

# SEXUAL ORIENTATION DISCORDANCE

Sexual Orientation Complexity and Psychosocial/Health Outcomes

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### Abstract

Individuals whose sexual attraction or behavior varies from others' expectations based on their sexual identity were initially described as exhibiting sexual orientation discordance. This conceptualization has been challenged as inaccurate and value-laden, and "branchedness" has been suggested as a value-neutral description (van Anders, 2015). Using a United States national sample of 4,530 participants from the 2013-2014 Center for Collegiate Mental Health database, we challenge the empirical distinctness of the phenomenon of sexual orientation discordance by 1) replicating previous work that indicates that branched individuals evidence unique psychosocial and health outcomes relative to non-branched individuals and 2) using stepwise regression to demonstrate that these differences in outcomes can be accounted for by variation in sexual attraction, behavior, and identity and that "discordance" between indicators failed to explain additional variation in outcomes. We encourage researchers to adopt non-normative language and conceptualizations in their study of sexual orientation complexity and branchedness.

*Keywords:* Sexual orientation discordance, sexual branchedness, sexual attraction, sexual behavior, sexual identity, mostly heterosexual, health outcomes

### **Sexual orientation complexity and psychosocial/health outcomes**

Sexual orientation is a profoundly multidimensional construct with individuals showing unique patterns along varying dimensions (Michaels, 1994). Yet empirical research on sexual orientation relies predominantly on single indicators of sexual orientation—typically sexual identity (Herek & Garents, 2007; Priebe & Svedin, 2013). Sexual orientation includes sexual identity (e.g., the labels used to convey information about sexuality to others), sexual attraction (e.g., sexual desire), sexual behavior (e.g., sexual engagement), and may also include the meaning, frequency, intensity, and quality of sexual attraction and experiences (Savin-Williams, 2014) as well as preferred partner (van Anders, 2015), age (Seto, 2017), lifestyle preferences, and social preferences (Klein, 1978). The complexity of sexual orientation is often ignored when researchers utilize a single indicator in isolation (Priebe & Svedin, 2013).

This lack of complexity is especially problematic given that many individuals report sexual attraction, behavior, and identity that do not "match" (e.g., *sexual discordance*; Talley, Aranda, Hughes, Everett, & Johnson, 2015). Indeed, individuals who identify as straight but evidence some degree of same-sex attraction or behavior outnumber lesbian, gay, and bisexual (LGB) individuals in many samples (Bauer, Jairam, & Baidoobonso, 2010; Gattis, Sacco, & Cunningham-Williams, 2012; Lourie & Needham, 2017; Mor & Davidovich, 2016). These individuals are often termed "discordant" implying that the "mismatch" between various indicators of sexual orientation may play a role in the distress reported by these individuals. The assumption of a normative alignment of sexual attraction, behavior, and identity is based in beliefs that sexual orientation is consistent (i.e., being solely straight or gay/lesbian; Young & Meyer, 2005) and that sexual identity development occurs at a single point in time during adolescence (Bell, Weinberg, & Hammersmith, 1981) ending with a discovery of one's authentic

self (Diamond, 2000). Research on sexual orientation, however, indicates that sexual attraction, behavior, and identity demonstrate remarkable variability *within* persons over time (Katz-Wise, 2015), making one's identity a poor indicator of lifetime attraction or behavior (Diamond, 2008). People are likely to explore their sexuality over their lifetime (Harper, Serrano, Bruce, & Bauermeister, 2016; Tolman & McClelland, 2011), during which one may engage in same-sex activities without adopting an LGB identity (Lefevor et al., in press).

Recently, researchers have called the construct of discordance into question based on its normative assumptions about sexual attraction, behavior, and identity and have proposed the language of sexual branchedness/coincidence as an alternative way to think about indicators of sexual orientation (van Anders, 2015). However, this language has not been embraced wholeheartedly in the study of sexuality due to empirical studies that continue to rely on normative conceptualizations of sexuality rooted as evidenced through their focus on sexual orientation discordance.

### **Sexual Orientation Discordance and Health**

Researchers have studied “sexual orientation discordance” as a way of explaining disparities in physical or mental health (Wolff, Wells, Ventura-DiPersia, Renson & Grov, 2017). At least five such studies (Bauer et al., 2010; Gattis et al., 2012; Lourie & Needham, 2017; Mor & Davidovich, 2016; Talley et al., 2015) using four health-related outcomes—substance use, mental health, victimization, and support—have been published in the last 10 years. The majority of these studies were conducted within the past five years and have been published in high impact journals, indicating that sexual discordance is an important topic of contemporary research. These studies examine discordance by comparing branched/discordant individuals with straight and LGB concordant individuals and largely conclude that branched/discordant

individuals are at an increased risk for a number of disorders including anxiety, depression, and substance use (Gattis et al., 2012; Lourie & Needham, 2017).

However, it is poorly understood why discordance is associated with poor health outcomes. The most commonly accepted explanation is that sexual orientation *discordance*, which etymologically implies a *lack of alignment*, is indicative of a discrepancy between the ideal self and the actual self, which results in increased distress for discordant individuals (Lourie & Needham, 2017). Although this reasoning is plausible and authenticity is related to positive mental health for sexual minorities (Legate, Ryan, & Rogge, 2017), discordance is rarely examined as a participant-identified variable. Rather, researchers assign participants to discordant and concordant groups based on the *researchers'* beliefs about what constitutes discordance. The conceptualization of discordance as a pathological "misalignment" infers an acceptable range of sexual attraction or behavior given a particular identity (van Anders, 2015). This idea contrasts sharply with current sociopolitical notions of queerness, which reject the idea of a normative way to express sexuality or gender. Following minority stress theory (Meyer, 2003), discordant individuals may not suffer from poor health outcomes because of discordance per se, but rather, differences in outcomes may be better explained by the stigma encountered from experiencing same-sex attraction or expressing same-sex behavior or identity. This explanation would predict that discordance would not confer risk above and beyond the variance in risk predicted by sexual attraction, behavior, and identity as independent predictors.

### **Present Study**

We organize the present study by two questions. First, do branched/discordant and concordant individuals differ along four psychosocial and health outcomes commonly assessed in the literature: support, victimization, substance use, and mental health? Second, does sexual

orientation discordance account for substantial variance in health-related outcomes beyond what can be accounted for by sexual attraction, behavior, or identity?

## Method

### Participants

Data for this study were part of the Center for Collegiate Mental Health (CCMH) 2013-2014 dataset. This dataset includes 101,027 unique clients at 140 college counseling centers in the United States, Canada, and the United Kingdom.

The present study examined a subset of 4,770 participants who provided basic demographic information through the Standardized Data Set (SDS; Center for Collegiate Mental Health, 2017; Locke et al., 2011), mental health outcome data through the Counseling Center Assessment of Psychological Symptoms-34 (CCAPS-34; Locke et al., 2012) and questions about sexual attraction, sexual identity, sexual behavior, and gender identity. Because the focal questions of the study involved sexual branchedness, individuals reporting their sexual identity as “questioning” ( $n = 128$ ) or “other” ( $n = 100$ ) were excluded as it was unclear if these individuals should be classified as branched or concordant. We also excluded individuals identifying outside the gender binary ( $n = 12$ ) as contemporary understandings of sexual orientation discordance are rooted in binary understandings of gender and sexuality and there were too few individuals to meaningfully conduct separate analyses. A total of 4,530 participants met inclusion criteria. Sample demographics are presented in *Table 1*.

### Measures

All constructs were assessed through items on the SDS and subscales of the CCAPS-34. The SDS is a set of demographic questions typically administered upon intake in participating college counseling centers and includes questions about gender, age, ethnicity, and sexual

orientation. The CCAPS-34 is a multidimensional assessment of psychological symptoms with seven subscales and is administered on intake.

**Sexual orientation discordance.** We followed Gattis et al. (2012) in creating our sexual orientation discordance variable. Discordance was measured as any degree of "discord" between sexual identity and sexual attraction or behavior as discordance is most frequently conceptualized as a discrepancy between what one reports (i.e., identity) and what one feels or does (i.e., attraction and behavior). To do so, we first created separate discordance terms between attraction-identity and behavior-identity. Most individuals who fell in this classification reported a straight identity, but reported some degree of same-sex attraction or behavior.

For behavior-identity concordance, participants were coded "LGB concordant" ( $N = 336$ ; men = 136; women = 200) if they labeled themselves as gay or lesbian and participated in some degree of same-sex behavior in their lifetime. Participants were also labeled "LGB concordant" if they identified as bisexual and endorsed some degree of sexual behavior with both men and women in their lifetime. Participants were labeled "straight concordant" ( $N = 3,757$ ; men = 1,461; women = 2,296) if they identified as straight and reported some degree of other-sex behavior and no same-sex sexual behavior. Participants were labeled "straight branched/discordant" ( $N = 437$ ; men = 79; women = 358) if they identified as straight and reported any degree of same-sex behavior. Throughout the manuscript we describe this group as "branched/discordant" in order to connect the literature on sexual orientation discordance with the literature on sexual branchedness. Four participants self-identified as gay/lesbian and reported only other-sex sexual behavior. This "LGB branched/discordant" group was judged to be too small to be meaningful and was consequently excluded from subsequent analyses.

For attraction-identity concordance, participants were labeled “LGB concordant” ( $N = 300$ ; men = 127; women = 173) if they labeled themselves as gay or lesbian and reported mostly or only being attracted to members of the same sex. Participants were also labeled “LGB concordant” if they identified as bisexual and reported some degree of sexual attraction to both men and women. Participants were labeled “straight concordant” ( $N = 3,913$ ; men = 1,473; women = 2,440) if they identified as straight and reported only other-sex attraction. Participants were labeled “branched/discordant” ( $N = 281$ ; men = 67; women = 214) if they identified as straight and reported any degree of same-sex attraction. No bisexual individuals reported exclusive same- or other-sex attraction, but two participants self-identified as gay/lesbian and reported exclusive other-sex attraction (none self-identified as gay/lesbian and reported equal same/other-sex attraction or mostly other-sex attraction). This “LGB branched/discordant” group was judged to be too small and was excluded from subsequent analyses.

Attraction-identity and behavior-identity concordance terms were combined to form a single discordance variable. If an individual evidenced either attraction-identity or behavior-identity discordance, they were termed “straight branched/discordant” for the purposes of the overall analyses. Overall, 336 participants were classified as “LGB concordant” (men = 136; women = 200), 3,605 as “straight concordant” (men = 1,416; women = 2,189), and 589 as “straight branched/discordant” (men = 124; women = 465; see *Table 2*).

**Health Outcomes.** We measured current family support, social support, lifetime experiences of harassment and trauma, and marijuana use through Likert-style items included in the SDS questionnaire (see CCMH 2017 for items). We measured alcohol use, depression, and anxiety through the respectively named subscales of the CCAPS. These subscales evidence

adequate reliability (.83, .88, .83 respectively) and convergent validity with established measures (Locke et al., 2012).

## Results

### Is Discordance Related to Health Outcomes?

As all studies reviewed of the influence of sexual orientation branchedness/discordance on psychosocial and health outcomes conducted analyses separately by gender, we maintained this trend. In *Table 3*, we present the results of univariate analyses of variance (ANOVAs) and post-hoc comparisons separately by gender for four psychosocial and health outcomes commonly assessed in the literature. To maintain an experiment wide type I error rate of .05, we used Bonferroni corrections for both the ANOVAs and the post-hoc comparisons (ANOVA:  $p < .003$ ; post-hoc:  $p < .001$ ). We found that family support, harassment, and depression significantly varied by sexual orientation groups for both men and women. Experiences of trauma, alcohol use, marijuana use, and anxiety significantly varied among women, but not men. Social support did not vary between groups for either gender. Effect sizes for significant relationships ranged from small to small-to-medium (Cohen, 1988).

### Does Discordance Predict Above and Beyond Attraction, Behavior and Identity?

We next asked whether the relationship between sexual orientation branchedness/discordance and health-related outcomes may be better explained by sexual attraction, behavior, and identity. We used stepwise regression to test this possibility. We dichotomized sexual orientation discordance, collapsing the LGB and straight groups into a single concordant group in order to isolate the effects of sexual orientation discordance.

In the first step (Model 1), we included sexual attraction, behavior, and identity as predictor variables. We created two dummy variables for each indicator using other-sex

attraction/behavior/identity as the reference group with dummy variables for same-sex and bisexual attraction/behavior/identity. In our next step (Model 2), we included the dichotomous sexual orientation discordance variable in addition to all variables previously entered. Models and the coefficients for the final model for each predicted variable are displayed in *Table 4* for women and *Table 5* for men.

We present  $F$  change,  $\Delta R^2$ , and the associated  $p$ -values in *Table 6* as our central question is whether the addition of discordance explained additional variance. Among women, discordance explained additional variance only in trauma and harassment, with effect sizes being unsubstantial for both (Cohen, 1988). Among men, discordance universally failed to explain additional variance beyond sexual attraction, behavior, and identity.

### **Discussion**

The present study was guided by two questions: 1) How do branched/discordant individuals compare to concordant straight and LGB individuals in psychosocial and health outcomes? and 2) Does sexual orientation discordance account for variance in outcomes beyond that accounted for by sexual attraction, behavior, and identity?

We found significant differences between straight concordant, straight branched/discordant, and LGB concordant groups. Among women, we found significant differences between groups in family support, harassment, trauma, alcohol use, marijuana use, anxiety, and depression with effect sizes ranging from small to moderate. Among men, we found significant group differences in family support, harassment, and depression, with effect sizes typically best classified as small. These findings support previous research on sexual orientation branchedness/discordance that indicates differences between straight concordant, LGB

concordant, and straight branched/discordant individuals in support, victimization, substance use, and mental health (Gattis et al., 2012; Lourie & Needham, 2017).

However, regression analyses indicate that out of 16 relationships tested (8 for women and 8 for men), after accounting for sexual attraction, behavior, and identity, sexual orientation discordance accounted for a significant amount of the variance in the dependent variable in only two cases. In both of these cases, the amount of additional variance predicted was not substantial, falling below Cohen's (1988) benchmark for a small effect size. We conclude that sexual orientation discordance did not account for a substantial—and typically not a significant—amount of the variance in outcomes beyond what can be accounted for by sexual attraction, behavior, or identity.

### **Reexamining the Assumptions of Discordance**

Given our findings, we sought to understand how sexual attraction, behavior, and identity may explain trends noted in branchedness/discordance research. First, it is important to understand how the assumptions made by this research may have influenced results. Discordance implies that there is a correct and normative way for indicators of sexual orientation to align. However, we largely failed to find an impact for discordance on health-related outcomes after accounting for sexual attraction, behavior, and identity. This finding contrasts with the assumption that sexual orientation discordance inherently results in distress whether due to misalignment between identity and self-perception or other factors (Talley et al., 2015). Although we do not dispute the possibility that sexual orientation discordance could result in distress, our data indicate that when researchers impose classifications of discordance on their data, these classifications are not inherently related to worse health outcomes.

As shown in *Table 2*, our branched/discordant sample consisted primarily of individuals experiencing high to moderate levels of other-sex attraction or behavior, with 94% – 97% of discordant participants falling in one of these categories. This means that at most 6%, though likely fewer, of branched/discordant individuals identified as straight while experiencing strong attractions to or frequent engagements with same-sex others. Though most other studies of sexual orientation branchedness/discordance do not report these demographics, we have no reason to believe our data to be unique in evidencing this trend. Moreover, the questionnaire did not include a sexual identity category for "mostly heterosexual", which may have better described these individuals. This suggests that only a low proportion of individuals classified as discordant under traditional criteria for discordance (e.g., Gattis et al., 2012) would likely experience substantial dissonance.

Individuals with complex sexualities do not necessarily view themselves as "sexually discordant" and may be better conceptualized under alternative frameworks such as sexual branchedness/coincidence (e.g., van Anders, 2015). In emerging adulthood, many individuals experience autonomy for the first time and begin to make decisions entirely on their own (Arnett, 2000; Ritchie et al., 2013). During this time, individuals may feel comfortable engaging in same-sex relationships without adopting a sexual minority identity label, especially since commitment to a sexual identity may emerge only after sustained exploration (Katz-Wise, 2015). Individuals may make the conscious choice not to identify as LGB due to stigmas often associated with minority sexual labels (Baldwin et al, 2015; Saewyc et al., 2004) and may also assign greater flexibility to sexual identity labels than the meanings commonly inferred by researchers.

Therefore, differences in outcomes between "sexually discordant" individuals may conceptually be best understood through the differences in sexual attraction, behavior, and

identity experienced by the individuals rather than resulting from discordance. We also suggest that sexual attraction or behavior alone may be sufficient for individuals to face discrimination and stigmatization similar to that of LGB individuals and that stigmatization may explain differences in outcomes (Meyer, 2003). Indeed, individuals who experience same-sex attraction or who engage in same-sex behavior frequently display gender atypical behaviors, even if these individuals never identify as LGB, and have been found to higher rates of distress than those who are other-sex attracted or do not engage in same-sex sexual behavior (Roberts, Rosario, Corliss, Koenen, & Austin, 2012; Zou & Andersen, 2015).

### **Limitations**

We caution against overly broad interpretation of our findings based on limitations inherent in the data. The present sample consisted primarily of emerging adults, whose experiences may differ in meaningful ways compared to adult or child samples (Lourie & Needham, 2017; Talley et al., 2015). Our sample also consisted of individuals presenting for psychological treatment, which may have also impacted the results. Finally, we acknowledge that sexual orientation discordance is rooted in binary assumptions about gender and as we excluded gender non-binary individuals from our present sample, it is unclear how these findings would apply to transgender and non-binary individuals. We welcome and encourage replication of our results using national datasets such as NESARC and Add Health and using a full range of gender identities and experiences.

### **Conclusions and Future Directions**

The present study drew used from a United States national, large, multi-site sample ( $N = 4,530$ ) to extend both theoretical and empirical work on sexual orientation discordance. We found that although sexual orientation branchedness/discordance was related to health outcomes,

when sexual attraction, behavior, and identity were accounted for, these relationships disappeared. The study of sexual orientation discordance is based on assumptions about the existence of a normative alignment between dimensions and the implication of dissonance and pathology where individuals do not meet the societal expectations based on their sexual identity. We encourage researchers to rely on participant-defined measures of discordance rather than classifying individuals as discordant based on other information collected. We further encourage researchers to study sexual attraction and behavior in conjunction sexual identity, noting that these indicators frequently vary from each other, and that each provides useful additional information beyond the others. We are hopeful that future research relying on this complex framework will better illuminate the mechanisms and processes in understanding minority sexual attraction, behavior, identity, and health-related outcomes.

*Table 1.* Demographics for all participants

Variable	
Client <i>N</i>	4,530
Gender identity	
Woman	63.0%
Man	37.0%
Race/ethnicity	
African American/Black	7.5%
American Indian or Alaskan Native	0.2%
Asian/Asian American	5.6%
Hispanic/Latino/a	6.5%
Native Hawaiian or Pacific Islander	0.2%
Multiracial	4.7%
White	73.9%
Self-identify	1.3%
Sexual identity	
Heterosexual	92.5%
Lesbian	1.3%
Gay	2.4%
Bisexual	3.8%
Concordance	
Straight concordant	79.6%
Straight branched/discordant	13.0%
LGB concordant	7.4%

*Table 2.* Sexual attraction and behavior by sexual orientation concordance.

	High other sex sexual behavior	Moderate other sex sexual behavior	Equal sexual behavior with men and women	Moderate same sex sexual behavior	High same sex sexual behavior
Straight concordant	2189	0	0	0	0
Branched/discordant	251	201	6	0	7
LGB concordant	26	89	29	33	23
	High other sex attraction	Moderate other sex attraction	Equal attraction to men and women	Moderate same sex attraction	High same sex attraction
Straight concordant	2189	0	0	0	0
Branched/discordant	107	332	5	2	19
LGB concordant	0	66	64	39	31

Note: cell counts indicate the number of participants at a given intersection

Table 3. Sexual orientation discordance group differences in outcomes.

	Women								Men							
	Straight Concordant ( <i>N</i> = 2189)		Straight Branched/ Discordant ( <i>N</i> = 465)		LGB Concordant ( <i>N</i> = 200)		<i>F</i>	$\eta^2$	Straight Concordant ( <i>N</i> = 1416)		Straight Branched/ Discordant ( <i>N</i> = 124)		LGB Concordant ( <i>N</i> = 136)		<i>F</i>	$\eta^2$
<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>			<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>		
Support																
Family Support	3.70 <sup>1,2</sup>	1.33	3.40 <sup>1</sup>	1.34	3.12 <sup>2</sup>	1.35	22.99*	.02	3.70 <sup>1,2</sup>	1.27	3.19 <sup>1</sup>	1.34	2.96 <sup>2</sup>	1.43	26.31*	.03
Social Support	3.71	1.19	3.61	1.20	3.70	1.18	1.06	< .01	3.54	1.19	3.32	1.20	3.70	1.14	2.79	< .01
Victimization																
Harassment	1.83 <sup>1,2</sup>	1.43	2.44 <sup>1</sup>	1.68	2.45 <sup>2</sup>	1.71	42.45*	.03	1.63 <sup>1</sup>	1.34	2.09 <sup>1</sup>	1.60	1.87	1.48	7.62*	.01
Trauma	1.67 <sup>1,2</sup>	1.05	2.17 <sup>1</sup>	1.33	2.13 <sup>2</sup>	1.39	47.82*	.03	1.60	1.04	1.72	1.07	1.75	1.21	1.69	< .01
Substance Use																
Marijuana Use	1.28 <sup>1,2</sup>	.89	1.72 <sup>1</sup>	1.45	1.60 <sup>2</sup>	1.30	40.25*	.03	1.70	1.44	2.07	1.77	1.69	1.33	3.72	< .01
Alcohol Use	.72 <sup>1</sup>	.92	.90 <sup>1</sup>	.99	.71	.91	7.31*	.01	.88	1.00	.94	1.04	.88	1.00	.18	< .01
Mental Health																
Depression	1.57 <sup>1</sup>	1.04	1.76 <sup>1</sup>	1.00	1.80	1.04	10.23*	.01	1.50	1.05	1.76	1.06	1.82	1.03	8.27*	.01
Anxiety	1.88 <sup>1</sup>	1.04	2.00 <sup>1</sup>	1.03	2.25	.99	13.11*	.01	1.71	1.05	1.86	.98	1.89	.99	2.80	< .01

Note: \*  $p < .003$  (Bonferroni adjusted value to maintain experiment-wide  $p < .05$ ); <sup>1,2</sup> groups differing significantly from each other in post-hoc tests ( $p < .001$ ) are indicated by the same superscript number; where there are two superscript numbers, one group differed significantly from two other groups

Table 4. Sexual orientation concordance and health outcomes among women.

Outcome	B	<i>t</i>	<i>F</i>	<i>R</i> <sup>2</sup>	Outcome	B	<i>t</i>	<i>F</i>	<i>R</i> <sup>2</sup>
Family Support					Marijuana Use				
Model 1			8.90**	.02	Model 1			17.29**	.03
Model 2			7.78**	.02	Model 2			15.06**	.03
SSA	0.01	0.19			SSA	0.01	0.33		
BSA	-.08	-2.04*			BSA	0.05	1.41		
SSB	0.01	0.57			SSB	-.01	-.35		
BSB	0.02	0.86			BSB	0.14	4.97**		
SSI	-.06	-2.01*			SSI	-.03	-.95		
BSI	-.05	-1.78			BSI	-.05	-1.94		
CONC	0.04	1.02			CONC	-.05	-1.29		
Social Support					Alcohol Use				
Model 1			1.01	<.01	Model 1			8.32**	.02
Model 2			1.05	<.01	Model 2			7.42**	.02
SSA	0.06	1.88			SSA	0.03	1.14		
BSA	0.02	0.44			BSA	0.05	1.32		
SSB	-.03	-1.24			SSB	<.01	-.19		
BSB	<.01	0.12			BSB	0.16	5.98**		
SSI	-.01	-.35			SSI	-.08	-3.04**		
BSI	0.01	0.36			BSI	-.09	-3.40**		
CONC	0.05	1.15			CONC	0.05	1.42		
Harassment					Depression				
Model 1			13.66**	.03	Model 1			3.83**	.01
Model 2			12.35**	.03	Model 2			3.77**	.01
SSA	0.02	0.76			SSA	<.01	0.01		
BSA	0.05	1.22			BSA	0.02	0.45		
SSB	<.01	-.16			SSB	<.01	-.10		
BSB	0.06	2.34*			BSB	<.01	0.07		
SSI	0.02	0.77			SSI	0.05	1.80		
BSI	-.02	-.91			BSI	-.02	-.66		
CONC	-.08	-2.09*			CONC	-.05	-1.34		
Trauma					Anxiety				
Model 1			15.54**	.03	Model 1			5.94**	.01
Model 2			14.80**	.03	Model 2			5.09**	.01
SSA	-.01	-.36			SSA	<.01	-.17		
BSA	0.03	0.67			BSA	0.06	1.60		
SSB	0.03	1.11			SSB	-.03	-1.24		
BSB	0.06	2.08*			BSB	0.01	0.21		
SSI	0.03	1.02			SSI	0.06	2.16*		
BSI	-.04	-1.50			BSI	0.03	1.10		
CONC	-.12	-3.17**			CONC	<.01	0.04		

Note: SSA = same-sex sexual attraction, BSA = bisexual-sexual attraction, SSB = same-sex sexual behavior, BSB = bisexual sexual behavior, SSI = same-sex identity, BSI = bisexual identity, CONC = concordance; \*\*  $p < .01$ , \*  $p < .05$

Table 5. Sexual orientation concordance and health outcomes among men.

Outcome	B	<i>t</i>	<i>F</i>	<i>R</i> <sup>2</sup>	Outcome	B	<i>t</i>	<i>F</i>	<i>R</i> <sup>2</sup>
Family Support					Marijuana Use				
Model 1			10.84**	.04	Model 1			1.91	<.01
Model 2			9.43**	.04	Model 2			1.69	<.01
SSA	0.02	0.39			SSA	0.03	0.72		
BSA	-.07	-1.31			BSA	0.05	1.02		
SSB	-.07	-1.59			SSB	-.01	-.17		
BSB	-.05	-1.04			BSB	0.03	0.66		
SSI	0.04	1.05			SSI	-.06	-1.56		
BSI	-.06	-1.19			BSI	-.06	-1.13		
CONC	0.06	0.98			CONC	-.04	-.61		
Social Support					Alcohol Use				
Model 1			2.32*	.01	Model 1			0.68	<.01
Model 2			2.11*	.01	Model 2			0.64	<.01
SSA	0.06	1.34			SSA	-.06	-1.28		
BSA	0.02	0.31			BSA	-.03	-.54		
SSB	-.03	-.55			SSB	0.03	0.69		
BSB	-.04	-.79			BSB	0.03	0.63		
SSI	0.09	2.12*			SSI	-.01	-.12		
BSI	0.01	0.24			BSI	<.01	0.01		
CONC	0.05	0.90			CONC	-.04	-.63		
Harassment					Depression				
Model 1			2.13*	<.01	Model 1			4.38**	.01
Model 2			1.97	<.01	Model 2			3.89**	.01
SSA	0.01	0.32			SSA	-.02	-.54		
BSA	<.01	-.04			BSA	0.11	2.11*		
SSB	0.05	1.18			SSB	0.08	1.71		
BSB	0.04	0.75			BSB	0.10	2.18*		
SSI	0.01	0.27			SSI	-.07	-1.83		
BSI	-.05	-.86			BSI	<.01	-.02		
CONC	-.06	-1.01			CONC	0.06	0.98		
Trauma					Anxiety				
Model 1			1.55	<.01	Model 1			1.30	<.01
Model 2			1.79	<.01	Model 2			1.12	<.01
SSA	-.02	-.50			SSA	<.01	-.07		
BSA	-.12	-2.15*			BSA	0.06	1.04		
SSB	-.02	-.47			SSB	<.01	0.07		
BSB	0.01	0.26			BSB	0.03	0.66		
SSI	0.04	1.17			SSI	-.01	-.23		
BSI	0.06	1.10			BSI	0.01	0.18		
CONC	-.10	-1.79			CONC	0.01	0.14		

Note: SSA = same-sex sexual attraction, BSA = bisexual-sexual attraction, SSB = same-sex sexual behavior, BSB = bisexual sexual behavior, SSI = same-sex identity, BSI = bisexual identity, CONC = concordance; \*\**p* < .01, \**p* < .05

Table 6. *F*-change and  $\Delta R^2$  for models upon including discordance.

Outcome	Women			Men		
	<i>F</i> change	<i>p</i>	$\Delta R^2$	<i>F</i> change	<i>p</i>	$\Delta R^2$
Family Support	1.04	.31	<.001	0.97	.33	.001
Social Support	1.33	.25	.001	0.82	.37	.001
Harassment	4.38*	.04	.002	1.02	.31	.001
Trauma	10.06**	<.01	.003	3.21	.07	.002
Marijuana Use	1.66	.20	.001	0.38	.54	<.001
Alcohol Use	2.01	.16	.001	0.40	.53	<.001
Depression	1.79	.18	.001	0.96	.33	.001
Anxiety	<.01	.97	<.001	0.02	.89	<.001

Note: \*\*  $p < .01$ , \*  $p < .05$

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