

Psychological Distress among Sexual and Religious Minorities:

An Examination of Power and Privilege

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## **Psychological distress among sexual and religious minorities:**

### **An examination of power and privilege**

With the legalization of same sex marriage in the United States 2015, there appears to be growing acceptance of the experience of lesbian, gay, bisexual, queer, and questioning (LGBQQ) individuals. With several major religious groups opposing the legalization of same sex marriage, many have raised questions about the impact of religious identity on well-being for both heterosexual and LGBQQ individuals.

### **Sexual Identity**

Despite the existence of a majority of Americans who believe that homosexuality should be accepted by society (63%; Pew Research Center, 2017), LGBQQ individuals continue to be the target of discrimination and prejudice. Sexual minorities report experiencing harassment and hate crimes at greater rates than their heterosexual peers (Balsam, Rothblum, & Beauchaine, 2005; Berrill, 1990; Herek, Cogan, & Gillis, 2002; Silverschanz, Cortina, Konk, & Magley, 2008) with meta-analytic findings indicated that 55% of sexual minorities experiencing verbal harassment and 41% experiencing discrimination (Katz-Wise & Hyde, 2012). Sexual minorities also are more likely to make suicide attempts (King et al., 2008; Marshal et al., 2013; Russell & Joyner, 2001), experience increased social isolation (Link, Struening, Rahav, Phelan, & Nuttbrock, 1997; Rosenfield, 1997; Wright, Gonfrein, & Owens, 2000), decreased well-being (Meyer, 2003), and increased prevalence rates of several psychological disorders such as depression and anxiety (King et al., 2008; Lick, Durso & Johnson, 2013). Minority stress (Meyer, 2003) resultant from increased discrimination, hypervigilance, and internalized homonegativity among sexual minorities has been proposed as a mechanism to explain these increased rates.

Despite increased awareness of the experience of lesbian and gay individuals, the challenges and discrimination faced by bisexual, queer, and questioning individuals are less well known (Friedman, 1999). Bisexual individuals tend to experience more internalized homophobia (Rosario, Schrimshaw, Hunter, & Gwadz, 2002), less perceived social support (Balsam & Mohr, 2007; Sheets & Mohr, 2009), and more psychological distress (Efrigg, Maloch, McAleavey, Locke, & Bieschke, 2014; McAleavey, Castonguay, & Locke, 2011) than gay men or lesbian women. Questioning individuals also experience increased psychological distress (McAleavey et al., 2011). These effects may be due in part to the discrimination, prejudice, and stigmatization experienced by bisexual, queer, and questioning individuals by both heterosexual and sexual minority groups (Russell & Joyner, 2001).

### **Religious Identity**

Religious participation and religiosity have largely been linked with improved physical and mental health (Miller & Thoresen, 2003), decreased substance abuse (Brenda & Corwyn, 2000), lower rates of depression (Koenig, McCullough, & Larson, 2001), increased psychological well-being (Levin, Markides, & Ray, 1996), decreased rates of suicide (Colucci & Martin, 2008; Rasic et al., 2009), and decreased levels of psychological distress (McIntosh, Silver, & Wortman, 1993). In a meta-analysis examining the relationship between religiosity/spirituality and mental health, 72% of the studies suggested a positive relationship (Bonelli & Koenig, 2013).

Contrary to the general positive relationship between religiosity/spirituality and psychological outcomes, some studies have found an inverse relationship. Religious affiliation has been associated with increased depression (McConnell, Pargament, Ellison, & Flannelly, 2006) and increased eating disorder symptoms (Smith, Richards, & Maglio, 2004). Several

studies have examined potential explanations for the adverse effects of religion and spirituality on mental health and have identified variables such as extrinsic/intrinsic religiosity (Maltby & Day, 2000; Smith et al., 2004), strength of religious belief (McIntosh et al., 1993), and religious coping style (Ano & Vasconcelos, 2005). This makes it unclear what kind of relationship to expect between religion and psychological distress.

Similar to sexual identities, certain religious identities are privileged over others. Within the cultural context of the United States of America, Jewish and Christian (including Catholic) religious identities have historically been associated with more privilege with other groups being discriminated against (Bowman & Small, 2012). Although more Americans than ever are declining religious identification (Pew Research Center, 2015), historically, individuals identifying as atheist or non-religious have also been marginalized. Due to the privileged position of Judeo-Christian identities (Schlosser, 2003), it is possible that the positive mental health benefit understood from religious participation may also be due to the increased privilege of possessing a majority identity.

### **The Intersection of Sexual and Religious Identities**

Though religion appears to be generally associated with positive mental health, the relationship is much more ambiguous for LGBTQ individuals. In many Judeo-Christian religions, homosexuality is condemned as immoral, with many LGBTQ individuals reporting negative experiences with religion (Dehlin et al., 2015). Many LGBTQ individuals may leave offending religions (Schuck & Liddle, 2001), likely leading to lower rates of Judeo-Christian affiliation. However, the presence of protective factors associated with Judaism and Christianity such as increased community and a formulated belief system along with being a dominant

religious identity makes it unclear whether an LGBQQ individual of faith is likely to experience increased or decreased distress relative to an LGBQQ individual not of faith.

Many studies report strong associations between religiosity and negative outcomes for sexual minority individuals (Barnes & Meyer, 2012; Dehlin et al., 2015; Hamblin & Gross, 2013). Further, LGBQQ individuals who grow up in non-affirming religions tend to leave behind their religious affiliation in adulthood (Herek, Norton, Allen, & Sims, 2010; Rodriguez & Ouellette, 2000; Sherkat, 2002), indicating that religion may be more distressing than beneficial. However, other studies have found positive relationships between religious affiliation or attendance and mental health for LGBQQ individuals (Gattis, Woodford, & Han, 2014; Kralovec, Fartacek, Fartacek, & Ploderl, 2012).

Despite these trends, many sexual minority individuals continue to affiliate religiously (Dahl & Galliher, 2009; Schuck & Liddle, 2001), including with religions whose formal policies are not affirmative of minority sexual identity. These individuals have been found to be more likely to evidence more internalized homonegativity (Barnes & Meyer, 2012; Harris, Cook, & Kashubeck-West, 2008; Herek, Gillis, & Cogan, 2009; Wagner, Serafini, Rabkin, Remien, & Williams, 1994), shame (Baames et al., 2015), and psychological distress (Mahaffy, 1996; Rodriguez & Ouellette, 2000).

### **Intersectionality, Privilege, and Power**

As many sects of Judaism and Christianity continue to not be supportive of LGBQQ identities, individuals who identify as LGBQQ and Judeo-Christian may report increased distress. However, these individuals may also benefit from the privileged status of a majority religious identity, which may be linked to lower levels of distress. Intersectionality theory which originated in analysis of the experience of Black lesbians (Cole, 2009; Crenshaw, 1989;

Crenshaw, 1991) proposes that identities must be understood as 1) socially co-constructed by the individual and context lived in, 2) embedded in historical systems of power and oppression, and 3) non-additive elements, such that individuals with intersecting identities may have experiences different from individuals from either identity category separately. An intersectional approach consequently examines the role of power and privilege within identities as well as the unique outcomes exhibited by individuals with intersecting identities. In the present study, we take an intersectional approach to investigate the role of power and privilege within sexual and religious identities and the relationship of these identities with psychological distress.

### **Hypotheses**

The present study was guided by the question, what is the influence of sexual identity, religious identity, and their interaction on psychological distress? Based on intersectionality theory and research on the influence of sexual identity and religion on mental health, we proposed three hypotheses. 1) Minority sexual identity will be significantly related to psychological distress, with individuals exhibiting more marginalized sexual identities evidencing greater distress than individuals with less marginalized identities. 2) Minority religious identity will similarly be significantly related to psychological distress with the lowest levels of distress evidenced by Judeo-Christian individuals and the highest levels of distress evidenced by religious minorities. 3) Sexual and religious identities will interact such that individuals who identify as sexual minorities and Judeo-Christian will experience more distress than individuals who identify as sexual minorities and non-Judeo-Christian as well as individuals who identify as Judeo-Christian and heterosexual.

### **Method**

#### **Participants**

Data for the study were collected from the Center for Collegiate Mental Health (CCMH) 2013-2014 data set, which includes data from 101,027 unique clients at 140 college counseling centers. These centers were located primarily in the United States, though one participating center was in the United Kingdom and two participating centers were in Canada. The CCMH is a practice-research network of nearly 500 college counseling centers and other partners and is dedicated to provide current information about the mental health of college students. All schools contributing data to the CCMH received approval from their respective institutional review boards prior to contributing data to CCMH. Additionally, institutional review board approval for the use of archival data was obtained from the primary author's board prior to commencing the present study.

Participants were included if they provided basic demographic information through the Standardized Data Set (SDS) and mental health outcome data either through the Counseling Center Assessment of Psychological Symptoms-62 (CCAPS-62; Locke et al., 2011) or CCAPS-34 (Locke et al., 2012). Participants who failed to respond to questions about sexual or religious identity were excluded from the study because the interpretation of no response was impossible to determine.

A total of 64,271 participants met inclusion criteria. Of these, 40,061 (62.3%) were women, 23,457 (36.5%) were men, 162 (0.3%) were transgender, and the remaining 591 (0.9%) did not provide information about their gender. Ethnically, 8.4% of participants identified as African American/Black, 0.3% as American Indian or Alaskan Native, 5.8% as Asian American, 7.1% as Hispanic/Latino, 0.2% as Native Hawaiian or Pacific Islander, 4.2% as multiracial, and 66.1% as White with 7.9% of participants not providing information about their ethnicity.

Participants were diverse as to sexual identity with 87.4% identifying as heterosexual, 1.6% as lesbian, 2.9% as gay, 4.5% as bisexual, 2.1% as questioning, and 1.5% as other sexual minority. The “other sexual minority” category was created by manually reviewing cases initially marked as “other, please explain” and including any expression of sexuality that did not fit into one of the aforementioned categories (e.g., asexual, demisexual, pansexual, queer, sexually fluid). Though the various expressions included in the “other sexual minority” category are experientially heterogeneous, they all include an additional component of being less understood by LGBQQ and heterosexual communities. Participants reported a variety of religious affiliations with 12.7% identifying as Agnostic, 8.8% as Atheist, 1.0% as Buddhist, 18.0% as Catholic, 32.0 % as Christian, non-Catholic 0.8% as Hindu, 2.8% as Jewish, 1.2% as Muslim, and 18.9% indicating no religious preference with 3.9% answering “other”.

Similar to Lefevor, Janis, and Park (2017), we created three groups based on religious affiliation and the degree of privilege and power experienced by each group. Participants identifying as Christian, Catholic, or Jewish were classified as “Dominant Religious”. Participants who reported another religious identification such as Buddhist, Hindu, or Muslim were classified as “Non-dominant Religious”, based on their shared minority religious identification within American culture. Participants identifying as atheist, agnostic, or without religious preference were classified as “Non-dominant Unaffiliated”.

## **Measures**

**Standardized Data Set.** The Standardized Data Set (SDS; CCMH, 2011) is a set of demographic questions typically administered upon intake at participating college counseling centers. The SDS includes questions about gender, age, ethnicity, class standing, religion, and sexual identity. The SDS also includes the following question about the importance of

religion/spirituality rated on a five-point Likert scale from “very important” to “very unimportant”: “To what extent does your religious or spiritual preference play an important role in your life?”

**CCAPS-62 and -34.** The CCAPS-62 (Locke et al., 2012) is a multidimensional assessment of psychological symptoms common in college populations. The CCAPS-34 (Locke et al., 2011) is a subset of items of the CCAPS-62 that is adapted for more frequent administration. Both versions consist of seven subscales (Depression, Generalized Anxiety, Social Anxiety, Academic Distress, Eating Concerns, Hostility, and Alcohol Use) that comprise a general Distress Index. The CCAPS-62 is typically administered upon intake with the CCAPS-34 administered at various points throughout treatment, depending on the policy of individual counseling centers. As not all participants completed the CCAPS-62, we converted any CCAPS-62 data into CCAPS-34 data such that all mental health outcome data could be analyzed together.

### **Data Analysis**

When working with large samples, it is common for many statistical tests to be significant. Thus, effect size estimations can be a better indicator of meaningful differences than significance testing. In the present analyses, we present both null-hypothesis significance testing and accompanying effect sizes but primarily interpret effect sizes.

## **Results**

### **The Influence of Sexual Identity on Psychological Distress**

We hypothesized that sexual identity would be related to psychological distress such that the more marginalized an individual’s sexual identity, the greater psychological distress that individual would experience. We conducted an ANOVA with sexual identity as the independent variable and the Distress Index as the dependent variable, maintaining sexual identities separate

as recommended in the literature (Rust, 2009). The overall ANOVA was significant ( $F(5, 64265) = 211.84, p < .01$ ) and yielded a small effect size ( $\eta^2 = 0.016$ ). Group means and standard deviations are reported in *Table 1*.

Tukey's post-hoc comparisons were conducted between groups to determine the significance and effect sizes of group differences, reported as Cohen's *d*. Heterosexual individuals experienced significantly and substantially—with the majority of effect sizes falling in the small to medium category—less distress than individuals identifying as gay ( $p < .01, d = .18$ ), lesbian ( $p < .01, d = .25$ ), bisexual ( $p < .01, d = .43$ ), questioning ( $p < .01, d = .49$ ), and “other sexual minority” ( $p < .01, d = .51$ ). Further, both gay and lesbian individuals experienced significantly and sizably less distress than individuals identifying as bisexual ( $p < .01, d = .18; p < .01, d = .25$ ), questioning ( $p < .01, d = .25; p < .01, d = .32$ ) and “other sexual minority” ( $p < .01, d = .27; p < .01, d = .33$ ). Similarly, bisexual individuals experienced significantly less distress than individuals identifying as questioning ( $p < .01, d = .06$ ) or “other sexual minority” ( $p < .01, d = .08$ ). The results of this analysis support hypothesis 1: individuals with increasingly marginalized identities experienced respective increases in psychological distress.

### **The Influence of Religious Identity on Psychological Distress**

We hypothesized that religious affiliation would be related to psychological distress such that the more marginalized an individual's religious identity, the greater the psychological distress that individual would experience. We conducted an ANOVA with religious affiliation as the independent variable and the Distress Index as the dependent variable. The overall ANOVA was significant ( $F(2, 64268) = 601.07, p < .01$ ) and yielded a small effect size ( $\eta^2 = 0.018$ ). Group means and standard deviations are reported in *Table 2*.

Tukey's post-hoc comparisons were conducted between groups to determine the significance and effect sizes of group differences. Dominant Religious individuals experienced significantly less distress than Non-Dominant Religious individuals ( $p < .01$ ;  $d = .28$ ) and Non-dominant Unaffiliated individuals ( $p < .01$ ;  $d = .27$ ). Non-dominant Religious individuals evidenced similar levels of distress to Non-dominant Unaffiliated individuals ( $p = .76$ ,  $d = .01$ ). These results of this analysis provide partial support for hypothesis 2: individuals with marginalized religious identities experienced more psychological distress than individuals with majority religious identities.

### **The Influence Sexual and Religious Identities on Mental Health**

We hypothesized an interaction between sexual and religious identities such that individuals who identify as religious and lesbian, gay, bisexual, queer, or questioning would experience increased psychological distress relative to other non-religious and heterosexual individuals. A mixed ANOVA was conducted with sexual and religious identities as independent variables and the Distress Index as the dependent variable. The ANOVA was significant ( $F(17, 64253) = 115.76$ ,  $p < .01$ ) and sizeable ( $\eta^2 = 0.030$ ). However, the interaction term was not significant ( $p = .99$ ) or sizeable ( $\eta^2 < 0.001$ ). The ANOVA table is reported in *Table 3* and group means are reported in *Table 4*. The results of this analysis do not support hypothesis 3 as there was not an identifiable interaction effect between sexual identity and religious identity.

We also examined the relationship between the importance of religion/spirituality and psychological distress among individuals identifying as religious and LGBQQ. The importance of religion/spirituality was significantly but not substantially related to psychological distress for Dominant Religious individuals ( $r = .05$ ,  $p < .01$ ), Non-dominant Religious individuals ( $r = .04$ ,  $p < .05$ ), and Non-dominant Non-religious individuals ( $r = -.04$ ,  $p < .01$ ).

## Discussion

### **Implications for the study of sexual identity**

As predicted by the minority stress theory (Meyer, 2003) sexual minorities experienced greater psychological distress than majority members. This trend is important but unsurprising as heterosexual identity is viewed as a societal “norm” and the increased stress experienced by queer individuals has been well-documented (e.g., King et al., 2008; Lick et al., 2013; Marshal et al., 2013).

More notable are the results indicating that within sexual identity groups, psychological distress was significantly and linearly related to the degree of marginalization of sexual identity. Gay men and lesbian women experienced less psychological distress than bisexual individuals who in turn evidenced less psychological distress than queer or questioning individuals. This is the first study to our knowledge to look at psychological distress over six different sexual identity categories and clearly demonstrate increasing psychological distress with increasingly marginalized sexual identities. Though other studies have noted similar trends (Effrig et al., 2014; McAleavey et al., 2011), they have not included an “other sexual minority” group. This trend of increasing psychological distress across increasingly marginalized sexual identity follows from intersectionality theory (Crenshaw, 1989; Crenshaw, 1991; Else-Quest & Hyde, 2015) as gay and lesbian individuals experience relative privilege within LGBTQ communities. Bisexuality has historically been understudied, and many bisexual individuals experience rejection from both hetero- and gay/lesbian communities (Russell & Joyner, 2001). Many “other sexual minority” individuals also experience discrimination by both the hetero- and gay/lesbian communities (Russell & Joyner, 2001) and may also experience discrimination from bisexual individuals, increasing their degree of marginalization.

**Implications for the study of religious identity**

Though religious affiliation has largely been linked to positive mental health outcomes (Bonelli & Koenig, 2013; McIntosh et al., 1993), intersectionality (Cole, 2009) has rarely been used as an explanatory framework for the mental health disparity between religious and non-religious individuals. In this study, we used intersectionality theory to include the experience of marginalized religious identification following others who have implied a minority label would be linked to stigmatization, which is believed to be linked to increased stress (Link et al., 1997; Rosenfield, 1997; Wright et al., 2000). We expected that religious minorities would report more psychological distress. Indeed, in the present study, religious identity was significantly related to psychological distress with the dominant religious group experiencing less distress than members of non-dominant groups.

In a society dominated by Judaism and Christianity, not belonging to the religious majority has been linked with feelings of increased discomfort and unease (Small & Bowman, 2011). This difference may be due to religious minority individuals being aware of differences between themselves and those belonging to religious majority groups (Schlosser, 2003) and may undergo stressors that are less relevant to individuals in the majority groups (Bowman & Small, 2012). Further, religious individuals may have increased access to greater network of others who share similar beliefs. The ability to share one's religious status has been linked to success among college students (Hill, 2009). Further, the experience of decreased social support is typical of the minority experience (Button, O'Connell, & Gealt, 2012; Frost, Meyer, & Schwartz, 2016) and may thus be seen as part of the larger problem of stigmatization of minorities rather than particular religious practices.

**Implication for the study of the intersection of sexual and religious identity**

In contradiction to our hypothesis, we did not find a significant interaction between sexual and religious identities. Further, even among LGBQQ Judeo-Christians, the importance of religion/spirituality was not substantially related to psychological distress. As many Judeo-Christian religions do not affirm LGBQQ identity and see homosexuality as a sin punishable by excommunication (Hamblin & Gross, 2013), we hypothesized that Judeo-Christian affiliation would increase distress for LGBQQ individuals. Nonetheless, we found that affiliation with Judeo-Christian religions was related to a decrease in distress in LGBQQ individuals, to a similar degree as it is in heterosexual samples. We offer three possible explanations for the finding.

First, the benefit of Judeo-Christian affiliation may simply outweigh the cost for LGBQQ individuals, even in branches of Judaism and Christianity that are not affirming of minority sexual identity. Individuals raised in Judeo-Christian religions may continue to experience the privilege associated with majority religious affiliation and be buffered against the effects of stress. Religious affiliation has been linked with increased social and community support (Cohen, 2004; Meyer, 2015), decreased religious-based discrimination (Schlosser, 2003), and increased psychological well-being (Levin et al., 1996). In an investigation of sexual minority youth, Gattis, Woodford, and Han (2014) found that religious affiliation significantly moderated the relationship between discrimination and depression. Thus, it is possible that the benefits of affiliation with Judeo-Christian religions may sufficiently buffer the distress caused by the faith.

Another explanation is that individuals identifying as religious and LGBQQ largely affiliated with LGBQQ-affirming denominations where they experienced less conflict between their sexuality and faith. Participation in affirming religions has been linked to positive mental health outcomes for LGBQQ individuals (Hamblin & Gross, 2013; Lease, Horne, & Noffsinger-Frazier, 2005). Unfortunately, we cannot make definitive conclusions about this from the data in

the present study as we did not assess denominational affiliation within the religious subcategories.

Finally, it is possible that LGBQQ individuals who experienced a high degree of conflict between their sexuality and faith left religion in favor of no religious affiliation. In our sample, approximately 64% of LGBQQ individuals identified as religiously unaffiliated while 36% were religiously affiliated. Comparatively, 39% of heterosexual individuals identified as religiously unaffiliated and 61% identified as religiously affiliated. Nationally LGBQQ individuals tend to abandon religion in favor of religious disaffiliation with 41% for LGBQQ and 21% of heterosexual individuals identifying as religiously unaffiliated (Murphy, 2015). Given a sample of emerging adults who are coming out at increasingly earlier ages (Herek et al., 2010), it is likely that those who chose to remain religiously affiliated did so in an intentional way, integrating their religion and sexuality. Additionally, there are an increasing number of LGBQQ affirming religious congregations and support organizations within historically non-affirming faiths, which may assist these individuals in decreasing their psychological distress.

### **Limitations**

The study has several limitations including the lack of measurement of potentially important moderating variables such as family/peer support, resilience, “outness”, spirituality, the level of engagement with religion, the racial/ethnic composition of a religious congregation, and the degree of to which a religion affirms an LGBQQ identity. Further, our results are necessarily confined by the sample of treatment-seeking, college students studied, who may be dissimilar to other emerging adults or adults as a whole who are not seeking mental health treatment. In particular, emerging adults tend to be less religious than the overall population (Pew Research Center, 2015) and may be experiencing turmoil about their religious and/or

sexual identities. Some religious college students may also have sought support from pastors or pastoral counseling rather than seeking services at the college counseling centers. Further, racial/ethnic minority groups with lower college attainment are likely underrepresented in our sample. Additional research should be undertaken to examine the impact of these variables in non-college student populations to better understand their role in moderating the role of sexuality and religion on psychological distress.

### Conclusion

Following intersectionality theory (Cole, 2009), we designed the present study to understand the influence of privileged religious and sexual minority identities on psychological distress. This was the first, large-scale study that we are aware of that assessed the influence of sexual identity, religious identity, and their intersection on psychological distress. In the present study, we found that possessing a minority sexual or religious identity was linked with increased psychological distress. These main effects held such that an individual possessing both minority sexual and religious identities experienced increased psychological distress relative to an individual possessing one or no minority identities. We did not find evidence for an interaction of religious and sexual identity. These differences may be attributed to the relative decreased privilege and power experienced by minority individuals. Future studies could examine the role of moderating variables such as spirituality and social support as well in non-clinical, adult populations.

## Tables and Figures

*Table 1. Psychological Distress by Sexual Identity.*

	<i>n</i>	<i>Mean</i>	<i>Standard Deviation</i>
Heterosexual	56,185	1.69	.84
Lesbian	1,038	1.90	.82
Gay	1,833	1.84	.81
Bisexual	2,912	2.05	.82
Questioning	1,354	2.10	.81
Self-identify	949	2.11	.78

*Table 2. Psychological Distress by Religious Identity.*

	<i>n</i>	<i>Mean</i>	<i>Standard Deviation</i>
Dominant Religious	33,886	1.62	.84
Non-dominant Religious	4,452	1.86	.83
Non-dominant Unaffiliated	25,933	1.85	.83

*Table 3. Psychological Distress by Sexual Identity and Religious Identity*

Source	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	$\eta^2$
Sexual Identity	319.35	5	63.87	92.52**	.007
Religious Identity	64.78	2	32.39	46.92**	.00
Interaction	1.41	10	.14	.20	< .001
Error	44355.43	64253	.37		
Total	238391.33	64271			

Note: \*\*  $p < .01$

*Table 4. Sexual Identity X Religious Identity Group Means*

Sexual Identity	Religious Identity	<i>n</i>	%	<i>Mean</i>	<i>SD</i>
Heterosexual	Dominant Religious	31421	55.92%	1.61	.84
	Non-dominant Religious	3557	6.33%	1.81	.84
	Non-dominant Unaffiliated	21207	37.74%	1.80	.82
Lesbian	Dominant Religious	386	37.19%	1.78	.85
	Non-dominant Religious	93	8.96%	2.02	.88
	Non-dominant Unaffiliated	559	53.85%	1.96	.77
Gay	Dominant Religious	619	33.77%	1.72	.83
	Non-dominant Religious	147	8.02%	1.87	.76
	Non-dominant Unaffiliated	1067	58.21%	1.91	.80
Bisexual	Dominant Religious	806	27.68%	1.91	.84
	Non-dominant Religious	327	11.23%	2.08	.79
	Non-dominant Unaffiliated	1779	61.09%	2.10	.81
Questioning	Dominant Religious	492	36.34%	1.99	.83
	Non-dominant Religious	139	10.26%	2.13	.70
	Non-dominant Unaffiliated	723	53.40%	2.17	.81
Self-identify	Dominant Religious	162	17.17%	1.97	.81
	Non-dominant Religious	189	19.91%	2.15	.76
	Non-dominant Unaffiliated	598	63.01%	2.13	.78

*Note:* the percentage refers to the percentage of people in each sexual identity group identifying with various religious groups.

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