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Effects Of The Interaction Of Religion And Internalized Homonegativity On Psychological Well-Being

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EFFECTS OF THE INTERACTION OF RELIGION AND INTERNALIZED HOMONEGATIVITY ON PSYCHOLOGICAL WELL-BEING

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ABSTRACT

The goal of the current research is to contribute to knowledge regarding the ways in which religion impacts the mental health of lesbian women and gay men. A body of existing literature shows support for religion as a means of bolstering psychological well-being. However, there is a dearth of research on the unique ways in which religious sexual minority individuals may be differentially affected by religion, considering the presence of heterosexist beliefs and norms in many mainline Western religions. The current research explores the effects of the interaction between religion and internalized homonegativity on psychological well-being. Possible relationships between religious coping, internalized homonegativity, and mental health outcomes are examined. The final sample consisted of 57 lesbian and gay individuals with 44 religious individuals and 13 agnostic individuals. Participants completed the Brief Symptom Inventory-18, the Brief RCOPE Long Form, and depending on self-identified gender, either the Lesbian Internalized Homophobia Scale (women) or the Internalized Homophobia Scale (men). Participants also completed a demographic scale, which included measures of religiosity and spirituality.

Consistent with research demonstrating the protective role of religion, the results demonstrated that better psychological health was associated with religiosity and religious involvement among a sample of only religious participants, as well as a sample of religious and agnostic participants combined. The hypothesized role of internalized

homonegativity as a mediator between religious coping and psychological well-being could not be explored due to lack of association between religious coping and internalized homonegativity. However, higher levels of internalized homonegativity were associated with worse psychological health among only religious participants as well as religious and agnostic participants combined. More frequent use of positive religious coping was associated with better psychological health among religious and agnostic participants combined, but not among only religious participants.

This research will contribute to the knowledge of how the mental health of sexual minority individuals is affected by religion. The results of the current research suggest that lesbian and gay individuals may benefit from the protective effects of religion on mental health, and that social stressors may have a deleterious effect on psychological well-being among lesbian and gay religious and agnostic individuals. Greater understanding of the interactions between religion, social stress, and psychological outcomes may assist clinicians in providing more effective treatment to assist religious sexual minority clients in navigating conflicts between potentially competing intersecting identities.

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TABLE OF CONTENTS

LIST OF TABLES

Effects of the Interaction of Religion and Internalized Homonegativity on Psychological Well-being

Religion holds a great deal of personal and societal importance in most nations and cultures. In the United States, over two-thirds of adults acknowledge some connection to religion, such as belief in a higher power, religious influence in family of origin, personal prayer and devotion, or attendance of religious services and ceremonies (Miller & Thoreson, 2003). According to a 2008 Gallup Poll, sixty-five percent of Americans describe religion as an important part of their daily lives (Newport, 2009). The importance placed on religion is adaptive, as religion has been shown to be a protective factor for physical and mental health and well-being (Levin, 2010). Religion not only affects the individual, but society at large. An issue that has garnered considerable controversy in the modern mass media is the intersection between homosexuality and religion. Controversy persists within religious organizations, where homosexuality has been described as one of the most divisive issues in the church (Olson & Cadge, 2002). The tenets of most Western religions condemn homosexuality as a sin, promote a punitive message regarding homosexual behavior, and do not support same-sex relationships or marriages. The real or perceived prejudice resulting from religious doctrine may inhibit lesbian, gay, and bisexual (LGB) individuals' access or willingness to engage in religion, or result in negative outcomes among LGB individuals who choose to be religious, thereby removing a potential resource for increased physical and mental health. Although there is literature regarding religious LGB individuals, and a wide range of research connecting religion and mental health, research addressing the impact of religiosity on mental health outcomes for LGB individuals is limited. Further study in this area is

necessary to inform mental health practitioners in their work with LGB clients who wish to explore issues of religious faith or lack thereof.

Religiosity and the LGB Individual

Despite the societal importance and potential personal benefits of religion for coping with stress and protecting against negative physical and mental health outcomes, LGB individuals may be more likely than heterosexual individuals to decline participation in organized religion (Ellis & Wagemann, 1993). A nation-wide sample of LBG adults with connections to religion found that 29.3% of respondents converted from a non-affirming (i.e., condemns same-sex relationships as immoral and unnatural) to an affirming religion, 10.5% rejected religion, 12.4% continued their religious beliefs but felt shame or guilt, and 10% continued to struggle with religious beliefs despite being out about their sexual orientation (Sherry, Adelman, Whilde, & Quick, 2010). Data suggest that conflicts between religious and sexual identities are common among LGB individuals. This conflict may be related to religious value systems that define homosexuality as immoral. Six biblical verses have been interpreted to promote heteronormative relationships and support the immorality of homosexuality (Genesis 1-2; Genesis 19:1-8; Leviticus 18:22, 20:13; Romans 1:24-27; 1 Corinthians 6:9; 1 Timothy 1:10). However, biblical scholars have long disputed whether or not these scriptures truly condemn homosexuality (Boswell, 1979). Similarly, congregations are known to vary in their general attitudes toward homosexuality and gay rights issues such as same-sex marriage and ordination of LGB religious leaders. In the United States, evangelical Protestants often hold the most negative opinions, whereas Catholics and mainline Protestants tend to hold moderate views, and Jews and liberal Protestants typically

espouse more progressive doctrinal stands (Walls, 2010).

Taking into consideration the diversity of religious traditions, the experiences of LGB individuals with ties to organized religion are likely to differ widely. Among those individuals who have encountered negativity within a religious context, the experience can be formative. In a qualitative study of young gay men, Kubicek and colleagues (2009) collected qualitative data indicating that among those with a Christian upbringing, participants heard the most severe homonegative messages in church (i.e., "you'll burn… you'll go to hell for being gay," p. 611). Participants also reported hearing both overt and covert homonegative messages from family members and friends. Encountering these religiously oriented homonegative messages led to a range of consequences, including questioning sexual identity, depression, suicidality, disordered eating behaviors, and drug and alcohol use (Kubicek et al., 2009). In addition to overt antigay messages, religious LGB individuals can be affected by covert expressions of heterosexism such as couples' ministries that emphasize heterosexual norms (Pitt, 2010), or a general acknowledgement of homosexuality as a sin despite lack of expressions of outright rejection (Levy & Reeves, 2011).

Cognitive dissonance and identity development. Despite the challenges LGB individuals may encounter in religious settings, many of these individuals desire and choose to commit to a rich religious and spiritual life. The resulting conflict between religious and sexual identities can result in "cognitive dissonance," which is the experience of tension felt by a person who holds two inconsistent beliefs (Rodriguez, 2010). Religious individuals experiencing cognitive dissonance must choose between abandoning either their sexual or religious identity, living with the dissonance, or

utilizing strategies to integrate identities and resolve the dissonance. A study of the dissonance experience of 163 lesbian Christians suggested that changing one's beliefs is the most common method of resolving dissonance; whereas 26.67% chose to live with the dissonance and 18.10% chose to leave the church, 55.24% of participants modified their beliefs to allow for integration of sexual and religious identities (Mahaffy, 1996). Although many individuals are able to develop strategies to satisfactorily resolve their dissonance, the process is often not easy. Inherent in the experience of cognitive dissonance is the presence of two competing identities, both of which develop in complex fashions.

Religious identity. The effects of religion on society and the individual are influential and multifaceted. Considering the complexity of religious development, it is not surprising that no one theory is thought to fully explain the intellectual, biological, and psychosocial processes inherent involved in the process (Erickson, 1992). However, Batson, Schoenrade, and Ventis (1993) describe a model of religious identity developed by Fowler (1981), a theologian and developmental psychologist. Fowler's analysis of faith development draws upon Kohlberg and Kramer's (1969) model of moral development, and Erikson's (1950) model of psychosocial development to suggest seven stages of growth in faith that may occur throughout the lifetime. The age ranges of the first four stages coincide with Piaget's (1953) stages of cognitive development, including the sensorimotor, preoperational, concrete-operational, and formal-operational stages. Despite the suggested age ranges, individuals may only experience three or four of the stages.

According to Fowler (1981), from birth to age two, a prestage called undifferentiated faith simply involves learning of one's environment as secure or insecure. The first true stage is called intuitive-projective faith and occurs from age three to seven. During this stage, the child's faith is defined by fantasy and imitation of adults, and may result in an understanding of religion through imagination. The second stage is mythic-literal faith and occurs during ages seven through eleven, but may persist throughout adulthood. During this stage, the individual uses stories and myths to understand faith in a more logical and meaningful way, and interprets information as concrete instead of symbolic. The third stage typically occurs around adolescence and is called synthetic-conventional faith. During this time, the individual grasps a sense of diversity and begins to develop an identity as separate from others. It is typical in this stage for the individual to understand his or her religious beliefs as the only acceptable ideology, and to gain stability by internalizing the views of authority figures and peers. It is common to remain at this stage through adulthood. The fourth stage is individuative-reflective faith and may occur during young adulthood. At this stage, the individual develops a less literal and more symbolic view of faith and gains a sense of his or her faith as relative to other belief systems. A person at this stage is likely to critically analyze religious beliefs and may feel a sense of struggle or angst. The fifth stage is conjunctive faith and may occur during middle adulthood. It is characterized by an appreciation of symbolism and interrelatedness between persons that transcends societal constructions such as race, class, and gender. For example, a person at the conjunctive faith stage can acknowledge differences between the self and others, but approaches these differences with openness instead of judgment. Although a person at this stage may feel excited about these new

revelations, a loyalty to one's own system remains. The sixth stage of faith development is called universalizing faith, and is rarely reached. During this stage, the individual is able to transcend loyalty to his or her own societal system and fully embrace an inclusive human community. Persons at this stage embrace tranquility and simplicity and become activists for unity, as demonstrated by individuals like Martin Luther King Jr., Gandhi, and Mother Teresa (Batson et al., 1993).

Although ages of experiencing sexual orientation related milestones vary widely, most LGB individuals initially experience same-sex attraction, self-identification as LGB, same-sex sexual experiences, and disclosure of sexual orientation during adolescence and early adulthood (Calzo, Antonucci, Mays, & Cochran, 2011). As such, Fowler's (1981) third and fourth stages are the most pertinent to consider in the exploration of religious and sexual identity dissonance. It is important to note the incredible strain that could result when a person experiences the awakening of same-sex attractions during the synthetic-conventional stage of faith development. At this stage, it is typical to perceive one's religion as the only acceptable option, surround oneself with likeminded others, and become upset when one's beliefs are challenged. Experiencing sexual attractions that are perceived as antithetical to one's religious beliefs is likely to result in considerable cognitive dissonance. Dissonance may abate during the individuative-reflective stage, during which an individual experiences some disillusionment with his or her faith upon realizing the possible validity of other belief systems. Reducing allegiance to faith may alleviate the intensity of cognitive dissonance and allow for further exploration of burgeoning sexual identity. The fifth and sixth stages are usually only experienced in middle and late adulthood, at which point sexual identity is typically solidified (Calzo et

al., 2011). It would appear that cognitive dissonance between religious and sexual identity would cease at these stages, as they are typified by an appreciation of diverse value systems.

Sexual identity. Similar to religious identity development, numerous models of sexual identity development have been proposed (Levy & Reeves, 2011). Developed through her work with gay men, Cass (1979) proposed one of the most widely cited theories of sexual identity development. Cass's (1979) model includes six stages: identity confusion, identity comparison, identity tolerance, identity acceptance, identity pride, and identity synthesis. Individuals may progress through the stages, stay at a particular stage, or inhibit movement through the stages and experience identity foreclosure. Identity confusion occurs upon initial awareness of same-sex attraction, and elicits alienation and inner turmoil. During identity comparison, social alienation increases awareness of differences between self and others, which may result in either positive or negative feelings about the differences. Identity tolerance is characterized by an even greater sense of alienation, which motivates the individual to seek out similar others. In the identity acceptance stage, contact with other homosexual individuals increases and the individual feels increasingly normal. Identity pride involves almost full acceptance of oneself, increased disclosure of sexual identity, and a perceived societal divide between heterosexual and homosexual individuals. The final stage is identity synthesis, and is characterized by an integration of sexual identity with other identities.

Cass's (1979) model has received criticism regarding its practical limitations with lesbians due to its development based on the experiences of gay men, as well as concerns for decreased validity as modern society becomes increasingly gay-affirming (Degges-

White, Rice, & Myers, 2000). However, the six-stage model continues to be one of the most influential theories of sexual identity development (Levy & Reeves, 2011). The stages illustrate many of the experiences of cognitive dissonance religious lesbian and gay individuals may encounter, which will either result in identity foreclosure or progress through the stages. Identity foreclosure may result at any point in the process, leading to dis-identification with a minority sexual identity. Individuals who dis-identify may choose to label themselves publicly and/or privately as heterosexual despite continued experiences of same-sex attraction (Yarhouse, Tan, & Pawlowski, 2005). Although dis-identification resolves the dissonance between religious and sexual identity, individuals may be met with continued difficulty. In Yarhouse et al.'s (2005) study of religious dis-identified individuals, eleven out of fourteen participants reported reconsidering their decision. Although some individuals reported feelings of security and satisfaction regarding their decision, others experienced confusion and a struggle to extinguish attraction for people of the same gender.

Whereas some individuals resolve their cognitive dissonance by foreclosing their sexual identity, others progress through some or all of the stages. The inner turmoil of identity confusion is similar to the feeling of horror upon recognizing same-sex attraction described by a participant in Levy and Reeves' (2011) qualitative study of lesbian, gay, and queer-identified individuals with a religious upbringing. During the identity comparison stage, individuals find that their attractions are not in line with religious doctrine and may attempt to abandon their sexuality through intense prayer, spending increased time at church and reading the Bible, and attending seminars with ex-gay speakers (Levy & Reeves, 2011). If efforts to deny sexual feelings are unsuccessful

individuals will enter the identity tolerance stage and develop an increased recognition of their sexual identity. To be able to maintain religious beliefs while progressing through the remaining stages, dissonance resolution strategies must be employed. Ellis and Wagemann (1993) identified several dissonance resolution strategies, including disregarding non-affirming portions of religious texts, acknowledging a difference between religion and spirituality, seeking therapy, and identifying with other religious LGB individuals. When cognitive dissonance is resolved, identity synthesis is achieved, tension is reduced, and psychological well-being increases.

Identity synthesis. Identifying strategies that allow for integration of religious identity and sexual identity is vital to achieving a complete sense of self-identity. Levy and Reeves (2011) suggested that a catalyst for integration is gaining new knowledge. This may occur by meeting gay-affirming religious heterosexuals, encountering fellow religious LGB people, reinterpreting religious doctrine and texts, attending support groups or individual therapy, and investigating other religious philosophies and theories of sexuality. Although these strategies vary in type and a specific process of change has not been identified, a common outcome of successful identity integration is a more positive mental state. For example, gay and lesbian individuals who use postconventional religious reasoning (i.e. less traditional beliefs, broader moral reasoning, less literal scripture interpretation) experience less internalized homophobia than those who subscribe to religious fundamentalism, which involves belief of a single set of inerrant truths and strictly defined religious practices (Harris, Cook, & Kashubeck-West, 2008). Pitt's (2010) interviews of Black gay Christian men yielded a number of strategies used by men who successfully integrated their sexual and religious identities, including

positive encounters with other Black gay Christians and sympathetic heterosexual Christians, alternate interpretations of scripture, and reaching a low point at which reconciliation of identities was necessary. Most men reported a sense of relief upon integrating their identities.

Spirituality and gay-affirming faith groups. Although membership and attendance at religious institutions is fairly low among the LGB population, many individuals choose to express spiritual commitment through private acts of faith such as prayer. As a result of the stigma and ostracism related to mainline organized religion, LGB individuals are likely to emphasize spirituality, which is conceptualized as a connection to a sacred or transcendent dimension of life, over religiosity, which emphasizes institutionalized faith and specific practices (Halkitis et al., 2009).

Another strategy for maintaining one's religious and sexual identity is seeking out a faith group that is welcoming to sexually diverse individuals. Dozens of these congregations exist within the United States, with the largest congregations found within the Universal Fellowship of Metropolitan Community Churches (MCC), Unitarian/Universalist groups, and Dignity, a Catholic organization (Maher, 2006). Although these denominations can be a welcoming respite from traditional religious organizations, gay-affirming institutions are not a satisfactory solution for some individuals. Access to gay-affirming denominations may be an obstacle for those who do not live in a community with a congregation. Individuals who do attend may be dissatisfied with the experience, as stated by an individual in a qualitative study of gay Black men: "…they seemed to be more about gay than God. Since they couldn't say that homosexuality was wrong, I think they were afraid to talk about any kind of sin" (Pitt,

2010, p. 46). Another individual in Pitt's (2010) study declined participation in gay-affirming religious organizations because of the lack of cultural diversity in most of these congregations.

Atheism and agnosticism. Despite the fact that many LGB individuals choose to reject religion altogether, there is a dearth of research on those who become secular. Seculars are individuals who are atheist or agnostic, and are generally described as having the most progressive views regarding morality issues (Walls, 2010). Abandoning religion may be adaptive and positive for some LGB individuals who have experienced discrimination within a religious setting. An atheist participant in Levy and Reeves' (2011) study reported feeling happier and more hopeful as a nonreligious person and stated, "'I push myself harder to be a good person in day-to-day life and to do a lot more service than I ever did when I believed in God'" (p. 63). A participant identifying as agnostic expressed that he replaced his religious faith with faith in other people.

The experience of finding meaning outside of religion is described as "existential well-being," and encapsulates a sense of satisfaction and purpose unrelated to religiosity. On the other hand, religious well-being is characterized by religious aspects of spirituality such as how one relates to God (Tan, 2005). In a study of 93 gay and lesbian individuals, Tan (2005) found that existential well-being is significantly related to higher self-esteem, feeling less alienated, and reduced experiences of internalized homophobia, whereas religious well-being does not significantly predict any of these adjustment factors. As would be expected, religious well-being was correlated with self-identification as religious and attendance at religious services. Existential well-being, however, had no significant relationship with religious factors, indicating that secular lesbian and gay

individuals can be well-adjusted and retain a sense of purpose, meaning, and morality notwithstanding a lack of religious affiliation.

Models of Social Stress

Internalized homonegativity. The stigma associated with negative attitudes toward homosexuality and same-sex relationships within religious institutions contribute to decreased religious involvement among LGB individuals, and can lead to internalized homonegativity (Lease, Horne, & Noffsinger-Frazier, 2005). Internalized homonegativity is defined as negative attitudes about homosexuality both in the self and other persons and arises as a result of encountering negative messages about homosexuality in the dominant society and turning those attitudes inward (Shidlo, 1994). These negative societal messages are referred to as "heterosexism," which is characterized as viewing heterosexuality as the norm and all other sexual orientations as abnormal (Dermer, Smith, & Barto, 2010). Heterosexism is a type of institutional discrimination, which is the unfair treatment of or failure to protect socially disadvantaged groups at a societal level due to laws or public policies (Haas et al., 2011). Institutionalized discrimination against sexual minorities has been referred to as institutionalized heterosexism, which is defined as the ideas and policies that normalize heterosexual families and label homosexual families deviant (Lind, 2004). Until recently, personal hostile and prejudicial attitudes about homosexuality have been referred to as "homophobia," but more recently have been labeled "homonegativity" to convey cognitive antigay processes such as beliefs, attitudes, and values instead of affective responses such as fear, anger, shame, or guilt (Stefurak, Taylor, & Mehta, 2010). Although the term "internalized homonegativity" can be used interchangeably with "internalized homophobia," the former is a more accurate

description of the process and is increasingly used in the literature. Considering the over-arching presence of heterosexism in society, it is not surprising that the experience of internalized homonegativity is widespread (Lease et al., 2005). In Shidlo's (1994) review of the literature, studies estimated that between 25% and 33% of gay men and lesbians may experience homonegative attitudes at some point throughout their lives. As internalized homonegativity may be both conscious and unconscious, these percentages may underestimate the true prevalence of internalized homonegativity.

Although negative messages about homosexuality that contribute to internalized homonegativity are commonly found in society at large, non-affirming sentiments are especially pervasive in religious settings. In fact, literature on heterosexual attitudes toward homosexual individuals comprises the majority of research on homosexuality (Barton, 2010), and a significant focus is placed on the attitudes of religious individuals. A meta-analysis of this literature demonstrates a clear connection between religiosity and negative attitudes toward homosexuality, which are primarily driven by doctrinal beliefs about the immorality of homosexuality and compounded by related factors such as right-wing authoritarianism, perceived threat to values, and beliefs about homosexuality as controllable and changeable (Whitley, 2009). Religion is commonly associated with political conservatism and associated attitudes, such as non-supportive views toward same-sex marriage. Theological conservatism, frequent attendance at religious services, and political conservatism have been found to predict lack of support for same-sex marriage (Todd & Ong, 2011).

Sexual orientation victimization. Heterosexism and homonegativity often result in sexual orientation victimization, which can range from jokes to direct physical and

sexual attacks (Dermer et al., 2010). The 1998 murders of Matthew Shepard and Billy Jack Gaither were brutal and widely-publicized instances of antigay violence, but are only two examples of the victimization that thousands of LGB individuals experience each year (Herek, 2000). It is well documented that experiences of discrimination such as bullying, hostility, rejection, harassment, and physical violence are common among sexual minority individuals (Haas et al., 2011). In Mustanski, Newcomb, and Garofalo's (2011) study of 425 LGB individuals aged 15-26 years, only 6% of participants reported never having experienced victimization such as physical and sexual assault, verbal threats and insults, property damage, and being chased, all of which were associated with psychological distress. Verbal insults and threats were the most commonly reported by both men and women, and men were significantly more likely than women to experience victimization. In a large-scale study of LGB individuals in Sacramento, approximately 20% of women and 25% of men reported experiencing at least one instance of robbery, vandalism, or physical or sexual assault related to their sexual orientation (Herek, Gillis, & Cogan, 1999).

Minority stress. When LGB individuals encounter social stigmatization and prejudice, "minority stress" may occur. Although many social theorists have contributed to descriptions of the minority stress model, the common factor explaining the excess social strain experienced by members of minorities is a disharmony between an individual and the dominant culture in which the individual resides. Factors contributing to this disharmony may include alienation, conflict between the dominant culture and minority culture, and gaining meaning about the self through comparison to others (Meyer, 2003). Meyer (2003) proposed that minority stress is composed of external

stressors relating to societal heterosexism, internalization of these stressors, expectations and vigilance associated with these stressors, and concealment of sexual identity.

Examples of minority stress were illustrated in a qualitative study of sexual minority stress, in which 43 gay men, lesbians, and bisexual men and women were asked to describe experiences of heterosexism. Female participants noted the eroticization of same-sex relationships among women, assumptions about sexual availability for heterosexual relationships, sexual harassment, and marginalization. Male participants reported hostility, discrimination, social perceptions of gay and bisexual men as promiscuous, and threats of violence. Bisexual individuals of both genders experienced judgment of inauthenticity, promiscuity, and untrustworthiness from both heterosexual and gay and lesbian people (Hequembourg & Brallier, 2009).

Negative Health Outcomes in the LGBT Population

Data from a population-based study of over 3,000 American adults show that, compared to heterosexuals of the same gender, LGB individuals experience higher rates of mood, anxiety, and substance use disorders and comorbid disorders, and are more likely to utilize mental health services (Cochran, Sullivan, & Mays, 2003). Psychological distress among sexual minority individuals becomes evident at a young age. In a study of an ethnically diverse community sample of youths aged 16 to 20 years who self-identified as lesbian, gay, bisexual, transgender (LGBT), queer, or questioning attraction to the same gender, one third of participants met DSM-IV criteria for at least one diagnosis, denoting a higher prevalence of psychopathology among LGBT youths compared to national samples (Mustanski, Garofalo, & Emerson, 2010). Mustanski et al. (2010) also identified within this sample a higher than national average endorsement of

suicidality, which is consistent with King et al.'s (2008) meta-analysis suggesting significantly higher rates of suicide attempts in lesbian, gay, and bisexual individuals. Distress has also been found to manifest in physical maladies. Data from the California Quality of Life Survey demonstrates greater health complaints among lesbian and bisexual women than heterosexual women, almost all of which can be accounted for by increased level of psychological distress (Cochran & Mays, 2007).

Compared to heterosexuals, LGB individuals are at increased risk for internalizing disorders and symptoms such as anxiety, depression, and loneliness. King et al.'s (2008) meta-analysis showed greater lifetime prevalence of depression and anxiety in sexual minority men and women compared to heterosexual individuals, as well as increased risk of 12 months prevalence of depression and anxiety. In a study of 435 heterosexual and non-heterosexual college students matched on gender, age, education level, race, and attachment security, non-heterosexual participants endorsed significantly higher levels of depression, anxiety, somatization, paranoid ideation, general symptom severity, suicidal ideation, and loneliness (Biernbaum & Ruscio, 2004). Sexual minority youth also experience internalizing disorders more often than their heterosexual counterparts. In a study of 1,071 racially and ethnically diverse 11-14 year olds, adolescents who reported experiencing a same- or both-sex romantic attraction endorsed more symptoms of anxiety and depression than those who did not endorse same- or both-sex attraction (Hatzenbuehler, McLaughlin, & Nolen-Hoeksema, 2008). Psychological research often groups bisexual people with gay men and lesbians despite differing experiences of sexual minority status. In several studies that examine bisexual people separately, data suggest poorer mental health outcomes for bisexual individuals than their

heterosexual or homosexual counterparts, which are hypothesized to be associated with self-questioning of sexual identity, societal perceptions of bisexuality as an illegitimate sexual identity, and social discrimination from both the heterosexual and gay and lesbian community (Ross, Dobinson, & Eady, 2010).

Evidence suggests that bisexual individuals also experience higher rates of substance abuse than gay men or lesbians, which has been explained as a method of coping with increased social stressors (Meyer, Dietrich, & Schwartz, 2008). Several studies have also found a higher prevalence of alcohol and drug abuse among gay and lesbian individuals compared to heterosexual individuals. In a study of 375 homeless youth in Seattle aged 13-21, sexual minority youths reported the use of more types of drugs than heterosexuals, as well as significantly more frequent use of cocaine, crack, and crystal methamphetamines (Cochran, Stewart, Ginzler, & Cauce, 2002). Cochran et al. (2002) suggest that substance abuse may be a coping strategy for homeless LGBT youth, who, in addition to facing the vulnerabilities and stressors of homelessness, were found to have experienced higher levels of physical and sexual victimization than their heterosexual counterparts. King et al.'s (2008) meta-analysis found an increased risk of lifetime prevalence of alcohol and drug abuse in sexual minority individuals of both sexes compared to their heterosexual counterparts, with elevated risks of alcohol and drug abuse found for lesbian and bisexual women compared to heterosexual women.

Increased prevalence of psychopathology among LGBT individuals likely contributes to suicide and suicide attempts. It is difficult to determine rates of completed suicide in LGBT people because death records do not usually include information about sexual orientation or gender identity (Haas et al., 2011). As such, Haas et al.'s (2011)

review of the literature yielded mixed results regarding prevalence of completed suicide among LGBT individuals; whereas some studies found no difference in suicide rates between heterosexual and sexual and gender minority individuals, others reported rates of LGBT suicide up to eight times higher than suicide among heterosexual individuals. Haas et al.'s (2011) review of the literature regarding nonfatal suicide attempts, however, demonstrated consistently higher rates of suicidal ideation and suicide attempts among LGBT people compared to heterosexual people. Regarding sex differences, the results of King et al.'s (2008) meta-analysis demonstrated a risk of suicide attempts in the preceding year double that of heterosexuals for LGB men and women, and a risk of lifetime suicide attempts in gay and bisexual men four times higher than heterosexual men. Factors contributing to suicidality reported in interviews with gay men include isolation and loneliness, the stress of attempting to "pass" as a heterosexual man, and perceived failure of meeting cultural expectations of masculinity (McAndrew & Warne, 2010).

Social Stress-Related Etiology of Psychopathology

Internalized homonegativity is a form of social stress experienced by LGB individuals. Internalized homonegativity has a significant inverse relationship to mental well-being, and shows strong ties to depression (Berghe, Dewaele, Cox, & Vincke, 2010). A meta-analysis of the literature demonstrated a correlation between internalized homonegativity and internalizing conditions such as mood disorders and anxiety (Newcomb & Mustanksi, 2010). Internalized homonegativity has also been associated with a number of negative mental health outcomes such as low self-esteem among lesbian women (Peterson & Gerrity, 2006), risky sexual behavior among HIV-positive

gay and bisexual men (Ross, Rosser, & Neumaier, 2008), and gay Latino men (Smolenski, Ross, Risser, & Rosser, 2009), and eating disorders in both men and women (Williamson, 1999). Sexual minority individuals in the Netherlands, a country with civil rights equity and relatively positive attitudes toward sexual diversity, were found to have increased prevalence of psychopathology due to internalized homonegativity, suggesting that internalization of negative attitudes may occur even within tolerant societies (Kuyper & Fokkema, 2011).

Concealment of same-sex attractions is a stressor known to influence mental health among LGB individuals (Meyer, 2003). Although revealing one's sexual orientation presents risks of social disapproval and avoidance, coming out is associated with personal benefits such as increased self-esteem, decreased psychological distress, and decreased risky sexual behavior (Corrigan & Matthews, 2003). An increase in the positive effects of coming out is positively correlated with the number of people to whom an individual discloses; LGB youth who were open about their sexual orientation to a larger number of people across broader social contexts reported lower levels of internalized homonegativity than those who disclosed to a smaller number of people across fewer social contexts (Cox, Dewaele, van Houtte, & Vincke, 2011). Attempting to "pass" as heterosexual is mentally taxing and has been hypothesized to deplete cognitive resources necessary for good job performance (Madera, 2010). The relationship between openness about sexual orientation and mental health may differ by gender. In a population-based study of adults in the Netherlands, lower incidence of mental disorders were found among sexual minority women who were out, but not among their male counterparts (Kuyper & Fokkema, 2011). Kuyper and Fokkema (2011) suggest this

finding may be attributable to a tendency for women to receive more positive reactions to openness about sexual orientation than men, and may also relate to increased importance of social connectedness to women's well-being.

Discrimination relating to sexual orientation is known to be associated with worse mental health among LGB individuals. According to data from the 2004-2005 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), LGB individuals who reported experiencing discrimination within the past year were two to three times more likely to have a mood, anxiety, or substance use disorder (McLaughlin, Hatzenbuehler, & Keyes, 2010). Gay and bisexual young men who recently experienced verbal harassment, discrimination, or physical violence reported lower self-esteem and were twice as likely to endorse suicidal ideation than those who had not recently been victimized (Huebner, Rebchook, & Kegeles, 2004). Among victimized LGB young adults, support from family and friends moderated the relationship between victimization and psychological distress, but did not eliminate the impact of discrimination on mental well-being (Mustanski et al., 2011). Gay men and lesbian survivors of hate crimes experience a greater degree of psychological distress, traumatic stress, anger, and symptoms of anxiety and depression than gay and lesbian individuals who experience crimes unrelated to sexual identity. The psychological impact of experiencing a crime related to sexual identity includes reduced belief in the benevolence of others, increased perceived vulnerability and fear of crime, decreased perception of control over life events, and an increased tendency to attribute personal setbacks to sexual prejudice (Herek et al., 1999). Herek and colleagues (1999) suggest that although these results could be explained by an overall sense of persecution that may lead to interpretations of incidents as antigay, the

important finding is that feelings of vulnerability and low personal mastery can be linked with sexual identity and lead to psychological distress.

In addition to the negative psychological impacts of discrimination at an individual level, LGB individuals can be strongly affected by institutional heterosexism. One of the most hotly debated and highly publicized examples of institutional heterosexism is the ban on same-sex marriage. In 1996, Congress defined marriage as the legal union between a man and a woman by passing the Defense of Marriage Act (DOMA), and constitutional amendments banning same-sex marriage continue to be voted on at a state level (Lind, 2004). Using data from the NESARC, Hatzenbuehler, McLaughlin, Keyes, and Hasin (2010) examined the impact of institutional discrimination on mental health of LGB individuals by comparing 2001-2002 NESARC data to 2004-2005 data on the prevalence of *DSM-IV* disorders among heterosexual and LGB individuals in 16 states that enacted amendments in 2004 or 2005. The prevalence of mood disorders, generalized anxiety disorder, substance use disorders, and comorbidity increased significantly between these time points among LGB individuals but not among heterosexual individuals. Hatzenbuehler et al. (2010) interpreted these results as evidence that institutionalized heterosexism such as DOMA can be psychologically harmful for sexual minority individuals. Another well-known example of institutional heterosexism is the 1994 National Defense Authorization Act (NDAA), known as “Don’t Ask, Don’t Tell” (DADT), a policy that prohibited asking about sexual orientation, and allowed LGB individuals to serve in the armed forces as long as they concealed their sexual orientation and did not engage in homosexual behavior (Oswald, 2007). Prior to its repeal in December 2010 and official end in September 2011, DADT

was responsible for the discharge of 13,000 service members (Burks, 2011), under the rationale that the presence of non-heterosexual individuals would negatively impact military readiness and unit cohesion (Knapp, 2008). DADT created a culture of sexual secrecy, in which LBG military members had to contend with sexual stigma, prejudice, victimization, and violence, which likely often went unreported due to the consequences of disclosing sexual orientation (Burks, 2011). Although the repeal of DADT was a victory for LGB rights, it is important to note that military regulations continue to ban transgender persons from serving due to medical and psychological restrictions and prohibitions against gender-non-conforming behaviors (Kerrigan, 2011).

Stressors such as internalized homonegativity, concealment, and discrimination contribute to minority stress, which is known to significantly predict psychological distress and psychopathology among both adolescents and adults (Meyer, 2003). Compared to those who did not report minority stressors, lesbian and bisexual women who reported victimization, concealment of sexual orientation, and internalized homonegativity were more likely to report more negative views of spirituality and less perceived social support, both of which were associated with substance use and psychopathology (Lehavot & Simoni, 2011). In a study of lesbian, gay, bisexual, transgendered, and questioning (LBGTQ) youth in Ireland, anxiety, depression, and suicidal ideation were linked to experiences of prejudice related to sexual identity, internalization of negative societal attitudes, and expectations of rejection (Kelleher, 2009). Kelleher (2009) suggested a cycle of minority stress in which experiences of heterosexism ranging from jokes to direct attacks result in internalization of social stressors and expectations of rejection, which are reinforced by subsequent social

stressors. Attempts to cope with minority stress include alcohol and drug use as a source of comfort and escape, especially among gay and bisexual men (Hequembourg & Brallier, 2009).

Although the links between psychopathology and social stressors are evident, the specific causes of psychopathology are somewhat unclear. Drawing from the literature on psychopathology and social stressors in sexual minority populations, Hatzenbuehler (2009) suggested a psychological mediation framework to illustrate the pathways between social stigma stress and mental health outcomes among the LGB population. When LGB individuals have the experience of being devalued in society, a number of responses can result. Affective, social, and cognitive responses to stigma are proposed as mediating factors in the relationship between social stigma and psychopathology. Social stigma can affect emotional regulation, which may result in rumination and emotional dysregulation, both of which are related to anxiety and depression. Stigma may also interfere with social and interpersonal processes, leading to social avoidance and isolation and decreased social support, which are associated with anxiety, depression, and suicidality. Finally, stigma-related stress may affect cognitive processes, resulting in cognitive risk factors for the development of anxiety and depression such as hopelessness, pessimism, and negative self-schemas. Social stressors commonly experienced by LGB individuals, such as minority stress and victimization, activate these mediating factors, which then may contribute to psychological disorders.

Religion and Mental Health

Within the past two decades, a growing body of literature has suggested important connections between religiosity and physical and mental health. Levin's (2010) overview

of mental health research on religion demonstrates that a variety of dimensions of religion show consistent and significant relationships to positive mental health outcomes such as self-esteem, self-efficacy, happiness, well-being, hope, and optimism. The connection between religious involvement and health is significant throughout the lifespan and has been replicated across samples varying in religious affiliation, race, ethnicity, social class, and gender. Religion appears to be a protective influence against depression in geriatric populations (Bosworth, Park, McQuoid, Hays, & Steffens, 2003), and among Jewish individuals, trust in God was negatively related to anxiety and depression (Rosmarin, Pargament, & Mahoney, 2009). In a large national sample, church attendance and religious beliefs were significantly and negatively related to alcohol and drug use, abuse, and dependence regardless of social support and symptoms of psychological distress (Edlund et al., 2010). Evidence from a study of adults reporting polysubstance abuse demonstrated that spirituality increased self-efficacy in coping with cravings, suggesting spirituality as a potential resource in treating substance abuse (Mason, Deane, Kelly, & Crowe, 2009). Protective benefits of religion have also been identified in adolescent populations, where religiosity has been linked to lower rates of substance use, depression, suicidality, anxiety, and delinquency (Dew et al., 2008).

Although there is strong evidence of a relationship between religiosity and improved mental health, data on the protective benefits of religion are not conclusive. In Exline, Yali, and Sanderson's (2000) study of 200 college students and 54 adults seeking treatment for anxiety or depression, religious strain was associated with depression and suicidality among religious individuals, even when those individuals also found comfort in religion. More specifically, in the clinical sample, depression was associated with

feelings of alienation from God, and suicidality was associated with fear and guilt about a perceived sin. Among college students, depression was associated with disagreements or conflicts with religious institutions or family and friends about religious issues. These results indicate that religion may concomitantly be a source of comfort and psychological distress. Among Black Christian students in South Africa, anxiety, depression, and somatic symptomatology were associated with being a born-again Christian, church attendance, prayer, and belief in heaven and hell, but negatively correlated with meaning and direction in life (Peltzer, 2005). Data from a national autopsy study of suicides in Finland demonstrated that actively religious victims of suicide were more likely than nonreligious suicide victims to have a history of inpatient psychiatric treatment and diagnosis of a psychotic or mood disorder, suggesting that among those who commit suicide, religious individuals may experience more psychopathology (Sorri, Henriksson, & Lonnqvist, 1996). Religiously active men have been found to have an increased risk of major depression, whereas women do not, indicating the presence of gender differences in religious involvement and mood disorders (Maselko & Buka, 2008).

Several hypotheses for the discrepant findings of the effect of religion on mental health have been proposed, emphasizing the complex pathways between religion, health, and biopsychosocial mediators (Baetz & Toews, 2009). For example, whereas social support is considered a primary mediator in the relationship between religion and mental health, depressive symptoms are differentially affected by positive and negative social interactions. Similarly, in the realm of psychological factors, religion is known to impact mental health by providing a model for appraisal of life events, but mental health can be positively or negatively affected depending on religious orientation and religious

behaviors and cognitions. Additionally, evidence suggests that biological factors such as variations in prefrontal cortex, cardiovascular, neurohormonal, and neuroimmunologic functions can differentially influence one's religious experience and mental health (Baetz & Toews, 2009). Due to the potential for religion to affect mental health both positively and negatively, it is important to consider the interaction between religion and populations at high risk for distress and psychopathology. Among LGB individuals, interaction with non-affirming faith groups is strongly associated with internalized homonegativity, which has a significant inverse relationship to mental well-being and shows strong ties to depression (Berghe et al., 2010). On the other hand, LGB individuals who affiliate with gay-affirming faith groups or acknowledge a personal spirituality have been found to have better psychological health (Lease et al., 2005). The interaction between religion, the stress associated with being a sexual minority person, and mental health is complex and has received little attention in clinical literature. Increased knowledge in this area would be beneficial in informing treatment of LGB individuals with ties to religion (Bartlett, Smith, & King, 2009).

Stress and religious coping. Stress has been described as perhaps the most common variable in predicting many forms of psychopathology (Monroe & Steiner, 1986). As such, considerable attention has been given to factors that may attenuate the negative psychological impact of stress by aiding coping. Lazarus (1993) conceptualized stress as a reaction arising from the cognitive appraisal of internal or external variables as exceeding one's resources. Coping comprises the process of changing thoughts and behaviors to make circumstances, or appraisals of circumstances, more positive (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986). Religiosity has been found to

moderate the relationship between stress and symptoms of psychological distress, suggesting that religion may contain coping strategies to inoculate against stress-related psychopathology (Lee, 2007). Considering the negative impact of social stigma-related stressors on the mental health of LGB individuals, it is important to consider the ways in which religion could impact psychopathology in sexual minority populations.

Patterns of positive and negative religious coping were first introduced by Pargament, Smith, Koenig, and Perez (1998). Religious coping encapsulates several religiously oriented mechanisms of handling stressors including behavioral, cognitive, and interpersonal responses. Religious coping can be positive or negative, and is defined as such depending on an action's impact on mental health. Examples of positive religious coping include seeking comfort and reassurance from clergy and congregation members, drawing strength from religion to aid in forgiveness of an offense, using religion as an aid in problem solving, seeking connection with transcendent forces, engaging in religious actions, using religion to redefine a stressor as potentially beneficial, and focusing on religion to gain relief from stressors. Examples of negative religious coping are feeling dissatisfied with God, clergy, or congregation members, viewing stressors as God's punishment for sins or acts of the Devil, and questioning God's power. Although most people use positive religious coping methods, negative methods are not uncommon and may co-occur with the use of positive methods (Pargament et al., 1998).

According to Pargament and colleagues (1998), positive religious coping is generally associated with lower levels of distress and increased spiritual and psychological growth in response to a stressor, whereas negative religious coping is linked to more symptoms of psychological distress, psychopathology, and poorer quality

of life. This finding is important because it illustrates the potentially harmful effects of religion on mental health. Despite ample evidence of a link between religious involvement and positive mental health outcomes, religiosity has been linked to negative psychological states such as guilt (Francis & Jackson, 2003), depression, and distress consistent with symptoms of anxiety and mood disorders (Jansen, Motley, & Hovey, 2010). Consistent with the connection between negative religious coping and distress, negative mental health outcomes are more common among individuals with negative core beliefs about religion such as belief in a malevolent God (Rosmarin, Krumrie, & Andersson, 2009).

Several studies suggest a connection between reduced stress and placing one's locus of control in a higher power. Locus of control is a person's belief of what causes both positive and negative outcomes in life, and is a form of reappraisal. As would be expected, it is well supported that religious individuals are more likely than nonreligious individuals to ascribe causes of events to a higher power (e.g., Loewenthal & Cornwall, 1993). A recent study of college and community samples with high religious attendance and reported importance of religion identified lower stress levels among individuals who acknowledged a higher level of surrender to God, a construct denoting a denial of one's own desires and actions in favor of placing control in God's will (Clements & Ermakova, 2011). Although these results are correlational, findings suggest that individuals who place their locus of control in a higher power may reduce their propensity to feel stress in adverse situations. In a study of religious college students, feelings of comfort and inspiration were associated with the belief that negative events are part of God's plan (Merrill, Read, & LeCheminant, 2009). Another form of reappraisal of stressors is finding

meaning in stressful situations. In a sample of bereaved college students, religion was positively related to positive reappraisal, long-term adjustment, and personal growth following the death of a loved one (Park, 2005).

Social support. Attending religious services and events provides increased opportunity for social integration and support (Nooney & Woodrum, 2002). Social support is correlated with life satisfaction in diverse populations (Fife, Adegoke, McCoy, & Brewer, 2011), and has been suggested as a partial mediating factor in the relationship between religiosity and decreased psychological distress (Salsman, Brown, Brechting, & Carlson, 2005). Social support is known to be protective against negative mental health outcomes among sexual minority individuals (Gallor & Fassinger, 2010). LGB adults typically rely more on friends and the LGB community than family, a friendship network called "families of choice" (Dewaele, Cox, Berghe, & Vincke, 2011, p. 313). Although feeling a sense of belonging with the LGB community is important, feeling part of the general community may be especially important, as illustrated by data indicating that a sense of belonging to the general community was predictive of lower rates of depression in lesbian women whereas feelings of belonging to the lesbian community was not (McLaren, 2009). Familial support may also be especially important in bolstering mental health by increasing self-acceptance of sexual orientation. A questionnaire study of 461 Israeli LGB youths and young adults aged 16-23 found a significant and negative correlation between support from family and friends and psychological distress, and a significant and positive correlation between social support and disclosure and self-acceptance of LGB identity. Interestingly, whereas support from friends correlated more strongly with disclosure, participants who received familial support reported better

psychological health and greater self-acceptance of LGB identity (Shilo & Savaya, 2011). This finding indicates that although friends are important in the coming out process, family acceptance may be especially important in moderating the effects of minority stress and preventing internalized homophobia among young LGB individuals. However, evidence suggests that the importance of family support for well-being decreases with age. In an adult sample, parental support of same-sex relationships did not affect relationship quality or mental well-being (Blair & Holmberg, 2008), and beginning in young adulthood, having friends and feeling accepted by one's peers appears to be more predictive of better mental health than does familial support (Mustanski et al., 2011).

The Proposed Study

Religion is purported to be a protective influence against psychopathology (Levin, 2010), and may provide several methods of coping with stressors (Pargament et al., 1998). Considering its role in bolstering mental health, religion could be an especially beneficial resource for sexual minority individuals, who experience higher rates of psychopathology than heterosexual individuals (Cochran et al., 2003). The increased prevalence of mental illness among sexual minority men and women has been explained by the minority stress model, which holds that psychological disorders are a result of internalized homonegativity brought on by discrimination, prejudice, and stigma (Meyer, 2003). Although religion is a potentially beneficial psychosocial resource, sexual minority individuals may be less likely to participate in organized religion than heterosexual individuals (Ellis & Wagemann, 1993). Avoidance of religion is likely related to heterosexist doctrine espoused by mainline western religions (Whitley, 2009), cognitive dissonance between religious identity and sexual identity (Rodriguez, 2010), and the

tendency for religious individuals to hold antigay attitudes (Walls, 2010). Numerous studies have investigated the effects of religion on psychological disorders, and many have examined the impact of social stressors, such as internalized homonegativity, on the mental health of sexual minority individuals. However, less attention has been given to the relationships between internalized homonegativity, religiosity, and mental health. This study will attempt to develop a better understanding of interactions between religious coping, social stressors experienced by lesbian and gay individuals, and psychopathology.

Hypotheses

1. Gay men and lesbian women who endorse higher levels of current religious involvement will report better psychological health than those who report low levels of current religious involvement.
2. Among people who espouse a religion, the use of positive religious coping methods and low levels of internalized homonegativity will be associated with good psychological health among gay men and lesbian women. In contrast, the use of negative religious coping methods and high levels of internalized homonegativity will predict poor psychological health.
3. Internalized homonegativity will mediate the relationship between religious coping and psychological health. More positive religious coping will predict lower levels of internalized homonegativity, which in turn will predict better psychological health.

Method

Design

This study used self-report questionnaires to investigate the relationships between religious coping, internalized homonegativity, and mental health. A correlational design was used. The predictor variables were internalized homonegativity and religious coping, and the criterion variable was self-reported psychological distress and psychopathology.

Participants

A total of 187 individuals responded to the survey. Data from 130 individuals were discarded prior to analysis for the following reasons: 14 did not indicate gender, 6 reported a gender other than male or female, 47 reported their sexual orientation as heterosexual, 35 reported a sexual orientation other than gay or lesbian (e.g., bisexual, "pansexual"), 16 reported that they were Atheist, and 12 had excessive missing data.

Participants were 57 lesbian and gay individuals recruited from online social networks and websites that target these populations, such as Facebook groups for LGBT organizations. The sample was composed of 32 (56.1%) men and 25 (43.9%) women. Respondents were between the ages of 19 and 75 years old, with a mean age of 38.7 years (*SD* = 16.0). The majority of participants (87.7%) described themselves as White/Caucasian, whereas 5.3% described themselves as Hispanic/Latino, 3.5% described themselves as Asian/Asian American, and 3.5% described themselves as Black/African American. Reported household income ranged from less than $20,000 to more than $100,000, with 40.4% reporting an income less than $40,000 (lower income group). Another 33.3% reported annual income between $40,000 and $80,000 (middle income group), and 26.4% reported income above $80,000 (upper income group). Regarding education level of participants, 15.8% reported some college, 22.8% reported

a college degree, 7% reported some graduate education, 52.6% reported having a graduate or professional degree, and one person did not respond to this question.

Regarding religious affiliation, 31.6% of participants described their religious preference as Protestant, 22.8% as Agnostic, 12.3% as Catholic, 12.3% as Buddhist, 3.5% as Jewish, and 17.5% as Other (e.g., Pagan, Eclectic, Greek Orthodox). Regarding frequency of prayer, 12.3% reported praying more than once a day, 8.8% once a day, 14% a few times a week, 10.5% once a week, 7% a few times a month, 15.8% less than once a month, and 31.6% never. Regarding frequency of meditation, 5.3% reported meditating more than once a day, 8.8% once a day, 12.3% a few times a week, 10.5% a few times a month, 3.5% once a month, 26.3% less than once a month, and 33.3% never. Regarding attending religious services, 1.8% reported attending several times a week, 1.8% every week, 5.3% two to three times a month, 7% about once a month, 19.3% several times a year, 21.1% about once or twice a year, 24.6% less than once a year, and 19.3% never.

Measures

Demographic questionnaire. Participants provided information on their age, gender, race/ethnicity, educational level, income level, sexual orientation, relationship status, identification as spiritual/religious, religious attendance, religious affiliation and denomination, and importance of religious or non-religious beliefs. Participants rated their current sexual orientation on a 7-point Likert scale from 1 (Only Heterosexual) to 7 [Only Gay or Lesbian; adapted from Klein, Sepekoff, & Wolf, (1985)]. Identification as spiritual (“To what extent do you consider yourself a spiritual person?”) and religious (“To what extent do you consider yourself a religious person?”) was assessed on separate self-report 4-point Likert scale from 1 (Very spiritual/religious) to 4 (Not

spiritual/religious at all). Importance of religious or non-religious beliefs was assessed with a self-report 4-point Likert scale ranging from 1 (Very important) to 4 (Not important at all). Data regarding the extent and importance of religiosity/spirituality was reverse scored for ease of interpretation. As such, high scores reflect greater extent and importance of religiosity/spirituality. Participants reported their frequency of religious attendance with a 9-point Likert scale from 1 (Never) to 9 (Several times a week). Frequencies of meditation and prayer were reported on two separate 8-point Likert scales ranging from 1 (More than once a day) to 8 (Never). To increase ease of interpretation, meditation and prayer ratings were reverse scored such that higher scores indicated higher frequencies of meditation and prayer. See Appendix A.

Four items were combined as an overall measure of religiosity, including "To what extent do you consider yourself a religious person," "To what extent do you consider yourself a spiritual person," "How important are your religious beliefs to you," and "How important are your spiritual beliefs to you," with higher scores indicating a lower level of religiosity/spirituality. The measure demonstrated good internal consistency ($\alpha = .86$).

Brief Symptom Inventory-18 (BSI-18). The Brief Symptom Inventory-18 (BSI-18; Derogatis, 2000) is an 18-item measure used as a screening tool for the most common psychiatric disorders, including depression, anxiety, and somatization. The measure has been widely used in clinical settings and epidemiological studies, and has been found to have adequate convergent validity with the 53-item Brief Symptom Inventory (BSI; Derogatis, 1993), from which it was derived. The BSI is an abbreviated version of the 90-item Symptom Checklist-90-Revised (SCL-90-R; Derogatis, 1994), which is a self-report

measure of nine dimensions of psychological distress.

The measure includes 18 statements divided equally among the dimensions of depression, anxiety, and somatization. The participant responds to each statement based on their past-week level of distress using a 5-point Likert scale ranging from 0 (Not at all) to 4 (Extremely). Dimension scores range from 0 to 24. The sum of all dimensions is the global severity index (GSI) of distress, and scores range from 0 to 72. Higher subscale and GSI scores indicate higher levels of psychological distress. Alpha coefficients demonstrate good internal consistency for the depression dimension ($\alpha = .84$), the anxiety dimension ($\alpha = .79$), the somatization dimension ($\alpha = .74$), and the GSI ($\alpha = .89$). Concurrent validity with the SCL-90-R is good, and ranges from .91 to .96 on dimension and GSI scores. See Appendix B. One item from the depression dimension was inadvertently left off ("How much were you distressed by feeling lonely?") and another from the somatization dimension was inadvertently repeated ("How much were you distressed by numbness or tingling in parts of your body?"), therefore, in this scale scores are only based on 16 items. In the current study, alpha coefficients demonstrated excellent internal consistency for the GSI ($\alpha = .90$), and good internal consistency for the depression dimension ($\alpha = .85$), the anxiety dimension ($\alpha = .87$), and the somatization dimension ($\alpha = .77$).

Brief RCOPE Long Form. The Brief RCOPE Long Form is a 10-item scale designed to measure positive and negative forms of religious coping (National Institute on Aging/Fetzer Institute, 1999). The measure is divided into two subscales. The first subscale, Positive Religious/Spiritual Coping, has five items that examine methods of positive religious and spiritual coping, including Search for Spiritual Connection ("I think

about how my life is part of a larger spiritual force"), Collaborative Religious Coping ("I work together with God as partners to get through hard times"), Seeking Spiritual Support ("I look to God for strength, support, and guidance in crises"), Benevolent Religious Appraisal ("I try to find the lesson from God in crises"), and Ritual Purification ("I confess my sins and ask for God's forgiveness").

The second subscale, Negative Religious/Spiritual Coping, has five items that examine methods of negative religious and spiritual coping, including Punishing God Reappraisal ("I feel that stressful situations are God's way of punishing me for my sins or lack of spirituality"), Spiritual Discontent ("I wonder whether God has abandoned me"), Self-Directed Religious Coping ("I try to make sense of the situation and decide what to do without relying on God"), Religious Doubts ("I question whether God really exists"), and Anger at God ("I express anger at God for letting terrible things happen").

Participants are asked to think about how they understand and cope with major problems in their lives, and rate on a Likert-type scale from 1 (A great deal) to 4 (Not at all) the extent to which each item is involved in the way they cope. Scores range from 10 to 40 for the total scale, 5 to 20 for the Positive Religious/Spiritual Coping subscale, and 5 to 20 for the Negative Religious/Spiritual Coping subscale. Scores were reverse coded such that higher scores indicate more frequent use of religious/spiritual coping strategies. See Appendix C.

The Brief RCOPE Long Form is derived from the 21-item Brief RCOPE, and consists of the five highest loading items on positive and negative religious/spiritual coping factors, respectively. The Brief RCOPE Long Form was developed by the Fetzer Institute/National Institute on Aging Working Group to be included in the

Multidimensional Measurement of Religious/Spirituality (MMRS) for use in health care research (National Institute on Aging/Fetzer Institute, 1999). Although this subset of items has not been directly tested for internal consistency, discriminant validity, and criterion-related validity, the Brief RCOPE demonstrates alpha coefficients of .90 and .81 for the positive and negative subscales, respectively (Pargament et al., 1998). The Brief RCOPE was adapted from the RCOPE, a 105-item comprehensive and theoretically based measure of 17 religious/spiritual coping methods (Pargament, Koenig, & Perez, 2000). In the current study, alpha coefficients demonstrated excellent internal consistency for the positive coping subscale ($\alpha = .90$). The negative coping subscale showed unacceptable internal consistency ($\alpha = .44$), and was therefore not used in further analyses.

Lesbian Internalized Homophobia Scale (LIHS). The Lesbian Internalized Homophobia Scale (LIHS; Szymanski & Chung, 2001) is a 52-item measure that assesses internalized homophobia (i.e., internalized homonegativity) in lesbian women. The measure is divided into five subscales. The first subscale, Connection With the Lesbian Community, has 13 items that examine a lesbian woman's separation from or connection to the lesbian community; for example, "Having lesbian friends is important to me." The second subscale, Public Identification as a Lesbian, has 16 items that describe the extent to which a lesbian woman is public with her lesbian identity; for example, "If my peers knew of my lesbianism, I am afraid that many would not want to be friends with me." The third subscale, Personal Feelings About Being a Lesbian, has 8 items that assess personal feelings about being a lesbian ranging from self-hatred to self-acceptance; for example, "As a lesbian, I am loveable and deserving of respect." The fourth subscale,

Moral and Religious Attitudes Toward Lesbians, has 7 items that describe moral and religious views ranging from condemnation to acceptance; for example, “Female homosexuality is a sin.” The fifth subscale, Attitudes toward other lesbians, has 8 items that refer to attitudes held about other lesbian women; for example, “I have respect and admiration for other lesbians.” Participants rate each item on a 7-point Likert scale from 1 (Strongly Disagree) to 7 (Strongly Agree). Scores range from 52 to 364, and higher scores indicate a greater degree of internalized homonegativity. See Appendix D.

Szymanski and Chung (2001) reported good construct validity and internal consistency for the total scale, (α = .94), the Connection for the Lesbian Community subscale (α = .87), the Public Identification as a Lesbian subscale (α = .92), the Personal Feelings About Being a Lesbian subscale (α = .79), the Moral and Religious Attitudes Toward Lesbians subscale (α = .74), and the Attitudes Toward Other Lesbians subscale (α = .77). In the current study, only the total score was used, and the alpha coefficient demonstrated good internal consistency (α = .76).

Internalized Homophobia Scale (IHS). The Internalized Homophobia Scale (IHS; Ross & Rosser, 1996) is a 26-item measure that assesses internalization of homophobia (i.e. internalized homonegativity) in gay and bisexual men. The measure is divided into four subscales. The first subscale, Public Identification as Gay, contains ten items measuring the extent to which a gay or bisexual man is comfortable with publically identifying himself as such; for example, “I feel comfortable about being homosexual.” The second subscale, Perception of Stigma Associated with Being Gay, uses six items to evaluate attitudes regarding social stigmas about being gay or bisexual; for example, “Society still punishes people for being gay.” The third subscale, Social Comfort with

Gay Men, contains six items that assess how comfortable a gay or bisexual man feels in the larger gay community; for example, “Most of my friends are homosexual.” The fourth subscale, Moral and Religious Acceptability of Being Gay, has four items related to attitudes about homosexuality on a more global scale; for example, “Homosexuality is as natural as heterosexuality.” Participants rate each item on a 7-point Likert scale from 1 (Strongly Disagree) to 7 (Strongly Agree), and high scores indicate elevated levels of internalized homonegativity. All subscales demonstrate adequate to good criterion-related validity and internal consistency. Alpha coefficients were .85 for Public Identification as Gay, .69 for Perception of Stigma Associated with Being Gay, .64 for Social Comfort with Gay Men, and .62 for Moral and Religious Acceptability of Being Gay. See Appendix E. In the current study, alpha coefficients demonstrated good internal consistency ($\alpha = .71$).

Procedure

Participants were recruited from websites and online social networking communities that target lesbian, women, gay men, and bisexual people. A link was posted on websites so that participants had the option to click on the link to take the online survey that was developed using Qualtrics. After clicking on the link, participants were routed to an Indiana State University webpage where they read an informed consent form (see Appendix F for the informed consent form). If they agreed to the parameters of the study, participants then clicked continue to participate in the study. After being routed to the Indiana State University webpage, participants indicated their gender and then completed the demographics questionnaire, the BSI-18, the Brief RCOPE Long Form, and either the LIHS or IHS, depending on reported gender. Upon completing the

questionnaires, participants had the opportunity to enter a drawing to win one of five $20 gift cards to Amazon.com. If participants decided to enter the drawing, they clicked on a separate link and entered their email address into a database. The drawing database had no connections to the participants' answers on the questionnaire to ensure anonymity. After data collection was completed, five email addresses were randomly selected from the drawing database and winners were contacted via email. The Amazon.com gift card was electronically delivered to their email account.

Results

Only data from participants who scored "7" or "Only Gay or Lesbian" on the Klein et al. (1985) sexual orientation scale were included in the analyses. Due to the different number of items on the LIHS and IHS, standardized z-scores were calculated prior to analysis.

An a priori power analysis indicated a necessary sample size of approximately 95 participants to find a medium effect size with an α of 0.05 and β of .80 (Cohen, 1992). This sample size was not reached, therefore the following analyses may have lower than desired power.

There were no statistically significant differences between men and women on any variables. A one-way ANOVA indicated that there were no gender differences on religiosity, $F(1, 55) = .248$, $p = .621$; positive religious coping, $F(1, 55) = .862$, $p = .267$; full-scale BSI-18, $F(1, 54) = .000$, $p = .996$; BSI-18 somatization dimension, $F(1, 54) = .551$, $p = .461$; BSI-18 depression dimension, $F(1, 54) = .071$, $p = .896$; BSI-18 anxiety dimension, $F(1, 54) = .265$, $p = .609$; and full-scale standardized internalized homonegativity, $F(1, 55) = .407$, $p = .526$. Raw scores for women on the LIHS ranged

from 3.3 to 5.1 (M = 4.1, SD = .43), and raw scores for men on the IHS ranged from 2.4-4.4 (M = 3.2, SD = .48), indicating scores at the middle or lower range and suggesting that internalized homonegativity scores were not especially high. Table 1 presents the means and standard deviations for these measures.

Religious Involvement and Psychological Health

To test the hypothesis that higher levels of religious involvement are positively correlated with better psychological health among gay men and lesbian women, zero-order correlations between measures of religious involvement and psychological health were calculated. Table 2 presents the zero order correlations between religiosity, measures of religious involvement (i.e., service attendance, prayer frequency, meditation frequency), internalized homonegativity scores, positive religious coping scores, and the BSI-18 full-scale and sub-scale scores for both men and women. Table 3 presents the results for men, and Table 4 presents the results for women.

For men and women combined, low levels of religiosity were associated with high levels of distress on the full-scale BSI-18, somatization subscale, depression subscale, and anxiety subscale. Infrequent prayer was associated with high distress on the full-scale BSI-18 and the depression subscale. Infrequent meditation was associated with high distress on the depression subscale. For men, low levels of religiosity were associated with high levels of distress on the full-scale BSI-18, somatization subscale, and depression subscale. For women, low levels of religiosity were associated with high distress on the full-scale BSI-18 and anxiety subscale.

Religious Coping, Internalized Homonegativity, and Psychological Health

To test the hypothesis that good psychological health is positively correlated with

use of positive religious coping methods and low levels of internalized homonegativity among gay men and lesbian women, zero-order correlations between measures of religious coping, internalized homonegativity, and psychological health were calculated (see Tables 2, 3, and 4). Negative religious coping was not included due to poor internal consistency.

High levels of internalized homonegativity were significantly associated with high levels of psychological symptomatology. It was also found that high levels of psychological symptomatology were significantly associated with low levels of positive religious coping. There was a non-significant relationship between positive religious coping and internalized homonegativity.

Four simultaneous regression analyses were calculated to determine the relative contributions of positive religious coping and internalized homonegativity to psychological well-being. Scores on the total BSI-18 and the somatization, depression, and anxiety subscales were the criterion variables and scores on the RCOPE positive subscale and the total internalized homonegativity scales were the predictor variables. The standardized beta coefficients are in Table 5.

The results of the regression on the total BSI-18 scores indicated that the two predictors explained 19.8% of the variance, $R = .445$, $F(2, 53)=6.56$, $p = .003$. Lower levels of internalized homonegativity and higher levels of positive religious coping were significantly associated with better psychological well-being. Similar results were found for depression scores, $R = .432$, $F(2, 53) = 6.10$, $p = .004$. Lower levels of internalized homonegativity and higher levels of positive religious coping were associated with lower levels of depression (see Table 5). In contrast, only internalized homonegativity

significantly predicted anxiety scores, $R = .426$, $F(2, 53) = 5.88$, $p = .005$. Lower levels of internalized homonegativity predicted lower levels of anxiety (see Table 5). Neither internalized homonegativity nor positive religious coping significantly predicted somatization scores, $R = .284$, $F(2, 53) = 2.33$, $p = .107$ (see Table 5).

Mediation analysis could not be calculated because although correlations between BSI-18 and internalized homonegativity, and BSI-18 and positive religious coping were significant, the correlation between positive religious coping and internalized homonegativity was not significant.

Analyses Excluding Agnostic Participants

Independent-samples *t* tests were conducted to evaluate whether religious participants and agnostic participants differed significantly on measures of religiosity, religious activity, religious coping, psychological well-being, and internalized homonegativity. Table 6 presents the means, standard deviations, and effect sizes for these measures. Religious participants reported significantly higher levels of religiosity, attendance at religious services, prayer, and meditation than agnostic participants. Meditation demonstrated moderate effect sizes, and all other effect sizes were large. In addition, religious participants reported significantly higher levels of positive religious coping than agnostic participants. There was no significant difference between agnostic and religious participants in level of internalized homonegativity, nor in level of psychological symptomatology as measured by the BSI-18.

Religious involvement and psychological health. There were no significant differences between religious men and women on any of the scales. Table 7 presents the

means and standard deviations for these variables. To test the hypothesis that higher levels of religious involvement are positively correlated with better psychological health among religious gay men and lesbian women, zero-order correlations between measures of religious involvement and psychological health were calculated. Table 8 presents the zero-order correlations between religiosity, measures of religious involvement, positive religious coping, internalized homonegativity, and the BSI-18 full scale and sub-scale scores for religious men and women. Table 9 presents the results for religious men, and Table 10 presents the results for religious women.

For religious men and women combined, low levels of religiosity were associated with high levels of distress on the full-scale BSI-18, depression subscale, and anxiety subscale. Infrequent prayer was associated with high distress on the depression subscale. Infrequent meditation was associated with high distress on the full-scale BSI-18 and the depression subscale. For religious men, low levels of religiosity were associated with high levels of distress on the full-scale BSI-18, as well as all three subscales. Infrequent meditation was associated with high levels of distress on the depression subscale. For religious women, there were no significant associations between measures of religious involvement and psychological health.

Religious coping, internalized homonegativity, and psychological health. To test the hypothesis that good psychological health is positively correlated with use of positive coping methods and low levels of internalized homonegativity among religious gay men and lesbian women, zero-order correlations between measures of religious coping, internalized homonegativity, and psychological health were calculated (see Tables 8, 9, and 10). For gay men and lesbian women combined, high levels of

internalized homonegativity were significantly associated with high levels of psychological symptomatology as represented by the full-scale BSI-18, the depression subscale, and the anxiety subscale. High levels of symptomatology as measured by the depression subscale were significantly associated with low levels of positive religious coping. There was a non-significant relationship between positive religious coping and internalized homonegativity.

Four simultaneous regression analyses were calculated to determine the relative contributions of positive religious coping and internalized homonegativity to psychological well-being. Scores on the total BSI-18 and the somatization, depression, and anxiety subscales were the criterion variables and scores on the RCOPE positive subscale and the total internalized homonegativity scales were the predictor variables. The standardized beta coefficients are in Table 11.

The results of the regression on the total BSI-18 scores indicated that the two predictors explained 18.4% of the variance, $R = .429$, $F(2, 41) = 4.62$, $p = .016$. Lower levels of internalized homonegativity were significantly associated with better psychological well-being. Positive religious coping did not significantly predict psychological well-being. Similar results were found for anxiety scores, $R = .388$, $F(2, 41) = 3.64$, $p = .035$. Lower levels of internalized homonegativity were associated lower levels of anxiety; positive religious coping did not significantly predict anxiety levels (see Table 11). In contrast, both positive religious coping and internalized homonegativity significantly predicted depression scores, $R = .498$, $F(2, 41) = 6.77$, $p = .003$. Higher levels of positive religious coping and lower levels of internalized homonegativity predicted lower levels of depression (see Table 11). Neither internalized homonegativity

nor positive religious coping significantly predicted somatization scores, $R = .155$, $F(2, 41) = .50$, $p = .608$ (see Table 11).

Mediation analysis could not be calculated because although correlations between BSI-18 and internalized homonegativity, and BSI-18 and positive religious coping were significant, the correlation between positive religious coping and internalized homonegativity was not significant.

Discussion

A large body of research has examined the relationship between religion and mental health, and a growing body of research focuses on the effects of social stressors on the mental health of lesbian and gay individuals. However, in spite of the societal focus on issues of controversy between institutionalized religion and sexual orientation, literature related to the interaction between religion and mental health among lesbian and gay individuals remains limited. The broad goal of this study was to examine interactions between religious coping, internalized homonegativity, and psychological well-being. Increased understanding of the associations between these constructs could inform clinical practice for practitioners who work with individuals who identify as religious or spiritual and sexual minorities.

Consistent with the hypothesis, better psychological health was associated with religiosity and religious involvement among a sample of only religious participants, as well as a sample of religious and agnostic participants combined. Better psychological health was expected to be associated with the use of positive religious coping as well as low levels of internalized homonegativity, and internalized homonegativity was expected to mediate the relationship between religious coping and psychological well-being.

Although mediation could not be explored due to lack of association between religious coping and internalized homonegativity, support was found for the hypothesized relationship between higher levels of internalized homonegativity and worse psychological health among only religious participants as well as religious and agnostic participants combined. Support for the hypothesized relationship between positive religious coping and improved psychological health was found among only religious participants as well as religious and agnostic participants combined.

Religiosity and Psychological Health

As predicted in the first hypothesis, religiosity and religious involvement was positively correlated with better psychological health. Specifically, among gay and lesbian religious men and women combined, those who considered themselves to be more religious and spiritual and who reported greater importance of religious and spiritual beliefs also reported significantly fewer symptoms of anxiety and depression. These results support the current literature demonstrating significant relationships between religion and positive mental health outcomes (e.g., Levin, 2010). Importantly, these results also add to limited existing data on mental health outcomes among religious sexual minority individuals, which show mixed findings that appear to vary based on affiliation with faith groups that are welcoming to LGBT members (Lease et al., 2005), and those that are not (Berge et al., 2010).

Results of the present study showed no significant association between frequency of attendance at religious services and mental health outcomes among religious individuals. This finding is somewhat unexpected given that social support associated with religious community involvement has been found to mediate the relationship

between religious involvement and mental health (Nooney & Woodrum, 2002; Salsman et al., 2005), and because social support is protective against negative mental health outcomes among sexual minority individuals (Gallor & Fassinger, 2010). However, social support has differential effects based on whether social interactions are positive or negative (Baetz & Toews, 2009). It is possible that religious gay and lesbian individuals experience less positive social support at religious services than heterosexual individuals, which could be associated with stigmatizing factors related to the often controversial intersection between religion and same-gender relationships (Olson & Cadge, 2002).

The lack of relationship between attendance at religious services and measures of mental health may also be explained by the fact that the average religious participant reported attending religious services just more than once or twice a year. Infrequent attendance may not allow for the formation of interpersonal relationships that provide social support meaningful enough to be protective against negative mental health outcomes. The tendency for religious participants in the present study to infrequently attend religious services is not surprising, given that LGB individuals are less likely than heterosexual individuals to participate in organized religion (Ellis & Wagemann, 1993).

In the present study, religious participants reported an average frequency of prayer ranging from a few times a month to once a week, and an average frequency of meditation ranging from once a week to a few times a week. The finding that religious participants engage in private acts of faith more frequently than attending religious services is consistent with literature indicating that LGB individuals tend to emphasize personal spirituality over the institutionalized faith and practices associated with religiousness (Halkitis et al., 2009). In support of existing literature demonstrating a link

between personal spirituality and good psychological health among LGB individuals (Lease et al., 2005; Tan, 2005), data from the present study demonstrate that higher prayer frequency is associated with fewer symptoms of depression, and higher meditation frequency is associated with less overall distress and fewer symptoms of depression.

Although significant relationships between measures of religious involvement and mental health were found in analyses of religious men and women combined, additional analyses demonstrate that these relationships appear to differ between women and men. Whereas greater extent and importance of religion and spirituality were associated with less overall distress and fewer symptoms of anxiety, depression, and somatization among religious men, no significant relationship between religiosity and any mental health outcomes was found among religious women. Furthermore, whereas religious men who reported more frequent meditation also reported fewer symptoms of depression, this association was not evident among religious women. This finding is especially compelling given that the literature suggests that gay men tend to experience more victimization and poorer mental health outcomes than lesbian women (King et al., 2008), which may be attributable to a tendency for men to experience less social support and more stigmatizing reactions to openness about their sexual orientation (Kuyper & Fokkema, 2011). The association between religious involvement and fewer symptoms of psychopathology may provide evidence that religious and spiritual connection could be especially beneficial as a protective influence against mental health concerns among gay men.

The association between religious involvement and psychological well-being was also explored in analyses of religious and agnostic participants combined. Among

religious and agnostic men and women, greater extent and importance of religion and spirituality were associated with less overall distress and fewer symptoms of anxiety, depression, and somatization. Given that analysis of religious participants alone demonstrated a link between religiosity and fewer symptoms of anxiety and depression, but no link between religiosity and fewer symptoms of somatization and lower overall distress, it seems that factors associated with individuals who identify as agnostic may contribute to improved mental health over and above factors associated with those who identify as religious. This finding may be explained by literature demonstrating that gay and lesbian individuals who reported high levels of "existential well-being" (Tan, 2005, p. 137), that is, a sense of purpose and life satisfaction unrelated to religion, also experienced high levels of adjustment factors, such as high self-esteem, decreased feeling of alienation, reduced experiences of internalized homophobia compared to those who reported high levels of "religious well-being" (Tan, 2005, p. 137). The present study's finding of an association between spirituality and improved mental health among a sample of both religious and agnostic individuals lends additional support to the link between personal spirituality and decreased symptoms of psychopathology found in the existing literature (Lease et al., 2005). Data from the analysis of religious and agnostic participants combined expand the protective benefits of spirituality to include non-religious spirituality, and suggest that for gay and lesbian individuals, non-religious spirituality may provide even greater benefit than spirituality that is associated with theistic belief.

This finding is further supported by comparison of only religious participants and combined religious and agnostic participants in analyses separated by gender. Results

demonstrated that among religious and agnostic men, greater extent and importance of religion and spirituality were associated with less overall distress and fewer symptoms of somatization and depression. These data do not differ dramatically from results demonstrating that among only religious men, greater extent and importance of religion and spirituality were associated with less overall distress and fewer symptoms of anxiety, depression, and somatization. However, findings do differ between analyses of only religious women and combined religious and agnostic women; whereas no relationship existed between religious and spiritual involvement and mental health outcomes among only religious women, analysis of religious and agnostic women combined showed a significant relationship between greater extent and importance of religion and spirituality and less overall distress and fewer anxiety symptoms. This is another indicator of the enhanced protective benefits of non-religious spirituality for sexual minority individuals, and extends the finding to suggest the possibility of particular benefit among women.

Although a gender difference existed in regard to the link between psychological well-being and extent and importance of religion and spirituality, no differences between religious and agnostic men and women were found regarding well-being and religious and spiritual involvement. Analyzed separately, each gender demonstrated no relationship between mental health outcomes and frequency of religious service attendance, prayer, and meditation. However, among religious and agnostic men and women combined, higher frequency of meditation was associated with fewer symptoms of depression and higher frequency of prayer was associated with less overall distress and fewer somatization symptoms. These findings are similar to the associations between greater prayer and meditation frequency and improved mental health found among religious only

participants. Surprisingly, among religious and agnostic men and women, higher frequency of attendance at religious services was associated with fewer somatization symptoms, which differs from the finding of no association between service attendance and mental health outcomes among only religious participants. It is unclear whether this is a reliable finding, given that the significant relationship could be attributable to increased power associated with the larger sample size of the religious and agnostic participants. Additional research is needed to clarify this result.

Religious Coping, Internalized Homonegativity, and Psychological Health

The second hypothesis contained two parts. The first part postulated an association between good psychological health and increased use of positive religious coping, as well as an association between poor psychological health and negative religious coping. Negative religious coping could not be examined because the scale had poor internal reliability. Regression analysis of only religious individuals demonstrated partial support for the hypothesis. Positive religious coping significantly predicted fewer symptoms of depression, but did not significantly predict overall psychological distress, anxiety, or somatization. Among religious and agnostic men and women combined, positive religious coping significantly predicted lower levels of overall distress and fewer symptoms of depression, but did not significantly predict anxiety or somatization symptoms.

These findings offer support to existing literature, which links positive religious coping with lower levels of distress (Pargament et al., 1998). The current results also lend support to the role of religiosity as a moderator between stress and psychological distress, suggesting that religion may contain coping strategies that guard against negative mental

health outcomes (Lee, 2007). Taking into consideration Hatzenbuehler's (2009) psychological mediation framework of the pathways between minority stress and poor mental health, positive religious coping may mitigate harmful mediating factors such as emotional dysregulation, damaged interpersonal processes, and negative cognitive processes, all of which are activated by minority stress and associated with psychopathology. Given the role of negative thoughts in the etiology of depression (e.g., Beck & Alford, 2009, the present study's finding of an association between decreased depressive symptomatology and religious coping may suggest that positive religious coping contains effective strategies for reappraising cognitions.

Gender differences were examined using zero-order correlations, as sample sizes for men and women were too small to perform separate regression analyses. Among religious women only, positive religious coping was associated with fewer symptoms of depression. No association between religious coping and mental health was found among religious men. Similar to results for only religious individuals, a gender difference was evident among religious and agnostic participants combined; whereas positive religious coping was correlated with less overall distress and fewer depression symptoms among religious and agnostic women, no significant relationships between the variables existed among religious and agnostic men. These results support previous findings that the use of religion in coping is more beneficial to women, as well as poor, less educated, widowed, elderly, and Black individuals (Pargament & Brant, 1998). Pargament and Brant (1998) suggested that due to these groups' relative lack of societal privilege, religion may be a more readily accessible resource than secular resources and power.

The second part of the second hypothesis posited that high levels of internalized

homonegativity would predict poor psychological health. This hypothesis was supported by regression analyses of data from only religious individuals as well as religious and agnostic individuals combined. Specifically, among only religious men and women, greater levels of overall distress and more symptoms of depression and anxiety were predicted by higher levels of internalized homonegativity. Among religious and agnostic men and women, high levels of internalized homonegativity predicted greater overall distress and more symptoms of anxiety and depression. These findings support existing literature demonstrating an inverse relationship between internalized homonegativity and psychological well-being (e.g., Berghe et al., 2010; Newcomb & Mustanskie, 2010; Peterson & Gerrity, 2006).

Gender differences were evident in analyses of internalized homonegativity among only religious individuals as well as combined religious and agnostic individuals. Whereas internalized homonegativity was associated with greater overall distress and more symptoms of depression among religious men, no relationships between internalized homonegativity and mental health outcomes were found among religious women. Among religious and agnostic individuals combined, whereas internalized homonegativity was associated with greater overall distress and more symptoms of anxiety among women, no relationships between internalized homonegativity and mental health outcomes were found among men. Prior studies have found significantly higher levels of internalized homonegativity among gay men compared to lesbian women (e.g., Balsam & Mohr, 2007; Feinstein, Goldfried, & Davila, 2012). Balsam and Mohr (2007) also found that gay men demonstrate significantly greater sensitivity to stigma, which they posited reflects the greater pressure men feel to conform to traditional gender roles,

as well as lower levels of acceptance of same-sex relationships among men compared to women. Given the tendency for religious individuals to adhere to traditional gender role norms and endorse sexual prejudice and antigay anger toward those who violate these norms (Vincent, Parrott, & Peterson, 2011), it is possible that religious gay men may be somewhat more affected by internalized homonegativity.

Findings did not support the hypothesized link between positive religious coping and low levels of internalized homonegativity. To date, no literature exists examining the relationship between religious coping and internalized homonegativity. Due to the lack of significant relationship between these variables in the current study, the final hypothesis suggesting internalized homonegativity as a mediating variable between religious coping and psychological health could not be examined. A possible inference to draw from the nonsignficant relationship between internalized homonegativity and positive religious coping is that positive religious coping as measured by the brief RCOPE may not have an effect on internalized homonegativity. All but one item ("I think about how my life is part of a larger spiritual force.") comprising measurement of positive religious coping includes direct reference to "God" (e.g., "I confess my sins and ask for God's forgiveness."), suggesting that measurement of positive religious coping seems to emphasize traditional religiousness over broader and less conventional aspects of religion and spirituality. The lack of a significant relationship between positive religious coping and internalized homonegativity is in line with results found by Harris et al. (2008), which showed lower levels of internalized homonegativity among LGB individuals who used post-conventional religious reasoning (e.g., having moral principles that transcend social and religious rules and laws) compared to those who subscribe to fundamentalist

beliefs and practices (e.g., literal interpretation of religious stories and symbols.

Given the link between fundamentalist religion and non-affirming sentiments that are associated with internalized homonegativity (e.g., condemning same-sex relationships as unnatural; Whitley, 2009), it makes sense that sexual minorities would more frequently adopt methods of coping that are more associated with support of same-sex relationships. This is in line with Tan's (2005) finding that less internalized homonegativity is associated with existential well-being but not religious well-being. It is possible that a more meaningful link could exist between internalized homonegativity and negative religious coping, the measurement of which includes items that may reflect the minority stressors found in some institutionalized religions (e.g., "I feel that stressful situations are God's way of punishing me for my sins or lack of spirituality.")

Limitations

There were several limitations to the present study. The self-report method of data collection is one limitation. Although self-report measures are commonly used in social science research, a disadvantage of this methodology is the potential for bias. Due to the subjective nature of self-report, data provided by participants may not accurately reflect their thoughts, attitudes, and behaviors. This may be due to limits in participants' self-knowledge, as well as social desirability effects. Participants may respond to questions in ways that they believe are socially acceptable rather than providing accurate information. Self-report biases could be controlled for with the use of more implicit measures such as the bogus pipeline procedure (Roese & Jamieson, 1993) or the Implicit Associations Test (Greenwald, McGhee, & Schwartz, 1998). Another limitation is the demographic homogeneity of the sample, which decreases the generalizability of the results. Given that

data were collected via an online survey using a convenience sampling method, the sample was limited to individuals with internet access, and White, highly educated adults comprised the majority of participants. People with more education tend to exhibit less sexual prejudice than less educated people (Herek, 2000). It is possible that better educated people are also more open about their own sexual orientation, which could influence the level of internalized homonegativity and its relationship with religion. Lack of racial diversity within the sample may limit the ability for inferences to be made for non-White gay and lesbian individuals, considering consistent and pervasive evidence that Black and Hispanic Americans are more likely to be involved in religious activities and report greater importance of religion than White Americans (Pew Forum on Religion and Public Life, 2008). However, although Black and Hispanic Americans tend to report greater levels of religiosity than White Americans, they may not experience any greater mental health benefits due to religiosity than White Americans (Sternthal, Williams, Musick, & Buck, 2012). Another limitation potentially influencing generalizability is the low levels of internalized homonegativity among most participants in the sample. People with more internalized homonegativity may have different relationships with religion than those with less internalized homonegativity. Generalizability is also limited by the relatively small size of the sample, which also affects the power needed to detect statistical differences.

A potential limitation in measurement of psychological distress was introduced given that one item from the BSI-18 depression dimension was inadvertently left off and another from the somatization dimension was inadvertently repeated, which resulted in scale scores being based on 16 items instead of 18 items. Although this did not affect full-

scale or sub-scale internal consistency, inclusion of all items may enhance measurement of psychological distress. In addition, the measurement of internalized homonegativity may be improved by use of a single scale instead of separate scales for gay men and lesbian women. Although LIHS and IHS have been determined to be valid and reliable measures of internalized homonegativity in prior studies, a single scale that is not bound to specific genders and sexual orientations would ensure that measurement of the construct is consistent across participants. Additionally, this would allow for inclusion of participants who identify with a broader range of gender and sexual orientation categories, such as bisexual, questioning, queer, transgender, and non-binary gender individuals.

Future Directions

Exploration of the interactions between sexual identity and religiosity is an emerging area of study, and further exploration is needed to clarify and expand findings. Considering the complexities involved in sexual identity and religious identity, there are myriad directions for future research in this area. As suggested in the discussion of limitations, future research would do well to include a broader range of diversity in samples of participants. Specifically, efforts should be made to include bisexual and transgender individuals. Although these populations are often grouped together with gay men and lesbian women (Ross et al., 2010), their differing societal, interpersonal, and intrapersonal experiences of sexual minority and gender minority status may interact differently with issues related to religion and spirituality. Additionally, future research should gather data on levels of religious fundamentalism among participants, both presently and within family of origin, as history of affiliation with religious traditions that ascribe to religious fundamentalism has been found to predict higher levels of

internalized homonegativity (Wilkerson, Smolenski, Brady, & Rosser, 2012). Future research should also examine a spectrum of age cohorts to explore the ways in which the processes of religious and sexual identity development may interact with mental health. Older participants are more likely than younger participants to have reached more advanced stages of religious and sexual identity development, which could enhance their ability to integrate their identities and decrease cognitive dissonance regarding conflicts between their sexual orientation and religious beliefs (Cass, 1979). It could be valuable to examine the dissonance resolution strategies used by religious sexual minority individuals at various stages of sexual and religious identity development.

Future research should also examine the ways in which religiosity and sexual identity intersect in negative ways. Due to lack of internal consistency in the measure of negative religious coping, the present study could not explore the ways in which participants may have used religion to negatively appraise situations. Given that encountering homonegative messages in a religious context has been found to lead to negative psychological outcomes (Kubicek et al., 2009), it is important to explore the potentially damaging effects of religiosity. Finally, there is a need for research that examines religion and spirituality as separate entities, and explores the negative and positive outcomes of each among LGB individuals. The findings of the present study seem to support prior research (e.g., Tan, 2005) that among sexual minority individuals, spirituality that is not associated with institutionalized religion may be more predictive of better psychological health than connection with institutionalized religion. To add context to this finding, it may be important to investigate in greater specificity the factors that contribute to mental health, including possible mediating or moderating variables, such as

social support, engagement in prosocial behavior, and intrapersonal factors such as developmental level, self-esteem, and personality traits.

Clinical Applications

Given the comparatively high rates of mental illness and suicidality among sexual minority individuals and the tendency for LGB individuals to utilize mental health services at higher rates than their heterosexual peers (Cochran et al., 2003), it is a near guarantee that over the course of a career, most mental health professionals will work with numerous LGB individuals. In order to enhance efficacy of clinical intervention, research on the LGB community is needed to increase understanding of the stressors and strengths unique to this population. A body of research on psychopathology among LGB individuals shows strong evidence of a link between poor well-being and social stress associated with heterosexism and related victimization, prejudice, and discrimination both at an individual (e.g., Hatzenbuehler & Keyes, 2010; Huebner et al., 2004; Mustanski et al., 2011) and institutional level (Hatzenbuehler et al., 2010). As such, practitioners could benefit from knowledge about how to mitigate the harmful effects of these stressors on mental health.

Given that religious culture often promotes homonegative attitudes (e.g., Kubicek et al., 2009; Levy & Reeves, 2011; Pitt, 2010) that contribute to internalized homonegativity (Lease et al., 2005), special consideration must be taken when working with clients whose sexual and spiritual or religious identities are intersecting and in competition. The results of the present study indicate that identification with religion and spirituality can be associated with improved well-being, suggesting that providers should seek to assist clients in exploring and negotiating conflicts between their identities with a

goal of acceptance and celebration of each. Religious institutions that sanction prejudice and discrimination have the potential to aid in this process by changing their theological and organizational stance to welcome and affirm sexual minority individuals and allies into their congregations, and clinical psychologists may a have a role to play in educating religious officials and advocating for these changes. Efforts toward these changes have occurred among some denominations, but most mainline Western religions continue to condemn homosexuality as a sin (Olson & Cadge, 2002), suggesting the likely continued presence of conflicting identities among many religious LGB individuals. Possible strategies to achieve synthesis between identities are discussed in the existing literature and include affiliation with faith groups that are welcoming to sexually diverse individuals (Maher, 2006), use of postconventional religious reasoning instead of fundamentalist approaches (Harris et al., 2008), contact with religious and gay-affirming allies and peers (Pitt, 2010), and gaining new knowledge about sexuality and spirituality to facilitate the integration of identities (Levy & Reeves, 2011). Continued research aimed at gaining a broader understanding of the intersection between religion and sexual orientation could foster a better foundation for assisting religious LGB individuals to navigate conflicts between their competing identities, thereby increasing satisfaction with each aspect of the self, successfully integrating the identities, and improving well-being.

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Table 1

Means and Standard Deviations for Scale Scores by Gender of Religious and Agnostic Participants

	Women	Men	Total
Measures	*M* (*SD*)	*M* (*SD*)	*M* (*SD*)
Religiosity	9.76 (3.43)	10.22 (3.47)	10.02 (3.43)
RCOPE Positive	10.40 (4.18)	9.84 (3.91)	10.09 (4.01)
IH Full-Scale	-.10 (.92)	.07 (1.06)	-.01 (1.00)
BSI Full-Scale	23.56 (9.66)	23.55 (8.09)	23.55 (8.74)
BSI Somatization	8.28 (3.95)	7.65 (2.39)	7.92 (3.17)
BSI Depression	8.32 (3.89)	8.45 (3.57)	8.39 (3.68)
BSI Anxiety	6.96 (3.55)	7.45 (3.57)	7.23 (3.53)

Note. $N = 25$ for women. $N = 32$ for men. Religiosity (scores range from 4 to 16; higher scores indicate greater extent and importance of religiosity/spirituality; RCOPE Positive = Positive Religious/Spiritual Coping Scale (scores range from 5 to 20; high scores indicate more frequent use of religious/spiritual coping strategies); IH = Internalized Homonegativity (standardized scores; more positive scores indicate higher levels of internalized homonegativity, more negative scores indicate lower levels of internalized homonegativity); BSI = Brief Symptom Inventory-18 (Full-scale scores range from 0 to 64, Somatization and Depression scores range from 0 to 20, Anxiety scores range from 0 to 24; higher scores indicate more symptomatology).

Table 2

Zero-Order Correlations Between Religiosity, Religious Involvement, BSI, Positive Religious Coping, and Internalized Homonegativity for Religious and Agnostic Men and Women

	1	2	3	4	5	6	7	8	9
1. Religiosity									
2. Attend services	.58***								
3. Prayer frequency	.71***	.54***							
4. Meditation frequency	.44***	.23	.45***						
5. BSI Full-scale	-.45***	-.23	-.28*	-.25					
6. BSI Somatization	-.27*	-.25*	-.21	-.11	-.79***				
7. BSI Depression	-.46***	-.17	-.30**	-.30*	-.82***	-.89***			
8. BSI Anxiety	-.40**	-.15	-.19	-.21	-.91***	-.66***	-.64***		
9. IH Full-Scale	-.12	.09	.09	-.13	.37**	.27*	.28*	.38**	
10. RCOPE Positive	.73***	.41**	.74***	.26*	-.28*	-.12	-.35**	-.22	-.06

Note. Sample sizes ranged from 56 to 57. Religiosity (scores range from 4 to 16; higher scores indicate greater extent and importance of religiosity/spirituality; BSI = Brief Symptom Inventory-18 (Full-scale scores range from 0 to 64, Somatization and Depression scores range from 0 to 20, Anxiety scores range from 0 to 24. Higher scores indicate more symptomatology); IH = Internalized Homonegativity (standardized scores; more positive scores indicate higher levels of internalized homonegativity, more negative scores indicate lower levels of internalized homonegativity); RCOPE Positive = Positive Religious/Spiritual Coping Scale (scores range from 5 to 20; high scores indicate more frequent use of religious/spiritual coping strategies).
* $p < .05$ ** $p < .01$. ***p <.001

Table 3

Zero-Order Correlations Between Religiosity, Religious Involvement, BSI, Positive Religious Coping, and Internalized Homonegativity for Religious and Agnostic Men

	1	2	3	4	5	6	7	8	9
1. Religiosity									
2. Attend services	.64***								
3. Prayer frequency	.79***	.72***							
4. Meditation frequency	.44***	.39*	.39*						
5. BSI Full-scale	-.49***	-.16	-.23	-.23					
6. BSI Somatization	-.36*	-.21	-.25	.01	.78***				
7. BSI Depression	-.53***	-.18	-.25	-.32	.87***	.54**			
8. BSI Anxiety	-.35	-.04	-.10	-.21	.88***	.57**	.61***		
9. IH Full-scale	-.02	-.16	.27	.08	.31	.23	.22	.32	
10. RCOPE Positive	.72***	.44*	.69***	.09	-.21	-.14	-.27	-.10	.01

Note. Sample sizes ranged from 31 to 32. Religiosity (scores range from 4 to 16; higher scores indicate greater extent and importance of religiosity/spirituality; BSI = Brief Symptom Inventory-18 (Full-scale scores range from 0 to 64, Somatization and Depression scores range from 0 to 20, Anxiety scores range from 0 to 24. Higher scores indicate more symptomatology); IH = Internalized Homonegativity (standardized scores; more positive scores indicate higher levels of internalized homonegativity, more negative scores indicate lower levels of internalized homonegativity); RCOPE Positive = Positive Religious/Spiritual Coping Scale (scores range from 5 to 20; high scores indicate more frequent use of religious/spiritual coping strategies).
* $p \leq .05$ ** $p \leq .01$. *** $p \leq .001$

Table 4

Zero-Order Correlations Between Religiosity, Religious Involvement, BSI, Positive Religious Coping, and Internalized Homonegativity for Religious and Agnostic Women

	1	2	3	4	5	6	7	8	9
1. Religiosity									
2. Attend services	.51**								
3. Prayer frequency	.61***	.30							
4. Meditation frequency	.43*	.02	.52**						
5. BSI Full-scale	-.42*	-.29	-.33	-.27					
6. BSI Somatization	-.21	-.28	-.19	-.21	.82***				
7. BSI Depression	-.39	-.17	-.35	-.27	.77***	.30			
8. BSI Anxiety	-.47*	-.30	-.31	-.21	.96***	.80***	.67***		
9. IH Full-scale	-.29	.09	-.19	-.44*	.46*	.35	.37	.46*	
10. RCOPE Positive	.75***	.39	.82***	.47*	-.35	-.11	-.44*	-.35	-.14

Note. Sample size was 25. Religiosity (scores range from 4 to 16; higher scores indicate greater extent and importance of religiosity/spirituality; BSI = Brief Symptom Inventory-18 (Full-scale scores range from 0 to 64, Somatization and Depression scores range from 0 to 20, Anxiety scores range from 0 to 24. Higher scores indicate more symptomatology); IH = Internalized Homonegativity (standardized scores; more positive scores indicate higher levels of internalized homonegativity, more negative scores indicate lower levels of internalized homonegativity); RCOPE Positive = Positive Religious/Spiritual Coping Scale (scores range from 5 to 20; high scores indicate more frequent use of religious/spiritual coping strategies).

* $p \leq .05$ ** $p \leq .01$. *** $p < .001$

Table 5

Standardized Beta Coefficients for Positive Religious Coping and Internalized Homonegativity – Religious and Agnostic Participants

Criterion	RCOPE Positive	IH Full-Scale
BSI Full-Scale	-.250*	.350**
BSI Somatization	-.095	.261
BSI Depression	-.331**	.253*
BSI Anxiety	-.188	.368**

Note. $N = 25$ for women. $N = 32$ for men. RCOPE Positive = Positive Religious/Spiritual Coping Scale (scores range from 5 to 20; high scores indicate more frequent use of religious/spiritual coping strategies); IH = Internalized Homonegativity (standardized scores; more positive scores indicate higher levels of internalized homonegativity, more negative scores indicate lower levels of internalized homonegativity); BSI = Brief Symptom Inventory-18 (Full-scale scores range from 0 to 64, Somatization and Depression scores range from 0 to 20, Anxiety scores range from 0 to 24; higher scores indicate more symptomatology).
*$p \leq .05$. ** $p \leq .01$.

Table 6

Means and Standard Deviations for Scale Scores for Religious and Agnostic Participants

	Religion				
	Religious	Agnostic	*t*	*df*	Cohen's *d*
Religiosity	11.23 (2.84)	5.92 (1.55)	6.42***	55	1.55
Attend services	3.43 (1.78)	1.77 (.83)	3.20*	55	.94
Prayer frequency	4.68 (2.49)	1.15 (.38)	5.07***	55	1.33
Meditation frequency	3.52 (2.39)	1.92 (1.90)	2.22**	55	.68
RCOPE Positive	11.34 (3.71)	5.85 (.55)	5.29***	55	1.37
BSI Full-scale	22.57 (7.13)	27.17 (12.86)	-1.64	54	-.53
BSI Somatization	7.59 (2.35)	9.17 (5.15)	-1.55	54	-.50
BSI Depression	7.98 (3.27)	9.92 (4.78)	-1.64	54	-.53
BSI Anxiety	7.00 (3.12)	8.08 (4.83)	-.94	54	-.31
IH Full-scale	-.02 (1.05)	.03 (.86)	-.15	55	-.02

Note. Sample size for religious participants was 44. Samples size for agnostic participants was 13. Standard deviations appear in parentheses below means.
* $p \leq .05$ ** $p \leq .01$. *** $p < .001$.

Table 7

Means and Standard Deviations for Scale Scores by Gender of Religious Participants

	Women	Men	Total
Measures	*M* (*SD*)	*M* (*SD*)	*M* (*SD*)
Religiosity	9.14 (2.50)	8.43 (3.15)	11.23 (2.84)
RCOPE Positive	13.62 (3.83)	13.70 (3.69)	11.34 (3.71)
IH Full-Scale	.00 (1.0)	.00 (1.0)	.00 (1.0)
BSI Full-Scale	21.67 (4.37)	23.39 (8.97)	22.57 (7.13)
BSI Somatization	7.67 (2.31)	7.52 (2.43)	7.59 (2.35)
BSI Depression	7.86 (3.15)	8.09 (3.44)	7.98 (3.27)
BSI Anxiety	6.14 (1.31)	7.78 (4.01)	7.00 (3.12)

Note. $N = 21$ for women. $N = 23$ for men. Religiosity (scores range from 4 to 16; higher scores indicate greater extent and importance of religiosity/spirituality; RCOPE Positive = Positive Religious/Spiritual Coping Scale (scores range from 5 to 20; high scores indicate more frequent use of religious/spiritual coping strategies); IH = Internalized Homonegativity (standardized scores; more positive scores indicate higher levels of internalized homonegativity, more negative scores indicate lower levels of internalized homonegativity); BSI = Brief Symptom Inventory-18 (Full-scale scores range from 0 to 64, Somatization and Depression scores range from 0 to 20, Anxiety scores range from 0 to 24; higher scores indicate more symptomatology).

Table 8

Zero-Order Correlations Between Religiosity, Religious Involvement, BSI, Positive Religious Coping, and Internalized Homonegativity for Religious Men and Women

	1	2	3	4	5	6	7	8	9	10
1. Religiosity										
2. Attend services	.49**									
3. Prayer frequency	.57***	.42**								
4. Meditation frequency	.34*	-.15	.39**							
5. BSI Full-scale	-.51	-.22	-.27	-.30*						
6. BSI Somatization	-.19	-.24	-.17	-.17	.80***					
7. BSI Depression	-.55***	-.20	-.30*	-.34*	.84***	.31*				
8. BSI Anxiety	-.45**	-.12	-.17	-.21	.89***	.48**	.65***			
9. IH Full-Scale	-.09	.18	.15	-.15	.38*	.15	.38*	.35*		
10. RCOPE Positive	.57**	.24	.15	.12	-.23	.04	-.34*	-.19	-.05	

Note. Sample size was 44. Religiosity (scores range from 4 to 16; higher scores indicate greater extent and importance of religiosity/spirituality; BSI = Brief Symptom Inventory-18 (Full-scale scores range from 0 to 64, Somatization and Depression scores range from 0 to 20, Anxiety scores range from 0 to 24. Higher scores indicate more symptomatology); IH = Internalized Homonegativity (standardized scores; more positive scores indicate higher levels of internalized homonegativity, more negative scores indicate lower levels of internalized homonegativity); RCOPE Positive = Positive Religious/Spiritual Coping Scale (scores range from 5 to 20; high scores indicate more frequent use of religious/spiritual coping strategies).
* $p < .05$ ** $p < .01$. ***p <.001

Table 9

Zero-Order Correlations Between Religiosity, Religious Involvement, BSI, Positive Religious Coping, and Internalized Homonegativity for Religious Men

	1	2	3	4	5	6	7	8	9	10
1. Religiosity										
2. Attend services	.54**									
3. Prayer frequency	.66**	.63**								
4. Meditation frequency	.44*	.44*	.39							
5. BSI Full-scale	-.65**	-.25	-.30	-.35						
6. BSI Somatization	-.43*	-.24	-.29	-.20	.84***					
7. BSI Depression	-.69***	-.29	-.28	-.42*	.94***	.74***				
8. BSI Anxiety	-.59**	-.16	-.26	-.31	.93***	.64**	-.80***			
9. IH Full-Scale	-.18	.06	.22	-.01	.42*	.25	.50*	.37		
10. RCOPE Positive	.56**	.22	.50*	-.06	-.24	-.14	-.26	-.24	-.16	

Note. Sample size was 23. Religiosity (scores range from 4 to 16; higher scores indicate greater extent and importance of religiosity/spirituality; BSI = Brief Symptom Inventory-18 (Full-scale scores range from 0 to 64, Somatization and Depression scores range from 0 to 20, Anxiety scores range from 0 to 24. Higher scores indicate more symptomatology); IH = Internalized Homonegativity (standardized scores; more positive scores indicate higher levels of internalized homonegativity, more negative scores indicate lower levels of internalized homonegativity); RCOPE Positive = Positive Religious/Spiritual Coping Scale (scores range from 5 to 20; high scores indicate more frequent use of religious/spiritual coping strategies).
* $p \leq .05$ ** $p \leq .01$. *** $p \leq .001$

Table 10

Zero-Order Correlations Between Religiosity, Religious Involvement, BSI, Positive Religious Coping, and Internalized Homonegativity for Religious Women

	1	2	3	4	5	6	7	8	9	10
1. Religiosity										
2. Attend services	.42									
3. Prayer frequency	.44*	.17								
4. Meditation frequency	.22	-.13	.41							
5. BSI Full-scale	-.27	-.30	-.31	-.23						
6. BSI Somatization	.17	-.23	-.03	-.13	.44*					
7. BSI Depression	-.37	-.12	-.34	-.23	.74***	-.23				
8. BSI Anxiety	-.31	-.30	-.17	.02	.77***	.26	.46			
9. IH Full-Scale	-.02	.27	-.01	-.36	.20	.02	.20	.16		
10. RCOPE Positive	.62**	.27	.75***	.32	-.23	.23	-.44*	-.13	.11	

Note. Sample size was 21. Religiosity (scores range from 4 to 16; higher scores indicate greater extent and importance of religiosity/spirituality; BSI = Brief Symptom Inventory-18 (Full-scale scores range from 0 to 64, Somatization and Depression scores range from 0 to 20, Anxiety scores range from 0 to 24. Higher scores indicate more symptomatology); IH = Internalized Homonegativity (standardized scores; more positive scores indicate higher levels of internalized homonegativity, more negative scores indicate lower levels of internalized homonegativity); RCOPE Positive = Positive Religious/Spiritual Coping Scale (scores range from 5 to 20; high scores indicate more frequent use of religious/spiritual coping strategies).
* $p \leq .05$ ** $p \leq .01$. *** $p < .001$

Table 11

Standardized Beta Coefficients for Positive Religious Coping and Internalized Homonegativity –

Religious Participants Only

Criterion	RCOPE Positive	IH Full-Scale
BSI Full-Scale	-.208	.365*
BSI Somatization	.045	.150
BSI Depression	-.323*	.364**
BSI Anxiety	-.171	.341*

Note. $N = 21$ for women. $N = 23$ for men. RCOPE Positive = Positive Religious/Spiritual Coping Scale (scores range from 5 to 20; high scores indicate more frequent use of religious/spiritual coping strategies); IH = Internalized Homonegativity (standardized scores; more positive scores indicate higher levels of internalized homonegativity, more negative scores indicate lower levels of internalized homonegativity); BSI = Brief Symptom Inventory-18 (Full-scale scores range from 0 to 64, Somatization and Depression scores range from 0 to 20, Anxiety scores range from 0 to 24; higher scores indicate more symptomatology).
*$p \leq .05$. ** $p \leq .01$.

Appendix A

Demographic and Religion/Spirituality Questionnaire

1. What is your age?: _____

2. What is your gender?: _____
    1. Male
    2. Female
    3. Other (please specify)_____

3. What is your current sexual orientation?:
    1. Only Heterosexual
    2. Mostly Heterosexual
    3. More Heterosexual
    4. Equally Heterosexual/Gay or Lesbian
    5. More Gay or Lesbian
    6. Mostly Gay or Lesbian
    7. Only Gay or Lesbian
    8. Other (please specify) _____

4. What is your household income?:
    1. Less than $ 20,000
    2. $20,000 –$ 30,000
    3. $30,000 - $40,000
    4. $40,000 - $50,000
    5. $50,000 - $60,000
    6. $60,000 - $70,000
    7. $70,000 - $80,000
    8. $80,000 - $90,000
    9. $90,000 - $ 100,000
    10. More than $100,000

5. What is your level of education?:
    1. Do not have a high school diploma or GED
    2. High School Diploma/GED
    3. Some College
    4. Bachelor's Degree
    5. Some Graduate School
    6. Graduate or Professional Degree (i.e. Masters, Ph.D., J.D., M.D., etc.)

6. What is your race?:
    1. White/Caucasian
    2. Black/African American
    3. Hispanic/Latino(a)
    4. Native American/American Indian

5. Asian/Asian American
6. Other (please specify) _____

7. To what extent do you consider yourself a religious person?
   1 – Very religious
   2 – Moderately religious
   3 – Slightly religious
   4 – Not religious at all

8. How important are your religious beliefs to you?
   1 – Very important
   2 – Moderately important
   3 – Slightly important
   4 – Not important at all

9. To what extent do you consider yourself a spiritual person?
   1 – Very spiritual
   2 – Moderately spiritual
   3 – Slightly spiritual
   4 – Not spiritual at all

10. How important are your spiritual beliefs to you?
   1 – Very important
   2 – Moderately important
   3 – Slightly important
   4 – Not important at all

11. At the present time, what is your religious preference? _____

IF PROTESTANT ASK:
Which specific denomination is that? _____

12. How often to you attend religious services?
   1 – Never
   2 – Less than once a year
   3 – About once or twice a year
   4 – Several times a year
   5 – About once a month
   6 – 2-3 times a month
   7 – Nearly every week
   8 – Every week
   9 – Several times a week

13. How often do you pray privately in places other than at church or synagogue?
   1 – More than once a day
   2 – Once a day

3 – A few times a week
4 – Once a week
5 – A few times a month
6 – Once a month
7 – Less than once a month
8 – Never

14. Within your religious or spiritual tradition, how often do you meditate?
    1 – More than once a day
    2 – Once a day
    3 – A few times a week
    4 – Once a week
    5 – A few times a month
    6 – Once a month
    7 – Less than once a month
    8 – Never

Appendix B

Brief Symptom Inventory-18

On this page is a list of problems people sometimes have. Please read each one carefully, and choose the number that describes how much that problem has distressed or bothered you during the past 7 days including today. Choose only one number for each problem and do not skip any items.

1 – Not at all
2 – A little bit
3 – Moderately
4 – Quite a bit
5 – Extremely

How much were you distressed by:

1. Faintness or dizziness
   1 – Not at all
   2 – A little bit
   3 – Moderately
   4 – Quite a bit
   5 – Extremely

2. Feeling no interest in things
   1 – Not at all
   2 – A little bit
   3 – Moderately
   4 – Quite a bit
   5 – Extremely

3. Nervousness or shakiness inside
   1 – Not at all
   2 – A little bit
   3 – Moderately
   4 – Quite a bit
   5 – Extremely

4. Pains in heart or chest
   1 – Not at all
   2 – A little bit
   3 – Moderately
   4 – Quite a bit
   5 – Extremely

5. Feeling lonely
   1 – Not at all
   2 – A little bit
   3 – Moderately
   4 – Quite a bit
   5 – Extremely

6. Feeling tense or keyed up
   1 – Not at all
   2 – A little bit
   3 – Moderately
   4 – Quite a bit
   5 – Extremely

7. Nausea or upset stomach
   1 – Not at all
   2 – A little bit
   3 – Moderately
   4 – Quite a bit
   5 – Extremely

8. Feeling blue
   1 – Not at all
   2 – A little bit
   3 – Moderately
   4 – Quite a bit
   5 – Extremely

9. Suddenly scared for no reason
   1 – Not at all

2 – A little bit
3 – Moderately
4 – Quite a bit
5 – Extremely

10. Trouble getting your breath
    1 – Not at all
    2 – A little bit
    3 – Moderately
    4 – Quite a bit
    5 – Extremely

11. Feelings of worthlessness
    1 – Not at all
    2 – A little bit
    3 – Moderately
    4 – Quite a bit
    5 – Extremely

12. Spells of terror or panic
    1 – Not at all
    2 – A little bit
    3 – Moderately
    4 – Quite a bit
    5 – Extremely

13. Numbness or tingling in parts of your body
    1 – Not at all
    2 – A little bit
    3 – Moderately
    4 – Quite a bit
    5 – Extremely

14. Feeling hopeless about the future
    1 – Not at all
    2 – A little bit
    3 – Moderately
    4 – Quite a bit
    5 – Extremely

15. Feeling so restless you couldn't sit still
    1 – Not at all
    2 – A little bit
    3 – Moderately
    4 – Quite a bit
    5 – Extremely

16. Feeling weak in parts of your body
    1 – Not at all
    2 – A little bit
    3 – Moderately
    4 – Quite a bit
    5 – Extremely

17. Thoughts of ending your life
    1 – Not at all
    2 – A little bit
    3 – Moderately
    4 – Quite a bit
    5 – Extremely

18. Feeling fearful
    1 – Not at all
    2 – A little bit
    3 – Moderately
    4 – Quite a bit
    5 – Extremely

Appendix C

Brief RCOPE Long Form

Think about how you try to understand and deal with major problems in your life. To what extent is each involved in the way you cope?

1. I think about how my life is part of a larger spiritual force.
   1 – A great deal
   2 – Quite a bit
   3 – Somewhat
   4 – Not at all

2. I work together with God as partners to get through hard times.
   1 – A great deal
   2 – Quite a bit
   3 – Somewhat
   4 – Not at all

3. I look to God for strength, support, and guidance in crises.
   1 – A great deal
   2 – Quite a bit
   3 – Somewhat
   4 – Not at all

4. I try to find the lesson from God in crises.
   1 – A great deal
   2 – Quite a bit
   3 – Somewhat
   4 – Not at all

5. I confess my sins and ask for God's forgiveness.
   1 – A great deal
   2 – Quite a bit
   3 – Somewhat
   4 – Not at all

6. I feel that stressful situations are God's way of punishing me for my sins or lack of spirituality.
   1 – A great deal
   2 – Quite a bit
   3 – Somewhat
   4 – Not at all

7. I wonder whether God has abandoned me.
   1 – A great deal

2 – Quite a bit
3 – Somewhat
4 – Not at all

8. I try to make sense of the situation and decide what to do without relying on God.
   1 – A great deal
   2 – Quite a bit
   3 – Somewhat
   4 – Not at all

9. I question whether God really exists.
   1 – A great deal
   2 – Quite a bit
   3 – Somewhat
   4 – Not at all

10. I express anger at God for letting terrible things happen.
   1 – A great deal
   2 – Quite a bit
   3 – Somewhat
   4 – Not at all

Appendix D

Lesbian Internalized Homophobia Scale

Please the following scale to indicate how much you agree or disagree with the statements below. Put your responses in the blank next to each statement.

Strongly disagree	Disagree	Somewhat disagree	Neutral	Somewhat agree	Agree	Strongly agree
1	2	3	4	5	6	7

1. _____When interacting with members of the lesbian community, I often feel different and alone, like I don't fit in.
2. _____ Attending lesbian events and organizations is important to me. *
3. _____ I feel isolated and separate from other lesbians.
4. _____ Social situations with other lesbians make me feel uncomfortable.
5. _____ Most of my friends are lesbians. *
6. _____ Being a part of the lesbian community is important to me. *
7. _____ Having lesbian friends is important to me. *
8. _____ I feel comfortable joining a lesbian social group, lesbian sports team, or lesbian organization. *
9. _____ I am familiar with community resources for lesbians (i.e., bookstores, support groups, bars, etc.). *
10. _____ I am aware of the history concerning the development of lesbian communities and/or the lesbian/gay rights movements. *
11. _____ I am familiar with lesbian books and/or magazines. *
12. _____ I am familiar with lesbian movies and/or music. *
13. _____ I am familiar with lesbian music festivals and conferences. *
14. _____ I try not to give signs that I am a lesbian. I am careful about the way I dress; the jewelry I wear; and the places, people, and events I talk about.
15. _____ I am comfortable being an "out" lesbian. I want others to know and see me as a lesbian. *
16. _____ I wouldn't mind if my boss knew that I was a lesbian. *

17. _____ It is important for me to conceal the fact that I am a lesbian from my family.
18. _____ I feel comfortable talking to my heterosexual friends about my everyday home life with my lesbian partner/lover or my everyday activities with my lesbian friends. *
19. _____ I am not worried about anyone finding out that I am a lesbian. *
20. _____ I live in fear that someone will find out I am a lesbian.
21. _____ I feel comfortable talking about homosexuality in public. *
22. _____ I do not feel the need to be on guard, lie, or hide my lesbianism to others. *
23. _____ If my peers knew of my lesbianism, I am afraid that many would not want to be friends with me.
24. _____ I could *not* confront a straight friend or acquaintance if she or he made a homophobic or heterosexist statement to me.
25. _____ I feel comfortable discussing my lesbianism with my family. *
26. _____ I don't like to be seen in public with lesbians who look "too butch" or are "too out" because others will then think I am a lesbian.
27. _____ I act as if my lesbian lovers are merely friends.
28. _____ When speaking of my lesbian lover/partner to a straight person, I often use neutral pronouns so the sex of the person is vague.
29. _____ When speaking of my lesbian lover/partner to a straight person, I change pronouns so that others will think I'm involved with a man rather than a woman.
30. _____ I hate myself for being attracted to other women.
31. _____ I am proud to be a lesbian. *
32. _____ I feel bad for acting on my lesbian desires.
33. _____ As a lesbian, I am loveable and deserving of respect. *
34. _____ I feel comfortable being a lesbian. *
35. _____ If I could change my sexual orientation and become heterosexual, I would.
36. _____ I don't feel disappointment in myself for being a lesbian. *
37. _____ Being a lesbian makes my future look bleak and hopeless.
38. _____ Just as in other species, female homosexuality is a natural expression of sexuality in human women. *
39. _____ Female homosexuality is a sin.

40. _____ Female homosexuality is an acceptable lifestyle. *
41. _____ Children should be taught that being gay is a normal and healthy way for people to be. *
42. _____ Lesbian couples should be allowed to adopt children the same as heterosexual couples. *
43. _____ Growing up in a lesbian family is detrimental for children.
44. _____ Lesbian lifestyles are viable and legitimate choices for women. *
45. _____ I feel comfortable with the diversity of women who make up the lesbian community. *
46. _____ If some lesbians would change and be more acceptable to the larger society, lesbians as a group would not have to deal with so much negativity and discrimination.
47. _____ I wish some lesbians wouldn't "flaunt" their lesbianism. They only do it for shock value and it doesn't accomplish anything.
48. _____ Lesbians are too aggressive.
49. _____ My feelings toward other lesbians are often negative.
50. _____ I frequently make negative comments about other lesbians.
51. _____ I have respect and admiration for other lesbians. *
52. _____ I can't stand lesbians who are too "butch." They make lesbians as a group look bad.

* Indicates reverse scored items

Appendix E

Internalized Homophobia Scale

Please the following scale to indicate how much you agree or disagree with the statements below. Put your responses in the blank next to each statement.

Strongly disagree	Disagree	Somewhat disagree	Neutral	Somewhat agree	Agree	Strongly agree
1	2	3	4	5	6	7

53. _____Obviously effeminate homosexual men make me feel uncomfortable.
54. _____ I prefer to have anonymous sexual partners.
55. _____ It would not be easier in life to be heterosexual. *
56. _____ Most of my friends are homosexual. *
57. _____ I do not feel confident about making an advance to another man.
58. _____ I feel comfortable in gay bars. *
59. _____ Social situations with gay men make me feel uncomfortable.
60. _____ I don't like thinking about my homosexuality.
61. _____ When I think about other homosexual men, I think of negative situations.
62. _____ I feel comfortable about being seen in public with an obviously gay person. *
63. _____ I feel comfortable discussing homosexuality in a public setting. *
64. _____ It is important to me to control who knows about my homosexuality.
65. _____ Most people have negative reactions to homosexuality.
66. _____ Homosexuality is not against the will of God. *
67. _____ Society still punishes people for being gay.
68. _____ I object if an anti-gay joke is told in my presence. *
69. _____ I worry about becoming old and gay.
70. _____ I worry about becoming unattractive.
71. _____ I would prefer to be more heterosexual.
72. _____ Most people don't discriminate against homosexuals. *
73. _____ I feel comfortable about being homosexual. *
74. _____ Homosexuality is morally acceptable. *