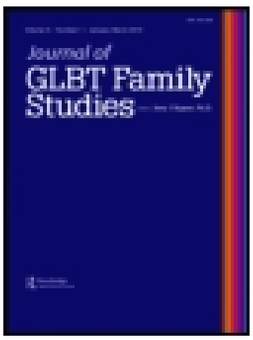

Journal of GLBT Family Studies

ISSN: 1550-428X (Print) 1550-4298 (Online) Journal homepage: https://www.tandfonline.com/loi/wgfs20

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To cite this article: James G. Bridges, G. Tyler Lefevor, Ronald L. Schow & Christopher H. Rosik (2019): Identity Affirmation and Mental Health among Sexual Minorities: A Raised-Mormon Sample, Journal of GLBT Family Studies, DOI: 10.1080/1550428X.2019.1629369

To link to this article: https://doi.org/10.1080/1550428X.2019.1629369

JOURNAL OF GLBT FAMILY STUDIES
https://doi.org/10.1080/1550428X.2019.1629369

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Identity Affirmation and Mental Health among Sexual Minorities: A Raised-Mormon Sample

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ABSTRACT

How can someone successfully integrate a lesbian, gay, or bisexual (LGB) identity and a Mormon identity? Using a sample of 530 LGB-identified individuals raised in the Later-Day Saints (LDS) church, this study asks how factors of empowerment are associated with sexual identity affirmation and mental health outcomes. We found that sexual identity support, connection needs support, LGBT community support, and educational attainment were significantly associated with more positive mental health outcomes. LGB women who were raised Mormon appear to fair worse than men, on average. We also found that those raised Mormon who had disaffiliated with the LDS church reported significantly lower levels of internalized homonegativity than those still affiliated. Clinicians working with LGB Mormons and post-Mormons should consider the effect that affirming sources of support may have on positive mental health outcomes.

KEYWORDS

Sexual minority; mental health; empowerment; Mormon; LDS; suicidality

Can someone really be queer and Christian? How about queer and Mormon? If so, what helps or hinders the integration of these identities? As many as half (52%) of lesbian, gay, bisexual, transgender, and queer (LGBTQ) adults reported affiliation with a religion, with a third of those individuals reporting conflict between their sexual minority identity and religious beliefs (Pew Research Center, 2013). Sexual minorities affiliated with conservative religious organizations, like the Church of Jesus Christ of Latter-Day Saints (LDS or Mormon), often experience discrimination (Hunter, 2010; Oswald, 2001), which is often linked to low support (Doty, Willoughby, Lindahl, & Malik, 2010; Swann & Spivey, 2004) and difficulty reconciling sexual minority and religious identities (Dehlin, Galliher, Bradshaw, & Crowell, 2015). Sexual-minority Mormons engage in a variety of strategies in an effort to reconcile their conflicting identities: (a) rejecting nonheterosexual identity, (b) rejecting religious identity, (c) integrating both identities, and (d) compartmentalizing (Levy & Reeves, 2011; Pitt, 2009; Rodriguez & Ouellette, 2000). Of these strategies, Dehlin et al. (2015) argued that sexual-minority Mormons most commonly reject their religious identity and least commonly affirm both sexual minority and religious identities. Additionally, residing outside of Utah has also been found to be associated with rejecting a religious identity for sexual-minority Mormons (Dehlin et al., 2015).

Because navigating conflict between sexual and religious identities affects well-being (Anton, 2008; Kauth, 2006), identifying the barriers and facilitators to navigating this conflict may help improve mental health for those thus navigating. Accordingly, this study has two main aims: (a)

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to identify group differences based on identity affirmation and mental health outcomes and then (b) to identify how these contextual factors for sexual-minority adults raised in the LDS church community relate to mental health outcomes while controlling for other variables.

Background

To identify specific contextual factors that may be linked to well-being among sexual minorities from conservative religions, we lean on two frameworks that make predictions about the kinds of factors that may be relevant: empowerment and minority stress theories. We then turn to examine the relationship between three individual-level empowerment factors—and the organizational and community factors that support them—and well-being among sexual-minority Mormons: sexual minority identity, religiousness, and gender.

Empowerment and minority stress theories

Empowerment theory posits that when the social environment grants people the ability to make change within that environment (empowerment processes)—otherwise understood as greater access to resources—a sense of control and greater well-being are experienced (empowerment outcomes; Perkins & Zimmerman, 1995), postulating a direct link between individual well-being and the social environment. Empowerment outcomes can include greater access to spiritual resources and privileges in a church, or can refer to fewer health disparities and greater life satisfaction. From this perspective, research with marginalized groups may help identify ways that individuals in these groups and concerned others (i.e., allies) may make changes in their environment such that those marginalized may gain access important resources for safe and healthy living (Perkins & Zimmerman, 1995). This perspective may be particularly applicable for research with queer Christians (Rodriquez, 2010) or Mormons, as these groups may experience a sense of marginalized identity in both LGBTQ and religious settings (Lefevor, Blaber, et al., in press). Applying empowerment theory to social issues involves four main steps: (a) identifying *empowerment deficits*; (b) promoting *empowerment awareness* to the targeted community or organization (the LDS church and queer Mormon community for this study); (c) *mobilization of economic, social, and political power* (social and political groups that are established for support and change); and (d) *changes in the levels of equity in society* (removing main barriers to empowerment; Garnets & D'Augelli, 1994).

Empowerment theory and minority stress theory conjointly provide a framework to understand why mental health disparities may exist and how these disparities may be addressed. Minority stress theory (Meyer, 2003) describes two specific types of stressors that may affect individuals on these levels. Distal stressors are contexts where prejudice, discrimination, or rejection are transferred to the individual. In contrast, proximal stressors are internalized negative beliefs and expectations that result from exposure to discriminatory contexts and experiences. Empowerment theory describes three distinct levels that these stressors may operate on, simultaneously highlighting three levels in which the process of empowerment may operate: individual, organization, and community (Zimmerman, 2000). Taken together, these two theories encourage researchers to examine how various stress-buffering factors are differentially available to minority groups. For example, a sexual-minority individual raised in the LDS church may experience individual factors related to empowerment (e.g., having a graduate degree), organizational factors (e.g., disaffiliation with a homonegative institution), and community factors (e.g., support around their sexual identity).

Empowerment among sexual-minority Mormons

The LDS church holds unique beliefs regarding heterosexual marriage, gender, and familial relationships in the afterlife (Church of Jesus Christ of Latter-day Saints, 2008), which may affect the experience of its sexual-minority members. The LDS church prohibits any form of same-sex sexual relationships (Church of Jesus Christ of Latter-day Saints, 2016a); as such, full participation and access to organizational privileges in the LDS church for sexual-minority Mormons is currently only possible through celibacy or heterosexual marriage. Those who engage in same-sex relationships are subject to church discipline, possibly including the loss of membership through excommunication (as outlined in *Church Handbook* 2, Section 21.4.6; Church of Jesus Christ of Latter-day Saints, 2016b). Excommunication is particularly severe, as it revokes an individual's *saving ordinances* (including baptism), which are seen as necessary for salvation after death (Church of Jesus Christ of Latter-day Saints, 2016c).

Sexual identity status and well-being

Excommunication and the shame that accompanies it may motivate many sexual-minority Mormons to reduce the salience of their same-sex attractions or sexual minority identity. Several organizations, support groups, and online resources have emerged to help Mormons who desire to follow the teachings of the LDS church (e.g., North Star, mormonandgay.lds.org). Many people who desire to do so choose to identify as *same-sex attracted* or *same-gender attracted* (SSA/SGA), rather than LGB, and may do so to indicate a prioritization of their religious identity over a sexual minority identity (Dehlin et al., 2015; Pitt, 2009; Rodriguez & Ouellette, 2000). Those who identify as SSA/SGA tend to be more religious and less engaged with the LGB community but report similar mental health outcomes to LGB-identified Mormons (Lefevor, Sorrell et al., 2019). From an empowerment lens, SSA/SGA Mormons are relatively privileged as they are afforded the organizational and community resources that the LDS church provides.

Where SSA/SGA Mormons appear to draw strength from their religiousness, Mormons who identify as LGB appear to frequently experience religiousness as problematic (Lefevor, Sorrell et al., 2019). This trend may be due to their experience of disempowerment within the LDS church and the nonaffirmation of their sexual identity (Dehlin et al., 2015) and may lead many LGB Mormons to seek empowerment through the mobilization of economic, social, and political power (i.e., level 3; Garnets & D'Augelli, 1994). This empowerment process has led to the development of several organizations designed to help LGB Mormons navigate their sexual and religious identities within a sexual-minority-affirming context including *Affirmation*, *Mormons Building Bridges*, and the *Open Stories Foundation*. Throughout this article, we refer to *sexual identity affirmation*, which we have defined as an individual's beliefs that being gay, lesbian, or bisexual is an important part of who they are and is not deviant or abnormal in any way. Other instances where we discuss affirming same-sex sexuality refers to seeing intimate sexual relations between two people of the same gender as normal and healthy. These organizations seek to help LGB Mormons feel less isolated, accept their same-sex attractions, and reduce their internalized negative beliefs about homosexuality.

Religiousness and well-being

The amount of conflict experienced by sexual-minority Mormons seems to be context dependent. In religious contexts supportive of same-sex desire and relationships, religious life can be a positive source of support and development for sexual minorities (Rodriguez & Ouellette, 2000; Rosenkrantz, Rostosky, Riggle & Cook, 2016). In religious contexts that uphold conservative heteronormative conceptualizations of relationships and partnerships, many sexual-minority individuals experience conflict (Hunter, 2010; Schuck & Liddle, 2001), remove themselves from those

contexts (Herek, Norton, Allen, & Sims, 2010), and experience mental health benefits from so doing (Dehlin et al., 2015). Nonetheless, some sexual-minority people continue engaging in conservative religion despite potential harm to well-being (Herek et al., 2010; Schuck & Liddle, 2001) and reinforcement of internalized homonegativity (Barnes & Meyer, 2012). Although many experience distress (Dehlin et al., 2015), for at least some of these individuals, their conservative faith may buffer the negative effects of internalized homonegativity on well-being (Lefevor, Blaber et al., 2019). Despite the multiplicity of ways in which sexual-minority individuals reconcile conflict with conservative religion, the resolution of this conflict in an authentic way appears to be central to both satisfaction with life and health (Lefevor, Blaber et al., 2019). Moreover, Utah residency has also been considered an important contextual factor, indicating its ability to predict sexual identity affirmation. It appears that a significantly higher percentage of sexual-minority people raised in the LDS church who reject LGB identities live in Utah when compared with those who reject a religious identity (Dehlin et al., 2015). It is still unknown to what degree Utah residency contributes to mental health for sexual-minority Mormons who use LGB labels.

Over 2 decades ago, Garnets and D'Augelli (1994) argued that the (a) stresses of coming out (Charbonnier & Graziani, 2016), (b) heterosexism (Meyer, 2003), and the (c) difficulties identifying with a community (Meyer, 2003) were the main barriers to individual and community development for queer populations. Accordingly, positive experiences in religious/spiritual spaces, sexual minority identity legitimacy, and nonheterosexual relationship legitimacy may be organizational and community level resources LGB Mormons may need greater access to within religious environments (Zimmerman, 2000).

Church affiliation and disaffiliation

If identifying with a community is a main barrier for sexual minority individual development, it is important to consider how sexual-minority Mormons experience the LDS church community. The results are nuanced and seem to depend a great deal on what identities are seen as more salient. On the one hand, church affiliation for sexual-minority Mormon adults has been linked to higher depression and minority stress when compared with those who had disaffiliated from the church (Dehlin, Galliher, Bradshaw, & Crowell, 2014). On the other hand, it has been observed that when religious identity is prioritized over sexual identity, minority stress is mitigated (Crowell, Galliher, Dehlin, & Bradshaw, 2015; Lefevor, Sorrell et al., 2019). Dehlin et al. (2015) also found that half of those who compartmentalized their religious and sexual minority identity and rejected their sexual minority identity lived in Utah—only one-third of those who integrated their religious and sexual minority identity lived in Utah. These findings seemed to suggest that Utah residency was an important consideration for this study. Other findings suggest that adult sexual-minority Mormons who consider their sexual identity more important than their Mormon identity also reported significantly higher rates of stigmatization when compared to those who saw their Mormon identity as more important (Grigoriou, 2014).

Gendered experiences of LGB Mormons

Mormon teaching and doctrine embraces heteronormativity, strongly valuing marriage, family, and traditional gender roles (Church of Jesus Christ of Latter-Day Saints, 2016d), making it unclear how sexual-minority Mormons fit in to these values. Sexual-minority Mormons have a variety of experiences navigating gender roles and expectations, though it seems fairly clear that men and women have distinct experiences (Crowell et al., 2015; Jacobsen & Wright, 2014). Sexual-minority Mormon men appear to be somewhat more likely than sexual-minority Mormon women to stay engaged with the LDS church (Dehlin Galliher, Bradshaw, & Crowell, 2015), perhaps at least in part because of their relative experience of empowerment within the organization as the governing councils at all levels of the LDS church are comprised entirely of men.

Sexual-minority Mormon women may feel more disenfranchized than men, leading them to experience more distress in the LDS church and to leave the organization more readily (Couch, Mulcare, Pitts, Smith, & Mitchell, 2008). Additionally, qualitative analyses have shown that social and cultural pressures to conform to more submissive gender roles experienced in the Mormon Church for sexual-minority Mormon women relate to more negative mental health consequences and decisions to leave the church (Jacobsen & Wright, 2014).

This study

Our review of the literature found that Utah residency (Dehlin et al., 2015), gender (Crowell et al., 2015), and LDS church affiliation (Dehlin et al., 2015)—all of which can be conceptualized as empowerment factors—were related to mental health among sexual-minority Mormons. We also found that sexual-minority Mormons have varied outcomes of well-being depending on how they affirm their identities, how they label themselves, and how these outcomes intersect with LDS church affiliation or disaffiliation (Crowell et al., 2015; Grigoriou, 2014). Given the disempowered role of sexual-minority Mormons—and particularly sexual-minority Mormon women—within the LDS church and guided by empowerment theory (Perkins & Zimmerman, 1995), we are interested in identifying deficits in empowerment and raising awareness of these deficits (i.e., levels 1 and 2) to enhance autonomy and empowerment among sexual-minority Mormons. SSA/SGA Mormons are historically empowered within the LDS church (i.e., safe from church discipline and excommunication). Those identifying as SSA/SGA are more likely to remain active and see their religious identity as more salient to their sexual minority identity, which means they are less likely to engage in same-sex sexual relations because they are adhering to church policy and doctrine. For this study, we focus exclusively on Mormons who identify as LGB and are consequently disempowered for identifying as such.

As our literature review uncovered several systemic deficits in empowerment experienced by LGB Mormons, in our study, we first examine the impact of an individual- (gender), community- (Utah residency), and organizational-level (LDS church affiliation) empowerment factor on the mental health to illustrate these deficits. As a way to structure potential interventions to address empowerment deficits noted, we next examine the relationship between various community- and organization-level empowerment factors and mental health (e.g., LGB community support, connection needs support, sexual-identity specific support) and mental health. Given that individuals would be unable to access these resources without affirming their sexuality, we conclude by examining the role that an individual's internal sense of sexual identity affirmation (acceptance of same-sex attractions, outness, internalized homonegativity) plays in mediating the relationships between empowerment factors and mental health. Our analyses were guided by the following research questions and hypotheses:

RQ1: How do sources of support (empowerment factors), affirmation of sexual identity, and mental health vary by gender, Utah residency, and current LDS church affiliation for LGB identifying sexual-minority individuals raised in the LDS church?

H1: Sexual-minority women will report lower scores of mental health outcomes than sexual-minority men on average.

H2: Sexual-minority individuals residing in Utah will report lower scores on mental health than sexual minorities residing outside the state of Utah.

H3: Sexual-minority individuals still affiliated with the LDS church will report lower scores on mental health and sexual minority identity affirmation than sexual minorities no longer affiliated with the LDS church.

RQ2: How are empowerment factors associated with mental health outcomes directly and indirectly through sexual identity affirmation for LGB identifying sexual minority individuals raised in the LDS church?

Both empowerment theory and minority stress theory argue that the social context influences the internal experiences of the individual. Generally speaking, the research questions and hypotheses assume that levels of support, and other social contexts, whether affirming or nonaffirming, will be associated with mental health outcomes of sexual-minority Mormons. Additionally, empowerment theory, as addressed previously, considers the stresses of coming out and heterosexism as two of the three main barriers to healthy development for sexual-minority populations (Garnets & D'Augelli, 1994). The manifestations of these barriers (measured in this study as acceptance for same-sex attractions, internalized homonegativity, and outness) are considered in light of their relationship to mental health for sexual-minority Mormons.

Method

Procedure

This study uses cross-sectional data from the four-option survey collected from 2016 to 2017, described by Lefevor, Beckstead, et al. (2019). The survey was accessible online through Survey Monkey software. An explanation of the survey, its purposes, and future use of the data was available to participants through a website, which included a link to the survey and necessary information regarding the possible harm and benefits of participation.

The survey was advertised in several outlets, including the *Salt Lake Tribune*, the *LDS Living Magazine*, and the *Online Religion News Source*. Other participants were gained through recruitment announcements in numerous forums for sexual-minority individuals that have a connection to conservative social or religious environments, including meetings for Affirmation, North Star, and the Alliance for Therapeutic Choice and Scientific Integrity. Announcements seeking participation were also posted in sexual-minority online groups like Mormons Building Bridges and emailed through listservs and to various people known to research members' in an attempt to increase the prominence of the study. Other than the listed benefits on the survey website, there was no compensation for the participants.

Participants

The subset for this study included only cisgender men and women who reported they had been raised in the LDS church and identified with sexual minority labels such as gay, lesbian, and bisexual ($n = 530$). Selecting participants raised in the LDS church was made to better isolate the unique experiences of Mormon Church culture and its effects on individuals. The average age for the subsample was 36.4, and 43% reported current affiliation with the LDS church. The majority of the participants identified as White (90%), men (73.6%), and had obtained a bachelor's degree (37%; see Table 1), which may be representative of the larger Mormon population in North America. Nonetheless, analyses should be considered in light of this cultural context. Although participants in this sample report affiliation or disaffiliation with the LDS church, we refer to all respondents as sexual-minority Mormons.

Measures

Demographic items of interest included age, education, ethnicity, gender, sexual orientation, current religious affiliation, and state of residence.

Life satisfaction

Life satisfaction was assessed using the Satisfaction with Life Scale (Diener, Emmons, Larsen, & Griffin, 1985). The scale asked survey participants to rate their satisfaction in life with 5 items.

Table 1. Demographic Information ($N = 530$).

	Women ($n = 140$)				Men ($n = 390$)			
Variables	*n*	%	*M*	*Range*	*n*	%	*M*	*Range*
Age (Years)			33.6	18–68			39.1	18–79
Race/Ethnicity								
Asian/Asian American	0	0%			1	.3%		
African American/Black	2	1.4%			3	.8%		
Latinx/Hispanic/American	4	2.9%			16	4.1%		
Middle Eastern	0	0%			2	.5%		
Native Hawaiian/Pacific Islander	2	1.4%			0	0%		
Native American/Alaskan Native	1	.7%			0	0%		
White/Caucasian	126	90%			358	91.8%		
Mixed Race/Multi-Ethnic	5	3.6%			10	2.6%		
Religious affiliation								
None/Unaffiliated	39	27.9%			135	34.6%		
Looking/Exploring options	8	5.7%			13	3.3%		
Buddhist	3	2.1%			2	.5		
Catholic	2	1.4%			12	3.1%		
Community of Christ	1	.7%			0	0%		
Fundamental LDS/Mormon	0	0%			1	.3%		
Humanist	1	.7%			5	1.3%		
Jehovah's Witness	0	0%			1	.3%		
Judaism	0	0%			4	1%		
Latter-Day Saint/Mormon	65	46.4%			163	41.8%		
Pagan	2	1.4%			0	0%		
Protestant	7	4.9			26	6.7%		
Other	11	7.9%			28	7.2%		
Level of education								
Some high school, no diploma	1	.7%			0	0%		
High school degree (or GED)	5	3.6%			16	4.1%		
Some college but no degree	39	27.9%			72	18.5%		
Associate degree	10	7.1%			20	5.1%		
Bachelor degree	52	37.1%			144	36.9%		
Graduate degree	33	23.6%			132	33.8%		
Vocational training	0	0%			6	1.5%		
Utah residency								
Non-Utah	222	56.9%			77	55%		
Utah	168	43.1%			63	45%		
Sexual orientation								
Lesbian/Gay	71	50.7%			335	85.9%		
Bisexual	69	49.3%			55	14.1%		

Sample statements included "In most ways my life is close to my ideal" and "I am satisfied with my life." Items were assessed on a 7-point scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). Items were coded where higher scores indicated higher levels of life satisfaction. The mean of these items was computed for participants. Internal reliability for this variable was .89 overall, .87 for women, and .90 for men.

Anxiety

Symptoms of anxiety were measured with the Generalized Anxiety Disorder Scale (GAD-7; Spitzer, Kroenke, Williams, & Lowe, 2006). The GAD-7 asked survey participants to rate their level of anxiety with 7 items within the past 2 weeks of reporting. Sample statements included "Not being able to stop or control worrying" and "Feeling afraid as if something awful might happen." Items were assessed on a 4-point scale ranging from 0 (*not at all*) to 3 (*nearly every day*). Items were coded where higher scores indicated higher levels of anxiety. The mean of these items was computed for participants. Internal reliability for this variable was .92 overall, .91 for women, and .92 for men.

Suicidality

The measure for suicidality consisted of one item taken from the patient health questionnaire (PHQ-9; Kroenke, Spitzer, & Williams, 2001) which asked how frequent in the past 2 weeks participants had "thoughts that you would be better off dead or of hurting yourself in some way." Participants indicated the frequency of suicidality on a 4-point Likert scale ranging from 0 (*not at all*) to 3 (*nearly every day*).

Internalized homonegativity

Internalized homonegativity was measured with the three-item internalized homonegativity subscale of the Lesbian, Gay, and Bisexual Identity Scale (Mohr & Kendra, 2011). It assessed internalized homonegativity for participants on a 6-point Likert scale ranging from 1 (*strongly agree*) to 6 (*strongly disagree*). Items included "If it were possible, I would choose to be straight, I wish I were heterosexual" and "I believe it is unfair that I am attracted to people of the same sex." Agreeing with scale items signified higher rates of internalized homonegativity. The mean of these items was computed for participants. Internal reliability for this variable was .89 overall, .90 for women, and .89 for men.

LGB self-acceptance

To measure self-acceptance of same-sex attraction, participants were asked to rate themselves on a 7-point Likert scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*) in response to the statement, "I experience self-acceptance about my same sex attractions."

Outness

Participants were asked to rate the degree to which they were open about their sexual orientation in the following way: "How open/out are you about your experience with same-sex attraction (current or former) and/or being LGBTQ+?" Options included: (1) *not at all open/out*, (2) *open/out to a few people I know*, (3) *open/out to about half of the people I know*, (4) *open/out to most people I know*, and (5) *open/out to all or most people I know*.

Sexual identity support

Participants indicated the degree to which they felt supported in their identities as sexual minorities with items with a 7-point Likert scale ranging from 1 (*never*) to 7 (*always*). Items included "I feel valued and supported for experiencing SSA/being LGBT+;" "I fear I will be ostracized, harmed, and/or lose too much if it were more known about my experiencing SSA/being LGBT+;" and "I am afraid of disappointing my family for experiencing SSA/being LGBT+." The second and third items were reversed coded, and agreement with these items signified higher rates of sexual identity support. The mean of these items was computed for participants. Internal reliability for this variable was .77 overall, .74 for women, and .77 for men.

Connection needs support

To indicate the degree to which participants felt their overall needs in life were being met, they were asked to rate themselves on a 7-point Likert scale ranging from 1 (*never*) to 7 (*always*) in response to the statement, "I meet my needs for connection, intimacy, and mutual understanding."

LGBT community support

To indicate the degree to which participants felt the LGBT community was a source of support, they were asked to rate themselves on a 7-point Likert scale ranging from 1 (*never*) to 7 (*always*) in response to the statement, "The out/open-LGBT community has felt like a supportive community for me."

Analytic plan

Independent samples *t*-tests using *SPSS* were computed to answer our first research question about empowerment deficits. Correlational analyses and a mediated path analysis structural equation model were conducted in *Mplus* to answer our second research question about the relationship between empowerment factors, sexual orientation affirmation, and mental health outcomes. Mediation was analyzed with a bootstrap estimation using 2,000 iterations. The data met assumptions of normality, and fell between −3 and 3 for skewness and −10 and 10 for kurtosis. Full information maximum likelihood was used to handle missing data. Due to the large number of hypothesis tests conducted, we chose a conservative alpha level of .01 to reduce the risk of type I error.

Results

Preliminary analyses

Main differences by gender

Independent samples *t*-tests were conducted to compare mean differences by gender on empowerment factors and mental health outcomes, which included support variables, identity affirmation, life satisfaction, anxiety, and suicidality. All statistics reported have been adjusted to account for violations of the homogeneity assumption where applicable. Due to the large number of hypothesis tests conducted, we chose a conservative alpha level of .01 to reduce the risk of type I error. Men reported significantly higher scores on sexual identity support (women, $M = 2.96$, $SD = 1.66$; men, $M = 3.85$, $SD = 1.56$), $t(528) = -5.72$, $p < .01$, $d = -.50$, and level of outness (women, $M = 2.96$, $SD = 1.66$; men, $M = 3.85$, $SD = 1.56$), $t(528) = -3.19$, $p < .01$, $d = -.28$, than women on average. Women reported significantly higher anxiety symptoms (women, $M = 7.81$, $SD = 5.64$; men, $M = 5.32$, $SD = 5.15$), $t(528) = 4.58$, $p < .01$, $d = .40$, and there was a marginally significant mean difference with higher suicidality scores reported by women at the .01 level (women, $M = .56$, $SD = .88$; men, $M = .36$, $SD = .73$), $t(528) = 2.46$, $p = .015$, $d = .21$, when compared to men on average. These findings mostly confirm our first hypothesis that, overall, LGB-identified sexual-minority women would report significantly more negative mental health outcomes than men. In addition, we found that LGB-identified sexual-minority women reported less sexual identity support and outness than men.

Differences by Utah residency

Independent samples *t*-tests were conducted separately by gender to compare mean differences by Utah residency on empowerment factors and mental health outcomes, which included support variables, identity affirmation, life satisfaction, anxiety, and suicidality. All statistics reported have been adjusted to account for violations of the homogeneity assumption where applicable. No significant mean differences were observed between Utah and non-Utah residency on mental health outcomes or empowerment factors for sexual-minority men and women. There was only a marginally significant mean difference for men residing in Utah reporting higher levels of suicidality (non-Utah, $M = .27$, $SD = .65$; Utah, $M = .47$, $SD = .82$), $t(388) = -2.55$, $p = .011$, $d = -.26$),

Table 2. Independent Samples *T*-test for Sexual-Minority Women and Men Comparing Predictor, Mediator, and Outcome Variables by LDS Church affiliation ($N = 530$).

	LDS Church Affiliation					
	Non-LDS		LDS			
Variables	*M*	*SD*	*M*	*SD*	*t*	*d*
Women ($n = 140$)						
Life satisfaction	4.71	1.28	4.38	1.35	1.50	.25
Anxiety	6.91	5.38	8.85	5.80	−2.05	−.35
Suicidality	.40	.74	.75	1.00	−2.35	−.40
LGB self-acceptance	4.40	.72	4.00	.77	3.18**	.54
Internalized homonegativity	2.47	1.62	3.71	1.80	−4.28**	−.72
Outness	3.87	1.20	2.94	1.69	4.33**	.73
LGBT community support	3.93	1.69	3.23	2.04	2.09	.35
Sexual identity support	3.34	1.53	2.51	1.71	3.05**	.52
Connection needs support	4.09	1.64	3.38	1.81	2.45	.41
Men ($n = 390$)						
Life satisfaction	4.84	1.34	4.27	1.55	3.83**	.39
Anxiety	4.75	4.77	6.10	5.56	−2.56	−.26
Suicidality	.25	.58	.51	.88	−3.27**	−.33
LGB self-acceptance	4.49	.69	4.07	.97	5.00**	.51
Internalized homonegativity	2.24	1.41	3.86	1.95	−9.07**	−.92
Outness	4.31	.99	3.20	1.18	9.78**	.99
LGBT community support	4.17	1.67	3.14	2.03	5.24**	.53
Sexual identity support	4.37	1.21	3.13	1.69	8.02**	.81
Connection needs support	4.12	1.72	2.88	1.79	6.82**	.69

Note. All statistics reported have been adjusted to account for violations of the homogeneity assumption where applicable.
**$p < .01$.

than men with non-Utah residency on average. Our second hypothesis that Utah-residency would be associated with lower scores of mental health for both male and female LGB-identified sexual minorities was not confirmed.

Differences by LDS Church affiliation

Independent samples *t*-tests were conducted separately by gender to compare mean differences by LDS church affiliation on empowerment factors and mental health outcomes, which included support variables, identity affirmation, life satisfaction, anxiety, and suicidality (see Table 2). All statistics reported in Table 2 have been adjusted to account for violations of the homogeneity assumption where applicable.

We found that, on average, women and men no longer affiliated with the LDS church reported significantly higher sexual identity support, with disaffiliated sexual-minority Mormon men also reporting significantly higher connection needs support and LGBT community support than men still affiliated with the LDS church. Women and men also reported significantly higher levels of outness, self-acceptance for their same-sex attractions, and lower internalized homonegativity. LGB-identified sexual-minority men disaffiliated from the LDS church reported significantly lower levels of suicidality and higher levels of life satisfaction compared to men still affiliated with the LDS church. In part, our third hypothesis was confirmed—but mostly for the male subsample, which may have also been due to a smaller sample of LGB-identified sexual-minority women—stating that sexual minorities no longer affiliated with the LDS church would report significantly higher scores on support variables, more affirming of their sexual minority identity, and report more positive mental health outcomes.

Correlations of all continuous variables

We expected that each of the various types of support would be positively associated with identity affirmation, outness, and LGB self-acceptance and negatively associated with lower internalized

Table 3. Correlations for Sexual-Minority Women (Bottom Left; $n = 140$) and Men (Top Right; $n = 390$).

Variables	1	2	3	4	5	6	7	8	9
1. Life satisfaction	–	−.60**	−.49**	.40**	−.38**	.32**	.40**	.64**	.29**
2. Anxiety	−.51**	–	.58**	−.35**	.30**	−.16**	−.32**	−.40**	−.16**
3. Suicidality	−.57**	.47**	–	−.39**	.25**	−.17**	−.27**	−.34**	.22**
4. LGB self-acceptance	.44**	−.32**	−.39**	–	−.51**	.44**	.50**	.36**	.41**
5. Internalized homonegativity	−.27**	.14	.30**	−.52**	–	−.53**	−.51**	−.44**	−.40**
6. Outness	.25**	−.09	−.15	.36**	−.36**	–	.68**	.47**	.52**
7. Sexual identity support	.47**	−.23**	−.33**	.42**	−.45**	.59**	–	.50**	.39**
8. Connection needs support	.56**	−.26**	−.43**	.56**	−.34**	.29**	.35**	–	.41**
9. LGBT community support	.06	.05	−.06	.25**	−.25**	.35**	.14	.10	–

**$p < .01$.

Table 4. Linear Regression Unstandardized, Standard Errors, Standardized Values and R Squared for Control Variables on Outcomes ($N = 529$).

	Life Satisfaction			Anxiety			Suicidality		
Parameter Estimate	*b*	*SE*	*B*	*b*	*SE*	*B*	*b*	*SE*	*B*
Age	−.04	.05	−.04	−.53**	.18	−.13	−.00	.03	−.00
Education	.22***	.06	.18	−.69**	.20	−.15	−.07*	.03	−.10
Gender	−.02	.14	−.01	−1.94***	.51	−.16	−.17*	.08	−.10
LDS affiliation	−.50***	.12	−.17	−1.34**	.45	.12	.26***	.07	.17
Utah residency	−.03	.13	−.01	.20	.46	.02	.14*	.07	.09
Constant			4.14			12.47			.78
df		5			5			5	
R^2		.06			.11			.07	

Note. "LDS Affiliation" is a dichotomous variable coded as such: 0 = Non-LDS; 1 = LDS affiliated. "Gender" is a dichotomous variable coded as such: 1 = Women; 2 = Men. "Utah Residency" is a dichotomous variable coded as such: 0 = Non-Utah; 1 = Utah resident.
*$p < .05$, **$p < .01$, ***$p < .001$.

homonegativity. We also expected that the types of support and identity affirmation would be positively associated with mental health. Overall, our correlational analyses confirmed our hypotheses (see Table 3). In addition to correlational analyses, we also computed linear regression statistics to determine the relationships between our control variables and our main three outcomes (see Table 4).

Mediated path analysis

To better understand the role of sexual orientation affirmation in helping individuals access the empowerment factors available (e.g., sexual identity support, LGBT community support, LDS church affiliation) and consequently affecting these individuals' mental health, we conducted a mediated path analysis using *Mplus*. In this analysis, we examined the direct effects of available individual, community, and organizational empowerment factors (LDS church affiliation, education, Utah residency, sexual identity support, connection needs support, and LGBT community support) on mental health outcomes (life satisfaction, anxiety, and suicidality). We also examined the indirect effects of these empowerment factors on mental health through sexual orientation affirmation (LGB self-acceptance, level of outness, and internalized homonegativity). We used full information maximum likelihood to address missing data, and the model terminated normally and was just identified—thus not requiring the reporting of fit indices (Kline, 2016).

Direct effects

Direct effects are reported in Table 5. Overall, sexual identity support and connection needs support but not LGBT community support were positively related to mental health. Similarly,

Table 5. Unstandardized, Standard Errors, and Standardized Values for Mediated Path Analysis ($N = 500$).

Parameter Estimate	Unstandardized	*SE*	Standardized
Sexual identity support →			
LGB self-acceptance	.18**	.02	.35
Internalized homonegativity	−.31**	.05	−.28
Outness	.37**	.03	.48
Life satisfaction	.15**	.05	.17
Anxiety	−.54*	.20	−.16
Suicidality	−.06	.03	−.12
Connection needs support →			
LGB self-acceptance	.09**	.02	.19
Internalized homonegativity	−.17**	.05	−.17
Outness	.06*	.03	.09
Life satisfaction	.40**	.03	.51
Anxiety	−.77**	.15	−.26
Suicidality	−.10**	.03	−.24
LGBT community support →			
LGB self-acceptance	.08**	.02	.17
Internalized homonegativity	−.16**	.04	−.17
Outness	.16**	.03	.25
Life satisfaction	−.00	.03	−.00
Anxiety	.10	.13	.03
Suicidality	−.01	.02	−.03
LDS affiliation →			
LGB self-acceptance	−.06	.07	−.03
Internalized homonegativity	.84**	.16	.23
Outness	−.37**	.10	−.15
Life satisfaction	.17	.11	.06
Anxiety	−.09	.48	−.01
Suicidality	.09	.07	.06
LGB self-acceptance →			
Life satisfaction	.24**	.07	.14
Anxiety	−1.32**	.39	−.20
Suicidality	−.24**	.06	−.26
Outness →			
Life satisfaction	−.11	.06	−.09
Anxiety	.88**	.25	.20
Suicidality	.13**	.04	.20
Internalized homonegativity →			
Life satisfaction	−.05	.04	−.06
Anxiety	.18	.16	.06
Suicidality	.01	.03	.03
Age →			
Life satisfaction	−.08	.04	−.08
Anxiety	−.44	.17	−.11
Education →			
Life satisfaction	.16**	.05	.13
Anxiety	−.58**	.20	−.13
Suicidality	−.06	.03	−.09
Gender →			
Anxiety	−1.68**	.52	−.14
Suicidality	−.16	.08	−.09
Utah residency →			
Internalized homonegativity	−.34	.14	−.09
Suicidality	.16	.06	.10

Note. Model was just identified, therefore no fit indices are reported. Though all of the outcome and mediator variables were regressed onto all control variables (i.e., age, gender, education, and Utah residency), only significant paths of these parameter estimates are reported within this table. *LDS affiliation* is a dichotomous variable coded as such: 0 = Non-LDS; 1 = LDS affiliated. *Gender* is a dichotomous variable coded as such: 1 = Women; 2 = Men. *Utah residency* is a dichotomous variable coded as such: 0 = Non-Utah; 1 = Utah resident.

**$p < .01$.

self-acceptance and outness but not internalized homonegativity were positively related to mental health. Additionally, sexual identity affirmation (LGB self-acceptance, internalized homonegativity, and outness) was positively related to all support variables (sexual identity,

Table 6. Indirect Effects for Mediated Path Analysis ($N = 500$).

Indirect Paths	*b* (95% CI)
Life satisfaction	
Sexual identity support → LGB self-acceptance → Life satisfaction	.04 (.02, .07)**
Connection needs support → LGB self-acceptance → Life satisfaction	.02 (.01, .04)**
LGBT community support → LGB self-acceptance → Life satisfaction	.02 (.01, .04)
Anxiety	
Sexual identity support → LGB self-acceptance → Anxiety	−.24 (−.41, −.09)**
Sexual identity support → Outness → Anxiety	.32 (.14, .52)**
Connection needs support → LGB self-acceptance → Anxiety	−.11 (−.21, −.04)**
LGBT community support → LGB self-acceptance → Anxiety	−.10 (−.18, −.04)**
LGBT community support → Outness → Anxiety	.14 (.06, .23)**
LDS affiliation → Outness → Anxiety	−.33 (−.62, −.11)
Suicidality	
Sexual identity support → LGB self-acceptance → Suicidality	−.04 (−.07, −.02)**
Sexual identity support → Outness → Suicidality	.05 (.02, .07)**
Connection needs support → LGB self-acceptance → Suicidality	−.02 (−.04, −.01)**
LGBT community support → LGB self-acceptance → Suicidality	−.02 (−.03, −.01)**
LGBT community support → Outness → Suicidality	.02 (.01, .03)**
LDS affiliation → Outness → Suicidality	−.05 (−.09, −.01)

Note. Though all of the outcome variables were regressed onto all predictor and control variables directly and indirectly, only significant paths are reported within this table. *LDS Affiliation* is a dichotomous variable coded as such: 0 = Non-LDS; 1 = LDS affiliated.
**$p < .01$.

connection needs, and LGBT community support). Various demographic variables were associated with mental health outcomes including age, education, and gender. No longer affiliating with the LDS church was negatively related to internalized homonegativity and positively related to outness, but also was not significantly associated in any way with mental health outcomes.

Indirect effects

All outcome variables were regressed onto all predictor and control variables indirectly through each of the three sexual identity affirmation variables (LGB self-acceptance, internalized homonegativity, and outness). Results reported here and in the table are only those indirect paths that were statistically significant (see Table 6). Because internalized homonegativity was not related to any of the mental health outcomes, it did not mediate any of the relationships between empowerment factors and mental health. Self-acceptance and outness, however, largely significantly mediated the relationship between sexual identity support and LGBT community support and mental health. Only self-acceptance mediated the relationship between connection needs support and mental health. Outness mediated the relationship between affiliating with the LDS church and both anxiety and suicidality.

Discussion

Empowerment theory argues that greater access to resources—which are based on individual and environmental factors—grants people the ability to make change within that environment, leading to a sense of control, and greater well-being is experienced (Garnets & D'Augelli, 1994). Applied to minority populations, empowerment theory encourages the identification of empowerment deficits to better understand how barriers to resources at each level of individual development (i.e., personal, community, and organizational) can be addressed and removed. From our findings, we identify the existence of empowerment deficits, the impact of empowerment factors on outcomes, and the role of sexual identity affirmation in accessing empowerment factors among LGB individuals raised Mormons.

What empowerment deficits exist for sexual minorities raised Mormon?

We found empowerment deficits among LGB individuals raised Mormon, based on gender (Perkins & Zimmerman, 1995). LGB-identified sexual-minority women reported more anxiety than did men. Though women, in general, report more psychological distress than men (American Psychological Association, 2010), these significant differences in mental health symptoms may be compounded by the position women in the LDS church hold. LGB-identified sexual-minority women raised Mormon have been noted to have unique mental health challenges and experiences of oppression that lead many to reconsider their relationship with the church (Couch et al., 2008; Jacobsen & Wright, 2014). In contrast, Phillips, Cragun, and Kosmin (2015) have found that more male members are leaving the LDS church, particularly in Utah. However, these findings were general to church population, which may be more indicative of a predominantly heterosexual group. That our study reflects LGB women raised Mormon fair worse is likely due to a unique outcome of marginalization from the experience of being lesbian or bisexual and female. Possibly, Mormon women who begin to identify with sexual minority labels may find that any orthodoxy from their Mormon upbringing shifts toward a more progressive faith framework, resulting in either leaving their religious community for more affirming ones or disconnecting completely with spiritual or religious life altogether.

We also found some evidence that LGB individuals who continue to affiliate with the LDS church experience deficits in empowerment. Though not all pairwise comparisons were significant, trends universally indicated that sexual minorities who no longer identified as LDS reported better mental health and less internalized homonegativity than those still affiliated. Studies examining the effects of affiliation with other conservative religious organizations have yielded similar findings for sexual minorities (Barnes & Meyer, 2012; Crowell et al., 2015).

Despite these apparent differences in mental health outcomes based on religious affiliation, in our path analysis we found that paths between religious affiliation and mental health outcomes were universally nonsignificant. This apparent reversal of effect may be due to the moderating role of internalized homonegativity and support variables. Studies have found that internalized homonegativity may function differently for those who are affiliated with conservative religions than for those who are religiously unaffiliated (Lefevor, Sorell, et al., 2019). Further, studies have consistently found that support buffers the effects of minority stress on psychological distress, such as may be encountered in conservative religious environments (Meyer, 2003). Thus, although there is some evidence that LDS affiliation may be negatively related to mental health, our results seem to indicate that this effect may be better explained by other factors such as the amount and quality of support.

Contrary to expectations, Utah residency was not significantly associated with mental health outcomes. However, suicidality was significantly associated with residing in Utah, while controlling for all other variables. The meaning of this finding is ambiguous and may reflect national trends that find increased suicidality in the mountain west (Pepper, 2017). Alternatively, the increased suicidality may reflect increased minority stress that may occur in states with more homonegative attitudes (Hatzenbuehler, McLaughlin, Keyes, & Hasin, 2010), which may also be supported by increased attention to the prevalence of LGBTQ suicides in Utah (Barker, Parkinson, & Knoll, 2016; Hale, 2018; Williams, 2018).

How might empowerment factors reduce these deficits?

Given the empowerment deficits noted, understanding the factors that may ameliorate these deficits is particularly important. We found that several empowerment factors were largely related to mental health outcomes among including sexual identity support, connection needs support, outness, and support from the LGB community. These findings largely mirror the literature

finding positive relationships between social support and mental health among sexual minorities (Lefevor, Blaber, et al., in press). They also confirm sexual-minority-specific findings that suggest that involvement with the LGB community, outness, and support around sexual identity may buffer the effects of minority stress to enhance well-being (Meyer, 2003).

However, we also found that these factors were not equally available throughout our sample. Women reported less sexual identity support and outness than did men. Those affiliated with the LDS church reported sexual identity support, connection needs support, outness, and support from the LGB community. Taken in light of intersectionality theory (Crenshaw, 1989), these findings suggest that experiencing multiple oppressed identities (i.e., being a woman and being a sexual minority within a conservative religion) may create unique forms of discrimination that result in negative outcomes, in this case, in reduced support around sexual identity. Given the relationship between these factors and mental health outcomes, it may be that diminished access to these empowerment factors may contribute to the mental health disparities noted previously.

How do people access these empowerment factors?

Because we were interested in not only noting deficits in empowerment but in identifying concrete ways to help people access empowerment factors, we conducted a mediated path analysis to better understand how LGB individuals raised Mormon may access empowerment factors. In particular, we focused on the role that outness and acceptance of same-sex attractions and the related connection needs support may play in helping individuals access the empowerment factors noted.

We found that, of all of the variables, both connection needs support and accepting one's same-sex attraction were the most strongly related to mental health outcomes. Additionally, we found that accepting same-sex attractions mediated the relationships between sexual identity support, connection needs support, and LGBT community support and all mental health outcomes. These findings seem to be supported by the previous literature, which identified the important role that self-acceptance plays in overall well-being for sexual-minority Mormons and other religiously oriented individuals (Dahl, & Galliher, 2009; Dehlin et al., 2014).

We also found that outness mediated the relationships between sexual identity support, LGBT community support, LDS church affiliation, and anxiety and suicidality. Though there is limited literature on outness and religious communities, it has been found that the process of coming out can be more difficult for individuals with more identity conflict with being a sexual minority and religious (Schuck, & Liddle, 2001). Our data also seems to reflect this, suggesting that being affiliated with the LDS church is associated with how out one is as a sexual minority, which is then related to how much anxiety or suicidality you experience. Considering the history of the church and sexual minority experiences (Grigoriou, 2014), this finding is to be expected and may shed light on the difficulty of not only holding both queer and Mormon identities, but allowing these integrated identities to be seen and affirmed in Mormon congregations.

Implications

We identified several deficits in empowerment and found various empowerment factors that are related to mental health among sexual-minority individuals raised Mormon. As we ultimately desire to empower sexual-minority individuals raised in conservative religions to exercise more autonomy in their lives, we provide several recommendations for ways clinicians, religious communities, researchers, and concerned others may use our findings to effect such change (Zimmerman, 2000).

Clinical settings

Psychotherapy may be a crucial setting for sexual-minority individuals from conservative religious backgrounds to foster self-acceptance (Bradshaw, Dehlin, Crowell, Galliher, & Bradshaw, 2015; Butler, 2010), which we found to be strongly related to the utilization of various community resources related to mental health. This study highlights how crucial various forms of identity affirming support are for well-being and self-acceptance of sexual minorities raised in the LDS church. The findings suggest that determining what social supports are in place and how affirming these social supports are of minority sexual identities is important. Specifically, considering the findings regarding the role that outness plays for this population, it also seems important that clinicians guide sexual-minority clients through what it would mean to come out, to what degree, how this would impact their religious life, and what kinds of connection needs supports are in place if coming out leads to a loss of community or significant portion of their community. Clinicians can also become informed of the support groups, online resources, and media outlets that provide support and validation for the unique struggles faced by sexual-minority religious adults raised Mormon.

Religious communities

With strong heteronormative religious teachings, the LDS church leaves little room for diverse theological interpretation—interpretation that could make room for nonheterosexual identities. Subsequently, Mormons gain greater access to religious privileges as they act and report more orthodoxy to ecclesiastical leaders. Because affirming one's nonheterosexual identity goes against LDS-authorized religious teaching (Oaks, 1995) religious privileges and opportunities to participate are often withdrawn (Church of Jesus Christ of Latter-Day Saints, 2016b). Because endorsed teachings and spaces leave little room for sexual minority identity affirmation—which we found to be directly linked to mental health—religious communities may need to create their own spaces, without the endorsement of church leaders. As sexual minorities experience self-acceptance around their same-sex attractions, come out, and gain access to these resources (i.e., Affirmation, Mormonspectrum.org, Open Stories Foundation, Family Acceptance Project), they are likely to improve their mental health.

Limitations and future directions

Despite our intentions to gather data in a generalizable way, our results are inherently limited by our sampling procedure, instruments used, and analysis plan. Our sample was limited to LGB-identified individuals who were raised Mormon. There are many sexual-minority Mormons who reject sexual identity labels for whom these results may not extend to (Lefevor, Sorell, et al., 2019). It is unclear how well our results generalize to sexual minorities raised in other Christian or religious traditions, as well as how outcomes may vary between individuals who identify as gay/lesbian and bisexual. Although we employed a variety of means to get as representative a sample as possible, it is likely that our sample does not accurately reflect the experience of LGB individuals raised Mormon generally. Access to the survey largely depended on individuals who were connected to online groups and news outlets—many based out of the Utah region. Moreover, though the LDS church is an international organization, the majority of its members reside in regions of the world that have majority Caucasian populations, with a little over half (56%) of its church membership residing in North America alone (Church of Jesus Christ of Latter-Day Saints, 2018). Our sample reflects a group that is highly educated and majority Caucasian and thus generalizability should be considered with this cultural context.

In this study, we conceptualized outness as a static variable that reflected the degree to which individuals disclose an LGB to others. Research on outness, however, indicates that its

relationship to mental health and other outcomes of well-being is context dependent (Kosciw, Palmer, & Kull, 2015). Future research should examine outness in this lens (D'Augelli, 1994). Further, although we assessed affiliation with the LDS church, we were not able to assess religiousness more generally, and future research should examine the role of religiousness more generally in the mental health of sexual minorities raised Mormon.

Conclusion

The aim of this study was to understand how factors of empowerment factors (i.e., sexual identity support, connection needs support, LGBT community support, Utah residency, education, and LDS church affiliation) were associated with sexual identity affirmation (i.e., LGB self-acceptance, internalized homonegativity, and level of outness) and mental health outcomes (i.e., life satisfaction, anxiety, and suicidality). We found that sources of support were strong predictors of positive sexual identity affirmation and mental health outcomes. We also found that disaffiliating with the LDS church was associated with lower internalized homonegativity and that support from LGBT communities improved mental health. We encourage clinicians to assess various forms of identity affirming support and provide established resources and communities for sexual minority clients raised Mormon. Considering the significant associations that sexual identity support and connection needs support has on mental health and well-being, we encourage family and friends of LGB-identified sexual-minority Mormons to honor their identity choices and support them in their chosen level of participation within the LDS church.

Conflicts of interest

We declare no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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References

American Psychological Association. (2010). Stress in America: Gender and stress. Retrieved from https://www.apa.org/news/press/releases/stress/2010/gender-stress.pdf.

Anton, B. S. (2008). Proceedings of the American Psychological Association for the legislative year 2007: Minutes of the annual meeting of the Council of Representatives and minutes of the meetings of the Board of Directors. *American Psychologist*, *63*(5), 360–402. doi:10.1037/0003-066X.63.5.360

Barker, M., Parkinson, D., & Knoll, B. (2016). The LGBTQ Mormon crisis: Responding to the empirical research on suicide. *Dialogue: A Journal of Mormon Thought*, *49*(2), 1–24.

Barnes, D. M., & Meyer, I. H. (2012). Religious affiliation, internalized homophobia, and mental health in lesbians, gay men, and bisexuals. *American Journal of Orthopsychiatry*, *82*(4), 505–515.

Bradshaw, K., Dehlin, J. P., Crowell, K. A., Galliher, R. V., & Bradshaw, W. S. (2015). 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*, *41*(4), 391–412. doi:10.1080/0092623X.2014.915907

Butler, C. (2010). Sexual and gender minorities: Consideration for therapy and training. In C. Butler, A. O'Donovan, & E. Shaw (Eds.), *Sex, sexuality and therapeutic practice: A manual for therapists and trainers* (pp. 85–128). New York, NY. Routledge/Taylor & Francis Group.

Charbonnier, E., & Graziani, P. (2016). The stress associated with the coming out process in the young adult population. *Journal of Gay & Lesbian Mental Health*, *20*, 319–328. doi:10.1080/19359705.2016.1182957

Church of Jesus Christ of Latter-day Saints. (2008). *Same-sex marriage and proposition 8*. Salt Lake City, UT: Newsroom. Retrieved from https://www.mormonnewsroom.org/article/same-sex-marriage-and-proposition-8.

Church of Jesus Christ of Latter-day Saints. (2016a). *Same-sex attraction*. Retrieved from https://www.lds.org/topics/same-sex-attraction?lang=eng.

Church of Jesus Christ of Latter-day Saints. (2016b). *Handbook 2: Administering the Church*. Retrieved from https://www.lds.org/handbook/handbook-2-administering-the-church/selected-church-policies/21.4.5?lang=eng&_r=1#214.

Church of Jesus Christ of Latter-day Saints. (2016c). *Baptism*. Retrieved from https://www.lds.org/topics/baptism?-lang=eng.

Church of Jesus Christ of Latter-day Saints. (2016d). *The family: A proclamation to the world*. Retrieved from https://www.lds.org/topics/family-proclamation?lang=eng&old=true.

Church of Jesus Christ of Latter-day Saints. (2018). *Newsroom: Facts and statistics*. Retrieved from https://www.mormonnewsroom.org/facts-and-statistics#.

Couch, M., Mulcare, H., Pitts, M., Smith, A., & Mitchell, A. (2008). The religious affiliation of gay, lesbian, bisexual, transgender and intersex Australians: A report from the private lives survey. *People and Place*, *16*, 1–11.

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum*, 1989, 139–167. Retrieved from http://chicagounbound.uchicago.edu/cgi/viewcontent.cgi?article=1052&context=uclf

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*, *62*(2), 242–267. doi:10.1080/00918369.2014.969611

D'Augelli, A. R. (1994). Identity development and sexual orientation: Toward a model of lesbian, gay, and bisexual development. E. J. Trickett, R. J. Watts, & D. Birman (Eds.), *Human diversity: Perspectives on people in context*. San Francisco. Jossey-Bass.

Dahl, A. L., & Galliher, R. V. (2009). LGBQQ young adult experiences of religious and sexual identity integration. *Journal of LGBT Issues in Counseling*, *3*(2), 92–112. doi:10.1080/15538600903005268

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*, *15*, 1–22. doi:10.1080/15283488.2014.989440

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 and Lesbian Mental Health*, *18*(3), 284–311. doi:10.1080/19359705.2014.912970

Diener, E., Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The satisfaction with life scale. *Journal of Personality Assessment*, *49*(1), 71–75. doi:10.1207/s15327752jpa4901_13

Doty, N. D., Willoughby, B. L., Lindahl, K. M., & Malik, N. M. (2010). Sexuality related social support among lesbian, gay, and bisexual youth. *Journal of Youth and Adolescence*, *39*(10), 1134–1147. doi:10.1007/s10964-010-9566-x

Garnets, L. D., & D'Augelli, A. R. (1994). Empowering lesbian and gay communities: A call for collaboration with community psychology. *American Journal of Community Psychology*, *22*(4), 447–470. doi:10.1007/BF02506889

Grigoriou, J. A. (2014). Minority stress factors for same-sex attracted Mormon adults. *Psychology of Sexual Orientation and Gender Diversity*, *1*(4), 471–479. doi:10.1037/sgd0000078

Hale, L. (2018). *Can the LDS church be blamed for Utah's LGBT suicides?* Retrieved from https://www.kuer.org/post/can-lds-church-be-blamed-utah-s-lgbt-suicides.

Hatzenbuehler, M. L., McLaughlin, K. A., Keyes, K. M., & Hasin, D. S. (2010). The impact of institutional discrimination on psychiatric disorders in lesbian, gay, and bisexual populations: A prospective study. *American Journal of Public Health*, *100*(3), 452–459. doi:10.2105/AJPH.2009.168815

Herek, G. M., Norton, A. T., Allen, A. J., & Sims, C. L. (2010). Demographic, psychological, and social characteristics of self-identified lesbian, gay, and bisexual adults in a US probability sample. *Sexuality Research and Social Policy*, *7*(3), 176–200. doi:10.1007/s13178-010-0017-y

Hunter, S. (2010). *Effects of conservative religion on lesbian and gay clients and practitioners: Practice implications*. Washington, DC: NASW Press.

Jacobsen, J., & Wright, R. (2014). Mental health implications in Mormon women's experiences with same-sex attraction: A qualitative study. *The Counseling Psychologist*, *42*(5), 664–696. doi:10.1177/0011000014533204

Kauth, M. R. (2006). The evolution of human sexuality: An introduction. *Journal of Psychology and Human Sexuality*, *18*(2–3), 1–22. doi:10.1300/J056v18n02_01

Kline, R. B. (2016). *Principles and practice of structural equation modeling*. 4th ed. New York: The Guilford Press.

Kosciw, J. G., Palmer, N. A., & Kull, R. M. (2015). Reflecting resiliency: Openness about sexual orientation and/or gender identity and its relationship to well-being and educational outcomes for LGBT students. *American Journal of Community Psychology*, *55*(1–2), 167–178. doi:10.1007/s10464-014-9642-6

Kroenke, K., Spitzer, R. L., & Williams, J. B. W. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine*, *16*(9), 606–613.

Lefevor, G. T., Beckstead, A. L., Schow, R. L., Raynes, M., Mansfield, T. R., & Rosik, C. H. (2019). Satisfaction and health within four sexual identity relationship options. *The Journal of Sex and Marital Therapy*. doi:10.1080/0092623X.2018.1531333

Lefevor, G. T., Blaber, I. P., Huffman, C. E., Schow, R. L., Beckstead, A. L., Raynes, M., & Rosik, C. H. (in press). Sexual minority Mormon well-being, religiousness, sex positivity, and beliefs about same-sex sexuality. *The Psychology of Religion and Spirituality*.

Lefevor, G. T., Sorrell, S. A., Kappers, G., Plunk, A., Schow, R. L., Rosik, C. H., & Beckstead, A. L. (2019). Same-sex attracted, not LGBQ: The implications of sexual identity labelling on religiosity, sexuality, and health among Mormons. *The Journal of Homosexuality*. doi:10.1080/00918369.2018.1564006

Levy, D. L., & Reeves, P. (2011). Resolving identity conflict: Gay, lesbian, and queer individuals with a Christian upbringing. *Journal of Gay & Lesbian Social Services*, *23*, 53–68. doi:10.1080/10538720.2010.530193

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, *129*(5), 674–697. doi:10.1037/0033-2909.129.5.674

Mohr, J. J., & Kendra, M. S. (2011). Revision and extension of a multidimensional measure of sexual minority identity: The lesbian, gay, and bisexual identity scale. *Journal of Counseling Psychology*, *58*(2), 234–245. doi:10.1037/a0022858

Oaks, D. H. (1995). *Same-gender attraction*. Retrieved from https://www.lds.org/study/ensign/1995/10/same-gender-attraction?lang=eng.

Oswald, R. F. (2001). Religion, family, and ritual: The production of gay, lesbian, bisexual, and transgender outsiders-within. *Review of Religious Research*, *43*(1), 39–50. doi:10.2307/3512242

Pepper, C. M. (2017). Suicide in the mountain west region of the United States. *Crisis*, *38*(5), 344–350. doi:10.1027/0227-5910/a000451

Perkins, D. D., & Zimmerman, M. A. (1995). Empowerment theory, research, and application. *American Journal of Community Psychology*, *23*(5), 569–579. doi:10.1007/BF02506982

Pew Research Center. (2013). *A survey of LGBT Americans: Attitudes, experiences and values in changing times*. Retrieved from http://www.pewsocialtrends.org/files/2013/06/SDT_LGBTAmericans_06-2013.pdf.

Phillips, R., Cragun, R. T., & Kosmin, B. A. (2015). Increasing sex ratio imbalance among Utah Mormons: Sources and implications. *Interdisciplinary Journal of Research on Religion*, *11*, 1–27.

Pitt, R. N. (2009). "Still looking for my Jonathan": Gay Black men's management of religious and sexual identity conflicts. *Journal of Homosexuality*, *57*(1), 39–53. doi:10.1080/00918360903285566

Rodriguez, E. M., & Ouellette, S. C. (2000). Gay and lesbian Christians: Homosexual and religious identity integration in the members and participants of a gay-positive church. *Journal for the Scientific Study of Religion*, *39*(3), 333–347. doi:10.1111/0021-8294.00028

Rosenkrantz, D. E., Rostosky, S. S., Riggle, E. D. B., & Cook, J. R. (2016). The positive aspects of intersecting religious/spiritual and LGBTQ identities. *Spirituality in Clinical Practice*, *3*(2), 127–138. doi:10.1037/scp0000095

Schuck, K. D., & Liddle, B. J. (2001). Religious conflicts experienced by lesbian, gay and bisexual individuals. *Journal of Gay & Lesbian Psychotherapy*, *5*, 63–82. doi:10.1300/J236v05n02_07

Spitzer, R. L., Kroenke, K., Williams, J. B. W., & Lowe, B. (2006). A brief measure for assessing generalized anxiety disorder. *Archives of Internal Medicine*, *166*(10), 1092–1097. doi:10.1001/archinte.166.10.1092

Swann, S. K., & Spivey, C. A. (2004). The relationship between self-esteem and lesbian identity during adolescence. *Child and Adolescent Social Work Journal*, *21*, 629–646. doi:10.1007/s10560-004-6408-2

Williams, T. (2018). *Utah is finally addressing its epidemic of youth suicide*. Retrieved from https://www.advocate.com/commentary/2018/4/26/utah-finally-addressing-its-epidemic-youth-suicide.

Zimmerman, M. A. (2000). Empowerment theory: Psychological, organizational and community levels of analysis. J. Rappaport & E. Seidman (Eds.), *The handbook of community psychology*. New York: Plenum Press.