RELIGIOUS EXPERIENCE, RELIGIOSITY, AND SUICIDALITY AMONG GENDER AND SEXUAL MINORITIES

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DEDICATION

To my mother, Sabrina, and the ancestors who paved a way

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ABSTRACT

Across demographic categories, suicide rates have been steadily increasing at both US and international levels. Gender and sexual minorities display even higher suicide rates than the others due to structural discrimination. For the general population, religious practice can be a source of coping and support. Yet, many religious institutions, their policies, and their followers exclude and discriminate against gender and sexual minorities (GSMs). Minority stress theory supports that gender and sexual minorities face unique minority stressors due to their membership in a stigmatized group and that these stressors manifest themselves socially. To examine the relationship between religion-specific minority stressors, suicide and depression, a combined sample of 102 GSM and 110 non-GSM individuals completed suicidality, depression, and religiosity measures. Comparison between the two groups displayed significantly higher means for suicidality and depression. Gender and sexual minorities also completed minority stress measures. For the GSM subset of the sample, minority stressors were positively correlated with religiosity across several domains. Also, minority stress factors of vigilance, isolation, and victimization were correlated with poorer mental health. A binary logistic regression was completed to observe the impact of ethnicity, religiosity, and GSM status on lifetime suicidal contemplation. Results indicated no significant impact of ethnic category or religiosity score. However, GSMs in the sample showed increased odds for experiencing suicidal contemplation compared to those endorsing straight, cisgender identities. Optional, open-ended qualitative prompts were included in the survey to observe the perceived impact of religion on mental health among GSMs. Thematic analysis yielded themes of non-negative impact on wellbeing, rejection, and dissonance. Lastly, discussion of results covered study limitations, recommendations, and future directions.

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GLOSSARY OF TERMS

This paper includes many terms associated with the LGBT+ community and religious communities. The following glossary terms are provided for the reader's convenience. To capture the diverse gender identities and sexuality identities covered in this study, specific acronyms (i.e., LGB, LGBT, etc.) denote specific study populations.

Cisgender: Describes people whose gender identity and/or gender expression aligns with the cultural expectations of the sex they were assigned at birth.

***Gender and Sexual Minorities*:** Covers a diverse range of gender and sexual minority identities. Analogous to LGBT+ or LGBTQIA+.

Gender Nonconforming: Describes people who do not conform to traditional cultural expectations of their gender.

Heterosexism: A belief that heterosexual attractions are superior to homosexual ones.

Homophobia: A dislike or hatred of homosexuality.

Internalized homophobia: Internalized self-hatred of one's sexuality or an acceptance of societal stigmas about one's sexual orientation (Herek et al., 2009).

Internalized Transphobia: Similar to internalized homophobia, internalized transphobia describes negative self-stigma regarding transgender identity.

LGBTQIA+: An acronym for lesbian, gay, bisexual, transgender, queer and/or questioning, intersex, asexual, and other gender and sexual orientations. LGBT, LGB, and LG are also commonly used acronyms.

Queer: A term that has been reclaimed from being a slur against gender and sexual minorities. It either denotes that a person is a member of the LGBT community or is used to describe people that have fluid sexual identities and gender expression.

Questioning: A term used to describe people who are exploring their identity as a member of a gender and/or sexual minority.

Transgender: Describes people whose gender identity and/or gender expression differs from the cultural expectations of the sex they were assigned at birth. Some transgender people identify as neither man nor woman or as a combination of the two. These individuals may use terms like non-binary and genderqueer to describe their gender identity (National Center for Transgender Equality, 2016).

Transphobia: A dislike or hatred of transgender people.

Religiosity: magnitude of importance, devotion, or salience of religion to an individual.

Religious experience: For this document, religious experience denotes religious experiences that occur internal and external to the individual. In this paper, experience is defined across ecological levels: intrapersonal (religiosity), interpersonal (religious importance of peers and family), institutional (childhood religious denomination and current denomination), and policy levels.

CHAPTER 1

INTRODUCTION

Suicide is one of the top 10 leading causes of death in the United States. It is the second leading cause of death for people aged 10 to 34 (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control [CDC], 2017). In 2018, an estimated 10.5% of adults aged 18–25 endorsed having serious thoughts of suicide in the preceding year, and about 7% of all adults experienced a major depressive episode (US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration [SAMSHA], Center for Behavioral Health Statistics and Quality, 2019). Additionally, the prevalence of depressive disorders (e.g., major depressive disorder and dysthymia) increased significantly between 2005 and 2015, with depressive disorders being the third leading cause of disability in 2015 (World Health Organization [WHO], 2017). Within the gender and sexual minority population (i.e., the LGBTQIA+ community), suicide and overall well-being are significant concerns for practitioners and researchers, specifically among children (Goldhammer et al., 2019; Ream, 2020; Standley, 2020).

The unique mental health challenges facing gender and sexual minorities (GSM's) have become a topic of interest among the research community. Nationally, 42.8% of lesbian, gay, or bisexual (LGB) high school students had considered attempting suicide within the previous 12 months, and about 30% of LGB students endorsed attempting suicide (CDC, 2016). Additionally, The National Center for Transgender Equality reports that 40% of transgender individuals have attempted suicide in their lifetime (James et al., 2016). A 2018 study discovered that, among those in early adulthood (aged 18–30), 14% of gay and lesbian individuals and 20% of bisexual individuals experienced a suicide attempt within their lifetime (Lytle et al., 2018). In

the same study, 3.3% of lesbian or gay individuals endorsed a recent suicide attempt compared to just 0.4% of heterosexuals (Lytle et al., 2018). Previous research also supports that internalized homophobia, which is internalized discrimination toward one's sexual orientation, is related to an increase in depressive symptoms (Herek et al., 1997; Igartua et al., 2003) and suicidality (McLaren, 2016). A 2015 study discovered a positive relationship between internalized transphobia and lifetime suicide attempt (Perez-Brumer et al., 2015). There is a dearth in the literature regarding personal and environmental predictive risk and protective factors for GSM suicide attempt, particularly in adults, despite sexual minority adults experiencing five times the risk of attempted suicide compared to their heterosexual peers (Salway et al., 2019).

Regarding protective factors, family acceptance serves as a protective factor against depressive symptoms and suicidal ideation for LGBT individuals (Hall, 2018; Ryan et al., 2010). Additionally, higher levels of outness or disclosure to social networks is related to having favorable views of one's sexual identity within LGB populations (Kosciw et al., 2015; Lapinski & McKirnan, 2013). However, societal stigma and discrimination may impact the relationships between GSM individuals, their families, and social networks. Religious beliefs specifically have been found to relate to societal perceptions of gender and sexual minority individuals (Whitley, 2009). A cross-national study of college students in Oklahoma, Texas, Italy, and Spain determined that, while most participants were accepting of GSMs, church attendance was significantly associated with LGBT prejudice in all locations but Spain (Worthen et al., 2017)

The purpose of this dissertation is to examine the complex impact of religious experiences on gender and sexual minority suicidality, depression symptomology, and internalized self-hatred within the adult gender and sexual minorities. For this study, religious experience is defined as the impact of one's own personal religious beliefs (religiosity), peers'

and family's beliefs, and the policies and practices promoted by current and former religious leaders and institutions. Often, negative views of gender and sexual minorities originate within religious communities, as most US religions do not accept homosexuality (Barnes & Meyer, 2012). Those who have exposure to unaccepting religious environments report significantly higher levels of internalized homophobia than others (Barnes & Meyer, 2012). Through examining stratified odds ratios, Lytle et al. (2018) found that increasing religious importance was associated with 38% increased odds of recent suicidal ideation among lesbian and gay individuals. This study explored how both personal and environmental religious factors contribute to negative mental health outcomes and suggest policy and practice interventions.

Bronfenbrenner's Ecological Framework for Human Development (1999) supports that environmental factors at multiple, interconnected levels (e.g., social circles, institutions, & cultural ideologies) impact individuals' behavior and development. A Social-ecological perspective provided a framework for understanding the impact of religious beliefs and behaviors across environmental domains. For example, within the gender and sexual minority (GSM) population, family acceptance (Shilo & Savaya, 2011; Snapp et al., 2015), increased social belongingness (Doty et al., 2010; Masini & Barrett, 2008; Romijnders et al., 2017), and the development of inclusive policies (Hatzenbuehler, 2009; Raifman et al., 2017), have been shown to have positive impacts on the LGBT community.

On the other hand, the negative influence of ecological factors can adversely impact individuals. For example, restrictive bathroom and housing policies on university campuses are significant predictors of lifetime suicide attempts (Seelm an, 2016). Conversely, socially transitioned transgender youth show no elevation in depression compared to the general youth population (Olson et al., 2016). Similarly, Meyer's minority stress theory postulates that a

combination of stressors, both distal (i.e., events of prejudice and events not directed to an individual) and proximal (i.e., stressors that impact self-appraisal), can generate negative mental health outcomes for sexual minorities (Meyer, 2003). Meyer (2003) observed that maladaptive coping strategies, like hiding one's sexual orientation, which are used to reduce minority stress, have instead caused negative health impacts.

Additionally, factors like race, sex, and socioeconomic status can cause an individual to experience a compounded impact of stressors (Consolacion et al., 2004; Diaz et al., 2001; Shangani et al., 2020). This concept is also conceptualized through intersectionality, a feminist theory and framework, which supports that race, gender, sexuality, and class interact and display differing power structures across individuals (Cho et al., 2013). There is some evidence that compound minority stressors can relate to increased psychological distress among GSM individuals (Hayes et al., 2011; Rood et al., 2016). Nevertheless, demographic characteristics associated with religious denomination are seldom observed.

Within the general population, individuals who frequently attend religious institution services and belong to more conservative religions display higher homophobia levels than others (Finlay & Walther, 2003). Conversely, attending religious services and praying can be a protective factor against suicide among the general population (Kleiman & Liu, 2014). Religiosity has been shown to negatively correlate with suicidal ideation among college students (Lester & Walker, 2017; Walker & Bishop, 2005). It has also been shown to be negatively correlated with depression symptomology (Ji et al., 2011).

Given the role that religion plays, not only in an individual's life but in society as a whole, it is essential to understand the impact that religious institutions and religious individuals have regarding gender and sexual minorities and the effect of religious experiences on the GSM

community. An explorative view of the multiple factors impacting gender and sexual minorities was done utilizing the Social-ecological model and minority stress theory to comprehend how discriminatory practices can occur at individual, family and peer, and policy levels.

CHAPTER 2

LITERATURE REVIEW

Suicide is when a person completes a self-injurious act with evidence of an attempt to die (Turecki & Brent, 2016). Suicide rates in the United States have been gradually increasing. The National Center for Health Statistics examined that males' suicide rate increased 21% between 2000 to 2006 (Hedgegaard et al., 2018). Among females, the rate increased by 50% during the same period (Hedgegaard et al., 2018). Overall, the same study determined that males are more likely than females to commit suicide, with the male-to-female suicide rate reaching 3.6 in 2016. Additionally, suicide has become a significant cause of death worldwide, with a million people dying of suicide annually (WHO, 2017). Suicidal ideation is defined as having either active thoughts about ending one's life, including having a plan or method, or passive ideations about wanting to be dead without said planning (Turecki & Brent, 2016). Suicidal ideation has become a great concern for those in the medical, environmental, and social science fields. Also, suicide is a matter of economic importance, accounting for over $50 billion in medical and work loss costs in 2013 —as those who complete suicide are typically within the working adult age group (Florence et al., 2015).

Recent investigation has led to the determination that several factors are attributable to the recent uptick in suicide. For example, social media is cited as a probable cause for increased suicide rates for younger adults (Intahchomphoo, 2018; Luxton et al., 2012; Sumner et al., 2019). Within older adults, suicide prevention in the United States is often focused on mental health conditions and psychiatric treatment; however, suicide may be caused by multiple social and environmental factors as well (US Department of Health and Human Services (HHS) Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012).

2.1 Gender and Sexual Minority Suicide

Historically, it has been challenging to obtain data regarding the number of gender and sexual minorities who died by suicide, as sexual orientation and gender identity are not recorded on death certificates (Haas et al., 2015). Overall, gender and sexual minorities experience disproportionate risks for suicidal ideation and suicide completion. Irwin et al. (2014) found that, among 770 LGBT individuals who completed an anonymous online survey in Nebraska, 49.6% of individuals endorsed that they had considered suicide during their lives, and 66% of transgender respondents endorsed suicidal ideation within their lifetime.

Increasing suicide rates for lesbian, gay, bisexual, and transgender (LGBT) youth have caused the issue to become a primary focus of mental health researchers and practitioners. In a study of LGBT asylum seekers, researchers determined that those persecuted in their home countries for sexuality or gender identity were more likely to experience suicidality, sexual violence, and earlier age of first trauma than those who sought asylum for other reasons (Hopkinson et al., 2017). Bisexual individuals are at increased risk for suicidal ideation (Mereish et al., 2014) and attempt compared to their heterosexual and homosexual peers (Lytle et al., 2018; Remafedi et al., 1998). Among adolescents, it was found that symptoms of depression, hopelessness, and impulsivity were correlated with lifetime suicide attempts, and the same study found that victimization and coming out at an early age were associated with lifetime suicide risk (Mustanski & Liu, 2013). Among LGB youth, suicide attempt risk was 20% higher in those with an unsupportive social environment (Hatzenbuehler, 2009). Among transgender individuals, a negative relationship between family support and suicidal attempt and ideation has been established (Kuper et al., 2018; Moody & Smith, 2013). Thus, increases in familiar support may serve as protective factors for suicidality. Solutions specific to gender and sexual minorities

within the families and communities in which they live are necessary. Given that suicide is influenced by a plethora of factors at both the individual and environmental level it is important to examine and assess what influences individuals to harm themselves. Social-ecological theory and minority stress theory both offer a lens through which these factors can be examined.

2.2 Social-Ecological Theory

Social-ecological theory postulates that social and environmental factors impact individual development and well-being (Stokols et al., 1996). Bronfenbrenner's (1979) ecological systems theory outlines that the microsystem (i.e., institutions and individuals that directly impact development), mesosystem (settings in which actors within the microsystem interact), exosystem (external social systems in which the individual does not interact), and macrosystem (socio-cultural beliefs and ideologies) are systems that distally or proximally affect development. An ecological model for health promotion reinterprets the model as interpersonal, intrapersonal, institutional, community, and public policy factors that inform patterned behavior (McLeroy et al., 1988). The McLeroy (1988) adaptation model is meant to inform health promotion programming; however, the complexity of the relationship between GSM and religion necessitates a similar multisystem approach. Ecological frameworks have been applied to GSM-oriented research in gay male identity development (Alderson, 2003) and factors leading to hostile school climates for LGBT youth (Kosciw et al., 2009). Additionally, a modified socioecological model was utilized in a systematic review of heath stigma for transgender persons (White Hughto et al., 2015). It was determined that multiple interventions across structural, interpersonal, and individual domains would be the most impactful on health stigma, as societal norms can impact interpersonal and intrapersonal domains.

Intrapersonal factors consist of individual attitudes, knowledge, skills, and self-concept (McLeroy et al., 1988). There is some evidence that religious beliefs inform self-concept (Blaine et al., 1998). Contrariwise, individual personality factors, like low self-esteem and high neuroticism, can predict future struggles with religion and spirituality (Grubbs et al., 2016). Regarding interpersonal factors, social support from families reduces suicide attempts among gender and sexual minorities (Moody & Smith, 2013; Mustanski & Liu, 2013). Within the general population, social support networks formed within religious institutions can positively impact mental health (Robins & Fiske, 2009). Religious institutions are also sometimes responsible for institutional nonacceptance of GSM within churches and can perpetuate the societal oppression of gay and lesbian individuals (Clarke et al., 1989). Community factors, the mesosystem, describe the interplay between social and environmental actors within the microsystem. For example, schools that build environments inclusive to LGBT parents can positively impact students (Byard et al., 2013). Within the McLeroy et al. (1988) model, the community is also defined as relationships between community organizations. The community can also represent geopolitical localities. There is some evidence that the legalization of same-sex marriage in the United States reduced youth suicide attempts, illustrating that policy can impact behaviors (Raifman et al., 2017). Raifman et al. (2017) analyzed a statewide youth risk survey via difference-in-difference analysis and found a 7% reduction in reported suicide attempts following same-sex marriage policies. Social-ecological theory highlights positive and negative environmental factors which individual development and well-being. Minority stress theory expands upon previous Social-ecological theory by highlighting the specific, cumulative negative impact that discrimination has on gender and sexual minority well-being. Combining the models provides a multifaceted view of the potential causes of LGBT suicide.

2.3 Minority Stress Theory

Minority Stress Theory postulates that the cumulative impact of prejudice and discrimination can negatively impact minority populations' well-being. Specifically, discrimination and violence, perceived stigma, and internalized homophobia negatively impact mental health (Meyer, 1995). Minority stress theory has foundations in social stress theories promoted by social psychologists, which theorize a socioecological approach to understanding stressors (Meyer, 2003). Minority stress theory posits that minority stress is unique, meaning that it is in addition to the other stressors that impact minority populations. Minority stress is chronic and represents underlying socio-cultural conditions; minority stress is socially based and manifests in institutions and structures outside of the individual (Meyer, 2003). For example, the recent switch from a more liberal to a conservative presidential administration may have increased minority stress experienced among LGBTQ individuals (Gonzalez et al., 2018). Gonzalez et al. (2018) found that individuals experienced significantly higher stress levels pertaining to sexual orientation rumination, daily experiences with discrimination, and depression and anxiety symptoms following the 2016 presidential election.

Meyer (2003) proposed that minority stress processes, both proximal and distal, impact well-being. Distal stressors are defined as those that are objectively impactful and do not rely on individual attributions. Specifically, distal stressors are external stressors like discrimination, societal disadvantages, and unconscious bias (Ramirez & Galupo, 2019). In comparison, proximal stressors are dependent on subjective social and personal experiences, like how one identifies within their sexuality and identity. Proximal stressors are related to concealing one's identity, internalized stigma, and anticipation of discrimination (Williams et al., 2017). External stressors include harassment and violence, while internal stressors include internalized

homophobia and personal stigmas related to gender and sexual minority status. There is some evidence that proximal stressors, like stigma and internalized prejudice, may mediate the relationship between distal stressors and mental health outcomes (Hatzenbuehler, 2009; Savin-Williams & Ream, 2003).

2.3.1 Distal Minority Stress

Minority stress has proven to be a significant predictor of suicidal ideation and attempt among gender and sexual minorities. Mereish et al. (2014) examined the relationship between suicide, substance use behaviors, and minority stressors, like victimization, because of one's gender identity or sexuality. They found that those who experienced verbal or physical attacks due to their status as a gender or sexual minority were at higher odds for a lifetime substance abuse problem, suicidal attempts, and suicidal ideation. The authors suggested that substance use may be used to cope with the negative experiences of discrimination and victimization. Among transgender populations, minority prejudice and stigma manifest in increased suicide risk and depression (Tebbe & Moradi, 2016). Mustanski and Liu (2013) also found that victimization contributes to suicide attempts among LGBT youth. Through regression, analysis the study above found that victimization might act as a distal risk factor that increases susceptibility to the proximal risk factors of hopelessness and major depression symptoms.

Transgender women of color are at a disproportionate risk for murder and violence (Waters et al., 2016). In 2015, of the 24 anti-LGBT homicides reported to the National Coalition of Anti-violence Programs, 54% were transgender women of color (Waters et al., 2016). Goldblum et al. (2012) found that, among 290 transgender adults, those who experienced victimization in high school for their gender identity or expression were four times more likely to commit suicide than those who did not. In this study, 39% of respondents with suicide attempts

had attempted three or more times, and almost 30% of the respondents had experienced a suicide attempt. (Goldblum et al., 2012). Clements-Nolle et al. (2006) observed that, in a sample of transgender female-to-male and male-to-female individuals, 62% of individuals had experienced gender discrimination in the workplace and 60% of participants fit the criteria for depression. Eighty-three percent of the sample experienced verbal discrimination, and 36% reported physical victimization. In this study, attempted suicide was significantly associated with gender discrimination in the workplace, verbal gender victimization, and physical gender victimization (Clements-Noelle, 2006).

2.3.2 Proximal Minority Stress

Internalized homophobia, internalized heterosexism, and internalized homonegativity are terms used to describe internalized negativity based on sexual orientation. Internalized homophobia represents a conflict that sexual minorities undergo in which they feel a need to be heterosexual (Herek, 2004). In examining heterosexism and sexism among lesbians, Szymanski (2005) found that their internalized heterosexism was a significant predictor of emotional distress, and internalized sexism was not. Among gay men, internalized homophobia has been shown to have a significant impact on suicidal ideation and suicide attempt among youth (Pereira & Rodrigues, 2015). Perez-Brumer et al. (2015) established a link between internalized transphobia lifetime suicide attempts. Additionally, lower levels of structural stigmas related to societal treatment of transgender people and anti-trans policies were associated with fewer lifetime suicide attempts. This suggests the interplay between distal stressors as causal factors for the proximal stressor of internalized stigma.

Additional proximal stressors for gender and sexual minorities include rejection sensitivity and concealment. Rejection sensitivity is the extent to which an individual expects

rejection (Wang & Pachankis, 2016). Wang and Pachankis (2016) found that higher anxiety regarding expectations of rejection based on sexuality significantly predicted lower condom use behaviors among gay and bisexual men. Rood et al. (2016) completed a qualitative research analysis of transgender and gender-nonconforming individuals' experiences with discrimination. They found that individuals expected rejection in work, restrooms, and unfamiliar environments. Expectations of rejection precipitated safety concerns, physical exhaustion, self-loathing, and feeling rejected by others. To cope with rejection, individuals practiced avoidance and escaping situations, substance use (marijuana, alcohol, or tobacco), and cognitive strategies of minimizing or ruminating on the situation (Rood et al., 2016). Outness, or the level to which an individual discloses their sexual or gender identity to others, was also associated with well-being. Kosciw et al. (2015) discovered that increased outness was associated with increased victimization but positive self-esteem and depression outcomes among youth.

2.3.3 Compound Minority Stressors

There is a shortage of literature about the compound effect of GSM identities and ethnic/racial minority stressors, specifically among Asian American, Native/Indigenous American, and Transgender populations. Rood et al. (2016) discovered that being White lowers the expectation for rejection within the transgender population. Some endorsed that their status as a person of color prepared them for possible rejection. Quantitative comparison of mental health assessments across GSM individuals, racial minorities, and White American students discovered that racial minorities experienced higher levels of emotional distress on depression, family distress, hostility, and academic distress subscales (Hayes et al., 2011).

Similarly, LGB participants endorsed greater distress than heterosexual participants on depression, anxiety, eating concerns, hostility, family distress, and social anxiety subscales. LGB

ethnic minorities showed more distress across subscales than heterosexual ethnic minorities, however similar distress to LGB White Americans (Hayes et al., 2011). Conversely, English et al. (2018) found intersecting racial and sexual orientation identities were associated with drinking and emotion regulation difficulties among Latino and Black men. Similarly, in a study of Black sexual minority women, researchers discovered that these women had poorer psychological well-being than White sexual minority women and Black minority men (Calabrese et al., 2015). In addition, they experienced greater levels of discrimination than White sexual minority women (Calabrese et al., 2015). Kalibatseva et al. (2020) found that more minority stress identities were related to higher depression and suicidality. Specifically, low socioeconomic status (SES), ethnic minority females were at higher risk for a depression diagnosis. A metanalytic model of stress and trauma among Asian Gender and Sexual Minorities suggests that intersectional stress among Asian Americans is related to higher depression symptomology, self-harm, and suicidal ideation compared to non-LGBT Asian Americans (Ching et al., 2018). Szymanski et al. (2008) also observed that differences in gender role socialization and experiences with sexism may cause differences in how both men and women experience internalized homophobia.

2.4 Depression

Depression may be the strongest predictor of suicide for youth (Cash & Bridge, 2009). Previous literature indicates that depression is a prominent risk factor for LGBT suicide, particularly among youth (Hatchel et al., 2019; Mustanski & Liu, 2013). Mustanski and Liu (2013) outlined that hopelessness and depression were proximal determinates for gender and sexual minority ideation while discrimination and victimization were distally related. Regarding suicide attempts, Puckett et al. (2015) discovered that youth who had lost friends due to coming

out as LGB were 29 times more likely to have attempted suicide. There is a lack of research examining the link between suicide and depression among GSM adults; however, the relationship between minority stressors and depression has been documented in the emerging adult (Parra et al., 2016) and adult populations (Hoy-Ellis & Fredriksen-Goldsen, 2017; McCarthy et al., 2014). There is an established commodity between mental disorders and suicidal ideation within the general population, specifically 66% of people who have seriously considered suicide have a mental disorder diagnosis (Nock et al., 2010). Due to the comorbidity of depression with other mental disorders (e.g. substance use disorder), it is difficult to attribute suicidal attempt and ideation to depressive symptoms alone (Nock et al., 2010). The connection between depressive symptoms and suicidal ideation and attempt is observed in the current study. Nock et al. (2010) found that depressive symptomology was a significant predictor for ideation, but suicidal attempt was related to substance use and impulse disorders.

2.5 Conceptualizing Religiosity

The conceptualization of religiosity differs across ideologies and research disciplines (Holdcroft, 2006). Research varies in examining visible, measurable concepts like church attendance and unobservable factors, like belief in an afterlife. Broadly, religiosity is a measure of devotion, practice, and faith, among other factors. Multidimensional models acknowledge that one's religiosity could be at the upper limits on one dimension, like religious knowledge, yet display low levels of religious attendance. Fukayama's multidimensional model (1960) defined religiosity as cognitive, cultic, creedal, and devotional dimensions (as cited in Holdcroft, 2006). The cognitive is composed of religious and scriptural knowledge. The cultic dimension reflects ritualistic behaviors, and the creedal dimension examines the level of belief. Lastly, the devotion dimension includes emotional experiences with religion (in Holdcroft, 2006). Similarly, Glock

and Stark (as cited in Holdcroft, 2006) theorized that religiosity is composed of experiential (religious experiences that lead to emotions and feelings), ritualistic (overt religious behaviors), ideological (belief), intellectual (cognitive or knowledge), and consequential (the impact of the aforementioned dimensions on the secular world) (coming/need library). Later, the consequential dimension was separated into intrinsic and extrinsic dimensions (Huber & Huber, 2012). Glock and Stark have received criticism that their model is Christian-centric and cannot apply to other cultures and religions (Clayton & Gladden, 1974). Overall, a multidimensional approach is widely accepted throughout the research community (Glock & Stark, 1965; Fukayama, 1961; Allport and Ross, 1967 as cited in Holdcroft, 2006).

2.6 Religion as a Protective Factor for Suicide

The relationship between religion and suicide has been examined within several research populations. Those who have higher perceptions of religious importance are associated with lower suicide risk. However, these findings are often not replicated within the clinical population (Lawrence et al., 2016). A survey by the Pew Center found that 53% of American adults say religion is important in their lives; however, younger generations rate themselves as less religious (Pew Research Center, 2015). The Pew Center also discovered that those who rate religion as very important are more likely to pray and attend religious ceremonies (2015). Within the general population, religious practice, which includes prayer and attending religious ceremonies, can positively affect mental health outcomes. (Rushing et al., 2013; Seybold & Hill, 2001). Protestant, Catholic, and Jewish respondents who attended church regularly had higher rates of perceived happiness than those who seldom attended religious services (Sander, 2017). Interestingly, Buddhists and Muslims showed the inverse, in which religious service attendance was negatively associated with happiness (Sander, 2017). In a meta-analysis, religion and

spirituality were determined to be related to better physical, cognitive, and functional well-being (Jim et al., 2015). Religious coping (e.g., engaging in religious behaviors to cope with stress) has also been shown to reduce maladaptive eating behaviors of Jewish Americans (Pirutinsky et al., 2012). Additionally, increased daily spiritual experiences, prayer, and church attendance have been related to lower levels of self-reported alcohol use in African Americans (Dodor et al., 2018).

2.6.1 Religious Service Attendance

Religious service attendance is associated with the public practice of communal religious experiences. (Kleiman & Liu, 2014). Kleiman and Liu (2014) examined religious service attendance as a protective factor for completed suicide. Within this longitudinal study, large-scale (n = 20,014) interviews were conducted to determine variables that contributed to future suicide completion among those who died during the study. Those who attended religious services were 67% less likely to die by suicide than others (Kleiman & Liu, 2014). Religious service attendance may be a stronger protective factor for women than men. Religious service attendance has been shown to be negatively related to suicide rates for women (Kralovec et al., 2014), and Vander Weele et al. (2016)found that suicide rates of women who never attended religious services were five times that of women who attended once a week. Church attendance has also been associated with a lower rate of suicidal ideation within the North American population (Nkansah-Amankra et al., 2012; Rasic et al., 2009; Robinson et al., 2012).

2.6.2 Religious Affiliation

Dervic et al. (2004) found that, among inpatients experiencing depression, those affiliated with a religion were less likely to have experienced a previous suicide attempt. Another study discovered that, among college students, those affiliated with a religion were less accepting

of suicide (King et al., 1996). Advanced cancer patients without a declared religion were more likely to experience suicidal ideation (Spencer et al., 2012).

2.7 Religion as a Deterrent for Suicide

Most organized religions disapprove of suicide. Historically, the level of participation in church has declined since the 1950s (Stack, 1983a). Stack (1983) found a significant relationship between increasing suicide rates and decreasing church attendance between 1954 and 1978; however, unemployment rates and military participation were also significant predictors for some groups. Similarly, suicide is more prevalent in secular countries than religious countries; thus, religious belief may deter suicidal behavior (Colucci & Martin, 2008). Colucci and Martin (2008) listed that Christian texts are not explicitly condemning suicide. However, religious institutions and leaders disapproved of suicide and historically refused proper burials for those who died by suicide. Similarly, Islam and Judaism condemn homicide toward oneself or others (Colucci & Martin, 2008). Hindu scripture allows occasional suicide for those suffering from illnesses, but suicide is not generally accepted (Agoramoorthy & Hsu, 2017). For many Hindus, being reincarnated as a human is rare, and suicide is seen as dishonorable. Overall, religious people are less tolerant of suicide as a solution; thus, this may reduce suicide attempts and completions. An international study found that suicide tolerance was lower among religious people, regardless of socioeconomic factors (Neeleman et al., 1997). Similarly, Neeleman et al. found that the difference between African American and White American suicide rates could be attributed to high levels of orthodox religious beliefs and African Americans were less tolerant of suicide (Neeleman et al., 1998). Institutional policies, societal factors, and individual religious practices lead to a diverse mix of religious experiences, even within specific religious denominations; however, religion appears to be overall associated with positive life outcomes.

Recent literature has examined the specific components that link religion and suicide, like social support.

2.7.1 Social Support

Robins and Fiske (2009) theorized that reduced suicidal behavior among religious individuals might be due to social support rather than characteristics of religion. Robins and Fiske, 2009) examined social support as a mediator for suicide and discovered that suicidal ideation was significantly negatively correlated with public religiousness and social support measures. Social support served as a mediator between public religiousness and suicidal ideation; however, private religiousness displayed an insignificant positive relationship with suicidality (Robins & Fiske, 2009). Thus, previous studies may have captured the social aspects of religious experience rather than individual beliefs. A meta-analytic study determined that religious affiliation was protective against suicidal attempts and not ideation when controlling for social support (Lawrence et al., 2016). Thus, there may be underlying aspects of belief and social influence that impact the observed results. Durkheim's (1966) theory of religious integration and suicide hypothesized that religions that support a more subordinate orientation toward others in society, associated with collectivistic societies, is associated with lower rates of suicide; thus, they reported that Catholics would show lower rates of suicidality than (as cited in Stack, 1983b). Durkheim (1966) theorized that this subordination creates integration into a religious society and purpose (Stack, 1983b). More recently, an examination of Muslim suicide rates showed that, internationally, Islam has an independent impact on reducing suicide (Simpson & Conklin, 1989). This finding has implications for the gender and sexual minority community, as increased social support and community belonging within alternative institutions may impact suicide rates.

2.8 Gender and Sexual Minority Discrimination in Religion

Overall, religiousness has been associated with less accepting attitudes toward homosexuality (Finlay & Walther, 2003; Rowatt et al., 2009). In a qualitative study examining microaggressions experienced within religious communities, overarching themes displayed that LGBT identities were challenged both within religious organizations and within personal relationships with religious individuals (Lomash et al., 2019). People were told that their identities were not valid. Additionally, several individuals experienced a "love the sinner, hate the sin" attitude from others in religious contexts (Lomash et al., 2019). For example, LGBT people were told that they are loved by members of the institution but were also told that their identities are sinful and wrong.

Religious freedom is an essential foundation of US law. Religion-based discrimination against gender and sexual minorities can extend to policy and law. The Religious Freedom Restoration Act dictates that the government cannot substantially interfere with religious exercise (Drinan & Huffman, 1993). In 2020, the United States Supreme Court ruled that the 1964 Civil Rights Act protects gender and sexual minorities from gender and sexuality-based discrimination (*Bostock v. Clayton County, 590 US ___ (2019),* 2019). Historically, state and federal religious exemptions have impacted the employment of gender and sexual minorities. Following Obergefell v. Hodges, the landmark case permitting gay marriage, government employees could deny marriage licenses, refuse LGBT customers, and deny adoption rights based on religious beliefs (Griffin, 2015). LGBT clergy are also subject to religious-based discrimination due to religious exemptions (Rodriguez & Etengoff, 2016)

Sexuality change efforts or conversion therapy include various mental and physical treatments aimed at changing sexual orientation or gender identity. Religious leaders are more

likely to practice conversion therapy despite being determined to be harmful and unnecessary by mental health and medical professionals (Mallory et al., 2019). The Williams Institute estimates that 57,000 of today's youth will be subjected to conversion practices by religious leaders before they turn 18 (Mallory et al., 2019). Transgender individuals are four times as likely to attempt suicide if they were subjected to conversion therapy before age 10, compared to peers with no conversion therapy experience (Turban et al., 2020). The Family Acceptance Project found that youth who experienced sexuality orientation change efforts by only parents (48%) or both parents and professional interventions (63%) experienced twice and nearly three times the rate of attempted suicide, compared to those without conversion experiences (22%) (Ryan et al., 2020).

2.8.1 Existing Religious Policies and Practices

Religion continues to contribute to the mistreatment of gender and sexual minorities through institutional policies or members' behaviors. Controlling for individual factors like income, age, and educational attainment, there are vast differences in how LGB individuals perceive religions to be friendly or unfriendly (Barringer, 2020). Most of the individuals (60%) viewed mainline protestants as being friendly or neutral. Judaism was also endorsed as friendly by the majority of respondents (58%). Evangelical protestant (21%) and Catholic (17%) churches were deemed to be less friendly (Barringer, 2020). American society has grown to be more accepting of gender and sexual minorities, however religious policies continue to bar these individuals from fully participating in marriage, ordination, and religious service attendance.

Christianity. About 70 % of the United States population identifies as part of the Christian religion, making it the most Christian country in the world (Pew Research Center, 2015). Within the religion, several denominations have differing views on the gender and sexual minority community. The largest denomination is Protestantism, which includes mainline,

evangelical, and historically Black groups (Pew Research Center, 2015). Protestant theology was developed in the 16th century as a movement to reject several practices within the catholic church. For example, protestants support that the supreme authority over church practices is the Bible, rather than the Pope (Melton, 2005)

Mainline Protestants are considered more theologically flexible to cultural changes than evangelical protestants (McKinney, 1998). Mainline Protestantism includes the Evangelical Lutheran Church in America, the United Methodist Church, the Episcopal Church, and the Presbyterian Church (USA) in the United States, among many others (Pew Research Center, 2015). Mainline protestants make up 14.7 % of the US population. The Evangelical Lutheran Church in America (ELCA) historically has struggled to address homosexuality. During the 1970s, the church promoted homosexuality as being against God's creation; however, it supported civil rights for GSM individuals (LCA, 1970 as cited in Cadge et al., 2007). Gays and lesbians were allowed to participate in church activities at this time. During the 1990s and early 2000's the ELCA completed a variety of surveys regarding the sexuality of church members and developed teaching materials for congregations to discuss homosexuality (Cadge et al., 2007). In 2005, the ELCA determined that LGB people could not be ordained if they were not celibate (Cadge et al., 2007). The current policies explicitly support non-discrimination toward LGBT individuals, and individual congregations are given autonomy to decide whether LGBT people can be ordained or married within the ELCA faith (Human Rights Campaign [HRC], 2018). The Human Rights Campaign, an organization aimed at procuring civil rights for gender and sexual minorities, considers it the most affirming of the mainline Protestant groups (HRC, 2018). The United Methodist Church has been at odds since a 2019 conference in which traditionalists against same-sex marriage and LGBT clergy were prompted to separate and form new

denominations (Hodges, 2020). CNN has documented that the Episcopal Church, Evangelical Lutheran Church, Presbyterian Church (USA), and American Baptist Churches have had denominations split over homosexuality and the role of gender and sexual minority members (Burke, 2020). The Presbyterian Church (USA) currently accepts transgender people into congregations (HRC, 2018), and ministers have the discretion to approve ordination and same-gender marriages for gender and sexual minorities (Parsons, 2014). American Baptist Churches official policy promotes traditional marriage and supports that homosexuality is incompatible with the bible; however individual congregations may elect to do otherwise (American Baptist Churches, n.d.) No clear stance has been taken on transgender issues.

Evangelical Protestants are comprised of the Southern Baptist Convention, the Presbyterian Church in America, the Assemblies of God, and other congregations (Pew Research Center, 2015). Evangelical Protestants make up 25.4 % of the U.S. Christian population (Pew Research Center, 2015). Pew's Religious Landscape Survey found that 55 % of Evangelical Protestants think homosexuality should be discouraged, and 36 % believe it should be accepted (2015). The Southern Baptist Convention is the largest Protestant denomination (Pew, 2014). The Southern Baptist Convention currently does not view LGBT people as being entitled to special protections, like racial classes (Southern Baptist Convention, 2012). Additionally, the Southern Baptist convention rejects homosexuality and same-sex marriages (Southern Baptist Convention, 2012). The Southern Baptist Convention affirms that gender identity is identical to biological sex, which has been designed by God (Southern Baptist Convention, 2014). The Presbyterian Church in America does not accept same-sex marriage and promotes that homosexual practice is sinful and should be corrected (HRC, 2018). The Assemblies of God posits that “It should be noted at the outset that there is absolutely no affirmation of homosexual

activity, same-sex marriage, or changes in sexual identity found anywhere in Scripture" (Assemblies of God, 2014). Schnabel (2016) found that Evangelical protestant groups are more conservative than other protestant groups and are slower to adapt toward national beliefs regarding the acceptance of LGBT people. All groups promote that LGBT people are loved, despite nonadherence to church beliefs.

The historically Black Protestant group includes the National Baptist Convention, the Church of God in Christ, the African Methodist Episcopal Church, the Progressive Baptist Convention, and others (Pew, 2015). Historically Black protestants account for 6.5% of all Christians in the United States (Pew, 2015). In the same study, 53% of Black respondents identified as historically Black Protestants. The Church of God in Christ (COGIC) currently advises churches to prohibit church facilities from being used for same-sex marriages and prohibits leaders from performing marriages for those who are not in good standing with the church (Office of the General Council, 2015). This denomination has remained silent regarding the status of gender and sexual minorities within their congregation. The National Baptist Convention has not released a formal statement on acceptance of LGBT members; however, individual church leaders are given autonomy to decide the status of these individuals within the church (HRC, 2018). In 2014, following the Defense of Marriage Act being declared unconstitutional, The National Baptist convention declared that military chaplains are forbidden from performing same-sex marriage ceremonies (National Baptist Convention Admin, 2014). The African Methodist Episcopal Church does not currently allow same-sex marriage and has not taken an official stance on other issues (HRC, 2018). A 2017 study discovered that, among historically Black Protestants, those who attended church more frequently displayed significant levels of intolerant beliefs regarding the civil liberties of LGBT people (Ledet, 2017). However,

the level of biblical belief did not significantly predict intolerant beliefs (Ledet, 2017). Thus, it is indicated that external societal factors may also impact how these individuals view gender and sexual minorities.

Catholicism. Catholics make up 20% of the Christian religious group in the United States (Pew, 2014). In 2014, a Pew Center survey observed that 70% of Catholics believed homosexuality should be accepted, and 57% were in favor of same-sex marriage (2014). The Catechism of the Catholic Church, which outlines church beliefs, notes that homosexual feelings are not themselves sinful, only practices. The Catholic Church also prohibits unjust discrimination against those with homosexual tendencies (*Compendium of the Catechism of the Catholic Church*, 2015). The church also prohibits same-sex marriage; however, the existence of transgender people is not discussed (HRC, 2018). Regarding clergy, in 2005, Pope Benedict stated that those with "deep-seated homosexual tendencies" should be discouraged from seeking ordination, and the current Pope has endorsed this belief (Congregation for the Clergy, 2016).

The Church of Jesus Christ of Latter-day Saints (LDS). The LDS Church and its followers, colloquially known as Mormons, have some of the strictest policies concerning gender and sexual minorities. Like the Catholic Church, the LDS church supports that there is nothing inherently wrong with same-sex attraction if sexual urges are not acted upon (The Church of Jesus Christ of Latter-Day Saints, 2010). Some research has been done attributing church beliefs to adverse mental health outcomes for gender and sexual minorities. Most notably, Simmons (2017) found that 73% of gender and sexual minority Mormons and ex-Mormons show PTSD symptomology, compared to just 8% of the United States population (Simmons, 2017).

Judaism. Acceptance of gender and sexual minorities is dependent on the sect of Judaism. In American Reform Judaism, a growing denomination of more progressive social and

political beliefs accept LGBT clergy if the congregation accepts them (Rodriguez & Etengoff, 2016). Orthodox Judaism is overall unaccepting of GSM's (Slomowitz & Feit, 2015)

Islam. The experiences of gender and sexual minority Muslims have also been left out of literature discussing religion. The level of acceptance is often based on cultural values rather than that of an established religious institution, as there is no central governing body (HRC, 2018). The Fiqh Council of North America, a group of legal scholars who use Islamic texts to interpret law, endorsed that homosexuality is wrong if feelings of same-sex attraction are acted on and warned that western society promotes homosexuality (Umar, 2020). Gender affirming surgeries, a group of procedures that alter the primary and secondary sex characteristics that some transgender people undergo, were supported by some Islamic scholars in Egypt and Iran, illustrating diversity within the group (Alipour, 2017). Modern scholars suggest that LGBT Muslims may integrate western and eastern teaching to build community and understand their lives as gender and sexual minorities (Blackwood, 2005; Rahman, 2010).

2.9 The Religious Beliefs of Gender and Sexual Minorities

There is a lack of recent research aimed at investigating the LGBT experiences of faith and religious practice. A 2009 survey examining the religious affiliation of LGBT adults at a pride festival found that about 27% of individuals identified as atheist or agnostic; however, agnostics and atheists only make up 7% of the current US population (Halkitis et al., 2009; Pew Research Center, 2015). The same survey observed that many LGBT individuals interviewed preferred to call themselves spiritual rather than religious. Spiritual denotes a personal relationship with the self, the divine, or the world and society.

A Gibbs and Goldbach (2015) study found that many (43%) LGBT young adults experienced conflict between their religion and their sexual orientation and/or gender identity

(Gibbs & Goldbach, 2015). Among those who matured in a religious environment, those with unresolved conflict between their religion and sexuality experienced significantly higher rates of internalized homophobia than those who were raised in a non-religious environment (Gibbs & Goldbach, 2015). Additionally, having parents that hold religious-based, homophobic beliefs was also significantly associated with higher levels of internalized homophobia. In this study, internalized homophobia and parental homophobic religious beliefs were significantly related to suicidal thoughts in the last month. Interestingly, leaving one's religion due to conflict between sexuality and religion was associated with a decrease in internalized homophobia but an increase in suicidality indicating that leaving religious environments may not be enough to combat the impact of religious conflict (Gibbs & Goldbach, 2015).

There is a dearth of literature regarding transgender experiences with religion and overall well-being. Among transgender women, religious stress-related growth, perceived positive life impacts related to stress, was negatively associated with unprotected sex. In comparison, higher levels of religious beliefs and behaviors increased the odds of unprotected sex, which contrasts with existing literature relating religion to positive health behaviors (Golub et al., 2010). Dahl and Galliher (2009) examined the religious experiences of LGBQQ young adults to view how they integrated their own sexual identity and their religious institutions' teachings. In this study, 46% of individuals experienced being openly LGBQQ and religious simultaneously (Dahl & Galliher, 2009). Participants who explained some integration of their religious beliefs and sexuality were asked to select the mechanisms by which they achieve integration. Respondents supported that self-acceptance, gaining knowledge of religious teachings, support from church peers, and family support were associated with their own integration of their identities and religion (Dahl & Galliher, 2009). Participants also described that they made several personal

changes to assimilate their identity with religion and spirituality, like considering oneself spiritual rather than religious, reinterpreting religious teachings, no longer identifying with a particular religion and changing religion facilitated integration.

Brewster et al. (2016) examined the relationship between minority stressors and positive and negative coping for gender and sexual minority individuals. Results displayed that positive religious coping moderated the relationship between internalized homophobia and psychological well-being (Brewster et al., 2016). Thus, positive religious coping was associated with higher levels of psychological well-being. Additionally, in a study of bisexual adults, results revealed that people with higher religiosity had lower perceptions of their fulfillment in life (Moscardini et al., 2018). Dahl & Galliher (2010) found that negative religious experiences, like believing God to be unkind or having religious fear or guilt, are more impactful on mental health outcomes than positive religiosity. In a study of sexual minority young men (aged 18–29), religious indicators of commitment and religious service attendance were significantly negatively associated with well-being even though the sample expressed using religious coping to deal with life stressors (Meanley et al., 2016). For example, respondents endorsed that they used religion to overcome life stressors and that they viewed religion as a source of strength.

2.9.1 GSM Suicide and Religion

There have been few studies examining the direct impact of religion on gender and sexual minority suicide attempt and ideation. However, the literature indicates that religious experience can have harmful effects on the mental well-being of many GSMs (Barnes & Meyer, 2012). Additionally, religious experiences —both internal religious beliefs and external peer/family experiences— impact internalized homophobia and other minority stressors, which are

documented predictors of suicidality within the gender and sexual minority population (Pereira & Rodrigues, 2015).

Lytle et al. (2018) examined the connection between religiosity and sexual minority suicide ideation and attempt. The researchers discovered that increased religious importance was associated with increased suicidal ideation for several gender and sexual minority groups. Participants' religious importance was quantified by participants endorsing how important religion was to their identity on a Likert scale. Gibbs and Goldbach (2015) found that conflict between sexual identity and religious beliefs predicted suicidal ideation in the past month and that leaving one's religion due to gender and sexual minority identity and parental religious beliefs related to suicide attempts in the past year. Typical of other studies, religiosity was a protective factor for heterosexuals. Among lesbian and gay individuals' religious importance was associated with increased odds of recent suicidal ideation. For questioning individuals, religious importance was associated with both increased odds of recent suicidal ideation and attempt (Gibbs & Goldbach, 2015). Similarly, Lease et al. (2005) found that affirming faith experiences, experiences which support GSM identities can cause positive impacts on mental well-being (e.g., on depression, satisfaction, & psychological well-being), like their straight, cisgender peers (Lease et al., 2005). Some literature suggests that religion may be both a risk and protective factor for suicide among gender and sexual minorities. For example, an Australian study found that being a part of a religious community was associated with lower suicide attempts and greater social support among heterosexual, cisgender people, and gender and sexual minorities (Hayes et al., 2011). However, in this study, individuals experienced gender and sexuality-specific social support deficits, such as not being able to discuss sexuality with family and negative experiences about coming out. Barnes and Meyer (2012) illustrated that those exposed to unaccepting

religious settings have higher rates of internalized homophobia than those from other religions. Previous literature suggests that religious beliefs and practices are associated with lower risk for suicidal ideation and suicide attempt within the general population, however religious factors may be damaging to the well-being of gender and sexual minorities.

The purpose of this dissertation was to address the limited body of literature examining the interplay between religious experiences and suicidality among gender and sexual minorities. This study examined how a diverse array of religious experiences, including current and childhood religious denomination and personal level of religious belief, relate to depression and suicidality. The present study applied an explorative lens to individual demographic factors and intersectional identities (e.g., race, sexual orientation, gender identity, current religion, and childhood religion) that impact the experiences of gender and sexual minorities. This study used both qualitative and quantitative methodology to examine the relationship between the minority stressors of victimization, discrimination, internalized stigma, religious experience stressors of religious environment and personal religiosity, and their relationship to well-being (i.e., suicidal ideation, suicide attempt, and depression symptomology).

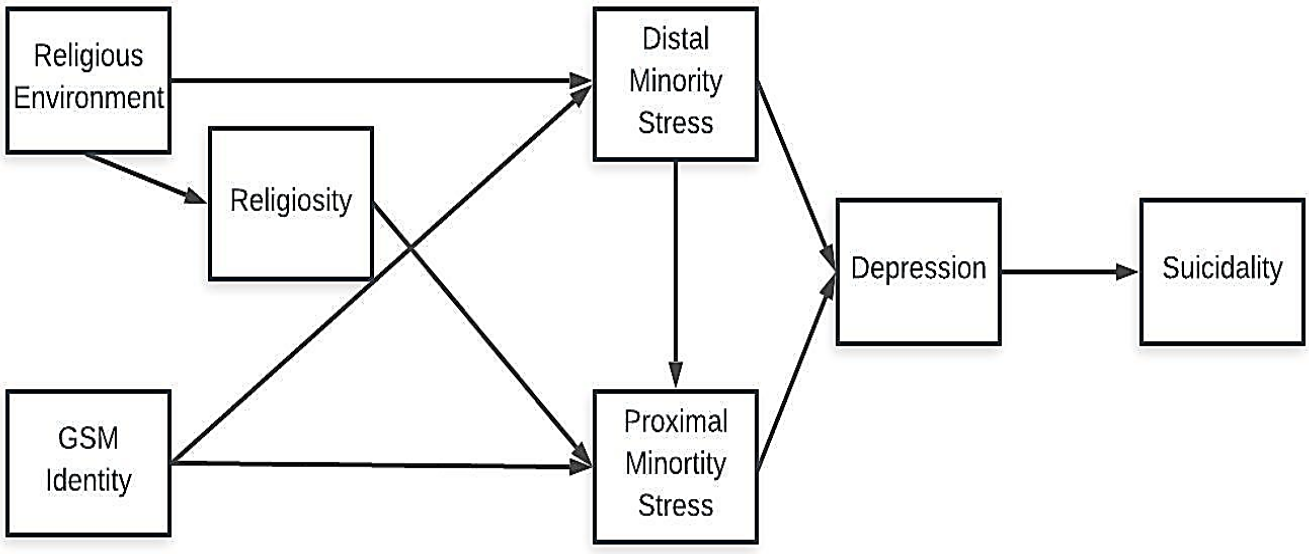


Figure 1. Theoretical Model

2.9.2 Research Questions

The following research questions are addressed in the present study:

1. **Is there a difference between religious importance/experience and suicidal ideation and suicide attempt among GSM?**

   Religion is a complex set of practices and beliefs that differs across denominations and individuals. This research question examines which internal and external aspects of religion might show a relationship with suicidal ideation and attempt. This question addresses which areas of religious experience may be the target of possible interventions. This question adds to a small body of research and address whether suicidal ideation and suicidal attempt relate to religious experience. It is documented that religion has a negative impact on the well-being of gender and sexual minorities; however, there is a lack of literature addressing possible suicidal behaviors and thoughts.

2. **Are individuals exposed to religion more likely to experience factors of internalized self-hatred, victimization, and discrimination (minority stress), compared to those not exposed to religion?**

   This question addressed whether religious experiences serve as contributing factors to proximal and distal factors minority stress (internalized homophobia and victimization and discrimination).

3. **Are there significant differences in reported suicidal ideation between demographic groups?**

   This question analyzed whether particular groups are at increased risk for suicidal ideation in comparison to their peers.

4. **What experiences and needs do gender and sexual minorities express across Social-ecological domains?**

   Gender and sexual minorities had the option to address other experiences related to religious experience and negative mental health outcomes. This gave them the opportunity to voice their own opinions and point out any gaps not addressed in the present study.

CHAPTER 3

METHODOLOGY

3.1 Participants and Setting

Adult respondents over the age of 18 that identify as gender and/or sexual minorities were included in the study. Participants were a convenience sample from nationwide websites to gather a broader representation of gender and sexual minorities and religious diversity in the United States. The online survey had 256 attempts. After cleaning and screening procedures, there was an analytic sample of 224 people. A smaller number endorsed GSM or non-GSM identities (102 GSM and 110 non-GSM). The majority of the sample was from Kansas (40.4%), Georgia (13.1%), or lived outside of the United States (5.2%). The median year of birth was 1993 and ranged from 1946 to 2002. Thirteen individuals did not select racial/ethnic or gender categories but were included in the sample as they completed one or more scales. The lack of demographic data for these respondents could be due to respondent fatigue, as demographic data was collected after religiosity, depression, and suicidality measures. All reported demographics represent valid percentages (missing values were omitted). Institutional IRB approval was given to collect data for the study.

3.2 Procedure

This study was an exploratory quantitative study using an online convenience sample. Participants also have the opportunity to share the online survey with social media peers, so snowball sampling occurred as well. Participants were recruited via SONA and emails to organizations (i.e., Equality Kansas, Spectrum, and Wichita State University's Office of Diversity and Inclusion) and online (Twitter, Facebook, Reddit, Instagram, etc.). Participants were given a warning indicating that the study's contents may be triggering for those who have

experienced suicidality, depression, and negative experience with religious situations to reduce risks associated with this study. At the end of the initial survey, individuals were invited to answer open-ended questions regarding their personal experiences with religion and their suggestions for social and policy interventions. Links and phone numbers to crisis resources, such as the National Suicide Hotline and National Alliance on Mental Illness, we provided at the end of the survey.

3.3 Demographics

Participants were able to select one or more race and ethnicity categories (Euro-American/White, Middle Eastern or North African American, African American/Black, Hispanic American/Latinx, Asian/Asian American, Native Hawaiian or Pacific Islander, Indigenous American/American Native/Alaskan Native, Not American, or other self-described race/ethnic group). European was the most selected ethnic group (Table 1). Twelve (5.3%) individuals did not select an ethnicity, 189 (84%) individuals selected one race category, 22 (9.8%) individuals selected two racial categories, and two individuals (.9%) selected three racial/ethnic categories.

Table 1

Race and Ethnicity Categories Reported by Participants

Race and Ethnicity Categories	Responses	
	N	%
Euro-American/White	142	66.7
Middle Eastern or North African American/Middle Eastern or North African	8	3.8
African American/Black	47	22.1
Hispanic American/Latinx	10	4.7
Asian/Asian American	10	4.7
Native Hawaiian or other Pacific Islander	1	.5
Indigenous American/American Native/Alaskan Native	7	3.3
Not American	11	5.2

Note: Percentages represent the percent of cases in the total sample, and participants could endorse one or more ethnic groups.

Participants were able to select one or more gender categories (agender, woman, man, nonbinary, genderqueer or gender fluid, intersex, questioning, prefer not to say, and prefer to self-describe). Woman was the most selected gender category (Table 2). Of the participants utilized for analysis, 12 (5.4%) did not select a gender category, 202 (90.2%) selected one gender category, seven participants (3.1%) selected two gender categories, and three individuals (1.3%) selected three gender categories. Additionally, 11 participants (5.2%) identified as trans or transgender. No participants identified as intersex. The majority of the sample identified as straight or heterosexual (N = 112), and 100 individuals identified as other sexual orientations (Table 3). Twelve individuals did not endorse straight, cisgender, or GSM identities.

Table 2

Gender Categories Reported by Participants

Gender Category	Responses	
	N	%
Agender	3	1.4
Woman	159	75
Man	42	19.8
Non-binary	9	4.2
Genderqueer or gender fluid	5	2.4
Questioning	5	2.4
Prefer to self-describe	2	.9

Note: Percentages represent the percent of cases in the total sample, and participants could endorse one or more genders.

Table 3

Sexual Orientation Frequencies

Sexual Orientation	Responses	
	N	%
Asexual	9	4.2
Gay	13	6.1
Straight (heterosexual)	112	52.8
Lesbian	18	8.5
Queer	8	3.8
Bisexual	24	11.3
Pansexual	16	7.5
Questioning	8	3.8
Prefer to self-describe:	4	1.9

The majority of the sample identified as single (46%). 26.3 percent of were married, 19.7% were living with a steady partner, and 6.1% were divorced. 206 people reported their income. Most respondents (24.8%) reported making less than $10,000 a year, followed by $10,000- $19,000 (12.1%) and $30,000- $39,999 (11.2%) income groups. 10.2% made $40,000 to $49,999, 9.2% made $50,000 to 59,999, 5.8% made $60,000 to $69,999, 3.9% made $70,000 to $79,000, 3.4% made $80,000 to $89,999, 2.4% made $90,000 to $99,999, and 6.3% endorsed making 100,000 to $149,999. Lastly, 1.5% made over $150,000. Additionally, most of the sample reported some college (31%), bachelor's degree (25.4%), or master's degree (22.5%) as their highest level of education obtained. Lastly, nine individuals in the analytic sample reported experiencing conversion therapy in the form of counseling or therapy aimed at changing their sexual orientation or gender identity.

Religious demographics were collected for both current religion and religion during childhood. Christianity made up the largest portion of the sample, with 100 individuals identifying as Christian and 27 identifying as not Christian. One hundred twenty-two individuals identified themselves as currently following a religion. Table 4 lists the frequencies for current

religious denominations and sects. Most identified as non-denominational Christian (26.2%) followed by Christian Protestant (18.9%). Other self-described religious denominations included pagan, Baha'i, Hellenic, Hoodoo, Non-Theistic Satanism, and Unitarian, Quaker, Brethren Mennonite, and "Spiritual with a Christian Base." Several individuals endorsed Baptist, Anglican, Lutheran, and Methodist identities yet did not identify as a protestant (N = 12).

Childhood Religious Demographics were also captured. One hundred eighty-three individuals identified themselves as being raised in a religious household, and 40 listed that they were not raised in a particular religion. Table 5 lists childhood denominations. Other religious denominations disclosed include Quaker Traditions, RLDS (Reorganized Church of Jesus Christ of Latter-Day Saints), Southern Baptist, Unitarian, New Church, and Pentecostal.

Table 4

Current Religious Denomination

Religious Denomination or Sect	*N*	%
Christian Protestant	23	18.9
Baptist	7	30.4
Lutheran	3	13.0
Methodist	4	17.4
Presbyterian	4	17.4
Pentecostal	3	13.0
Anglican	1	4.3
Other Protestant	1	4.3
Protestant Traditions		
Evangelical Protestant	9	39.1
Mainline Protestant	6	26.1
Historically Black Protestant	4	17.4
Neither Tradition	4	17.4
Non-denominational Christian	32	26.2
Other Christian religion	17	13.9

Table 4 (continued)

Catholic	17	13.9
Latter- Day Saint (Mormon)	10	8.2
Orthodox Christian	1	.8
Buddhist	1	.8
Hindu	2	1.6
Another Non-Christian Religion	9	7.4
Reform Judaism	3	2.5
Muslim	7	5.7

Table 5

Religious Denomination During Childhood

Religious Denomination or Sect	*N*	%
Christian Protestant	52	28.6
Baptist	24	47.1
Lutheran	2	3.9
Methodist	9	17.6
Presbyterian	3	5.9
Seventh-Day Adventist	1	2.0
Pentecostal	4	7.8
Anglican	2	3.9
Other Protestant	6	11.8
Protestant Traditions		
Evangelical Protestant	25	48.1
Mainline Protestant	18	34.6
Historically Black Protestant	3	5.8
Neither Tradition	6	11.5
Catholic	39	21.4
Other Christian religion:	34	18.7
Latter-Day Saint (Mormon)	20	11.0
Non-denominational Christian	20	11.0
Orthodox Christian	1	.5
Jehovah's Witness	1	.5
Muslim	8	4.4
Jewish	3	1.6

Table 5 (continued)

Conservative Judaism	1	33.0
Reform Judaism	1	33.0
Messianic Judaism	1	33.0
Hindu	2	1.1
Buddhist	1	.5
Another Non-Christian religion:	1	.5

Table 6

Centrality of Religiosity Scores and Sexual Orientation, MINI, and CES-D Scores

Scale	Sexual Orientation								
	Asexual	Gay	Straight	Lesbian	Queer	Bisexual	Pansexual	Questioning	Other
	N = 9	*N* = 13	*N* = 112	*N* = 18	*N* = 8	*N* = 24	*N* = 16	*N* = 8	*N = 4*
	M (SD)	*M (SD)*	*M (SD)*	*M (SD)*	*M (SD)*	*M (SD)*	*M (SD)*	*M (SD)*	*M (SD)*
MINI	6.36 (7.75)	5.5 (8.95)	4.01 (7.21)	4.89 (4.52)	1.63 (2.72)	5.21 (8.27)	8.88 (6.04)	14.13 (13.36)	12.00 (7.79)
CES-D	25.22 (9.67)	18.69 (7.26)	19.65 (11.74)	28.06 (13.55)	19.5 (10.94)	21.25 (11.08)	26.00 (11.08)	21.25 (6.90)	30.50 (7.59)
CRS-15	2.22 (.98)	3.17 (1.14)	3.14(1.10)	2.79 (.91)	2.82 (1.29)	2.72 (1.09)	2.71 (1.03)	2.88 (.95)	2.95 (1.09)
Intellect	2.67 (.55)	3.15 (1.05)	2.97(.92)	2.87 (.92)	3.08 (.99)	3.13 (.98)	3.13 (1.0)	3.21 (.91)	3.5 (.88)
Ideology	2.78 (1.67)	3.79(1.27)	3.87(1.20)	3.46 (1.07)	3.58 (1.38)	3.18 (1.32)	3.44 (1.27)	3.5 (.99)	3.92 (1.75)
Public Practice	1.81 (1.04)	2.64 (1.47)	2.80 (1.36)	2.46 (1.35)	2.21 (1.58)	2.28 (1.43)	2.19 (1.14)	2.58(1.16)	1.58 (.96)
Private Practice	1.96 (1.31)	3.23(1.62)	3.17(1.45)	2.67 (1.5)	2.63 (1.87)	2.58 (1.42)	2.46(1.33)	2.71 (1.45)	2.58 (1.55)
Experience	1.89 (1.07)	3.05 (1.28)	2.90 (1.19)	2.50 (1.03)	2.58 (1.38)	2.42 (1.16)	2.33 (1.18)	2.42 (1.11)	3.17 (1.93)

Note: MINI (Mini International Neuropsychiatric Interview) Suicidality mean scores represent total scores (max = 33), CES-D (Center for Epidemiological Studies Depression) means represent total scores (max = 60), CRS (Centrality of Religiosity) mean scores represent the total score divided by the number of scale/subscale items (max = 5).

3.4 Measures

The survey consisted of 111 questions. Fifteen questions covered the demographic categories of race, ethnicity, age, gender, gender identity, sexual orientation, and income. The demographic portion also asked respondents to endorse both their childhood and current religious affiliations. Current and childhood religious denominations were categorized using the PEW research center's Religious Landscape Survey (2014), which separated common American religious denominations into both broad and narrow categories (i.e., Christian, Evangelical Protestant, Baptist).

3.4.1 The Centrality of Religiosity Scale

The Centrality of Religiosity Scale (CRS-15) is a scale aimed at capturing religiosity, or individual level of religious practice and belief (Huber & Huber, 2012). The scale purports to measure the interplay between social and personal constructions of religious beliefs (Table 7). Responses are across intellect, ideology, public practice, private practice, and experience dimensions. Items are scored across five score levels to measure the objective frequencies of participation in religious services (i.e., more than once a week to never), objective frequencies of prayer (i.e., several times a day to never), items measuring the frequency (i.e., very often to never) and importance (very much so to not at all) of thinking about and believing in religious concepts. To score the assessment, the item sum score was divided by the number of scale items. Scores of 1–2 indicate non-religious individuals, scores ranging from 2.1–3.9 indicate religious individuals, and scores of 4 or higher indicate highly religious individuals. The scale has been adapted to an array of languages, countries and applies to most religions. The CRS consists of 5–, 10–, or 15–items with optional interreligious versions that observe spirituality. For the current study, the 15–item English version was used, the CRS–15. This assessment has the

highest reliability scores among the Abrahamic religions (.80 to .93). Additionally, this study followed the survey developer's recommendations to change questions to read "God or something divine" rather than "God" to be more applicable to other religious groups.

Table 7

Centrality of Religion Dimensions (Huber & Huber, 2012)

Dimension	Sociological and Personal Perspective
Intellectual	Social: Social expectation that individuals have knowledge of and can explain their beliefs. Personal: Bodies of knowledge, interest, and interpretation.
Ideology	Social: Social expectation that individuals have beliefs in the existence of a higher power. Personal: Individual beliefs, convictions, and perceived plausibility of the divine.
Public Practice	Social: Social expectation that people participate in communal religious experiences. Personal: a sense of belonging to a religious community and patterns of attendance within the community.
Private Practice	Social: Social expectation that individuals privately devote themselves to religious activities and rituals, like prayer. Personal: Includes patterns of these ritualistic behaviors and their own style of devotion to the divine.

Table 7 (continued)

Religious Experience	Social: Social expectation that individuals will be emotionally affected through direct contact with the divine. Personal: Includes religious experiences and feelings.

3.4.2 Minority Stress Scales

The Daily Heterosexist Experiences Questionnaire (DHEQ) is a 50–item measure of minority stressors experienced by LGBT individuals over the past 12 months (Balsam et al., 2013). The measure has nine subscales: vigilance, harassment and discrimination, gender expression, victimization, family of origin, vicarious trauma, isolation, and HIV/AIDS. To fit the scope of the current study, vigilance, harassment, victimization, family of origin (experiences of familial rejection), and isolation items were used (for a total of 26 questions). For all 50 items, the scale has an alpha of .92. Subscales also show internal reliability vigilance (α =.86), harassment and discrimination (α =.85), victimization (α = .87), Family of Origin (α =.79) and isolation (α = .76). This measure provided insight into individuals' discrimination and victimization experiences. Additionally, family items and isolation items allow for observation of social factors contributing to perceived minority stress. On the DHEQ measure, individuals endorse how much a particular experience bothered them over the past 12 months. For example, "Being called names such as fag or dyke" on a scale from 0 (did not happen/not applicable to me) to 5 (it happened, and it bothered me extremely).

The Transgender Congruence Scale (TCS) is a 12–item scale that measures transgender congruence or level of comfort with their gender identity and physical appearance (Kozee et al., 2012). Items are rated on a 5–point Likert type scale to describe individual experiences over the past few weeks. Items include: "My physical body represents my gender identity" and "I am not

proud of my gender identity." Higher scores indicate a higher level of transgender congruence, and the scale is internally consistent (Kozee et al., 2012).

Internalized homophobia was be measured using the Internalized Homophobia Scale-Revised (IHP-R) (Herek et al., 2009). Initially developed by John Martin and Laura Dean, the scale measures ego-dystonic homosexuality (i.e., distress with or a desire to change one's sexual orientation) a DSM III diagnosis (Herek et al., 2009; Meyer, 1995). On the original scale, respondents rate how frequently they experienced thoughts of discomfort and avoidance about same-gender attraction on a 5-point scale (disagree strongly to agree strongly). The scale was initially developed for gay men. For this study's purpose, the revised form of the scale was used, which has five questions and has been deemed a better fit for lesbians, bisexuals, and gay men (Herek et al., 2009; Huynh et al., 2020). Internal reliability for the 2009 study was relatively high ($\alpha = .82$). Higher scores indicate higher levels of internalized homophobia. Individuals who identify as transgender and lesbian, bisexual, queer, or gay were prompted to complete internalized homophobia and transgender congruence items.

3.4.3 Suicide Attempt and Ideation Scales

The MINI suicidality scale was used to observe suicidality over the past month (Sheehan et al., 2002). On this scale, six binary yes/no suicidality-oriented questions ranging in severity are scored from 1 to 10 to yield a total score of 0 to 33 (i.e., wanting to harm oneself is rated as less severe than attempting suicide). One study found the internal consistency of the MINI to be .84 (Roaldset et al., 2012). Four additional items measuring suicidality were adapted from the Lytle et al. (2018) study. Respondents answered yes or no to a question asking whether they have ever seriously considered suicide at some point in their life. Those who answered yes were asked the following about suicidal attempts and ideation: "During the past 12 months have you

seriously considered attempting suicide?" and "How many times in your life have you attempted suicide?". If respondents endorse that they have attempted suicide one or more times, they were also promoted to an item asking how many attempts occurred in the last 12 months.

3.4.4 CES-D Scale

The Center for Epidemiologic Studies Depression Scale (CES-D) provided insight into the current mental well-being of study participants. The CES-D is a brief self-report scale that measures self-reported symptoms associated with depressed mood, feelings of guilt, feelings of hopelessness, feelings of worthlessness, poor sleep and appetite, and psychomotor retardation (Radloff, 1977). The CES-D is a 20–item scale in which participants endorse use a 4–point (rarely to most of the time) Likert scale to examine the occurrence of depression symptomology during the past week. Scores over 16 indicate significance, with higher scores displaying higher levels of symptomology. The 1977 study that examined reliability and validity showed the test to have a coefficient alpha of .80 among White and Black individuals and across age groups (Radloff, 1977). Subsequent studies have found the CES-D to be appropriate for young adults (Radloff, 1991) and ethnic minority populations (Canady et al., 2009).

3.4.5 Needs and Experiences

Participants were also prompted to provide insight into positive and negative experiences with religion and the needs that they have of religious institutions, peers, and communities via a series of vignettes (see appendix). Thematic analysis was used to code, analyze, and conceptualize data. Through this process, the researcher read and reviewed data, generated initial codes, synthesized these codes into broad themes, and reviewed and revised these codes by referring to codes and data. In this process, a second coder was consulted for the generation of codes and themes to encourage greater interrater reliability.

3.5 Descriptive Statistics

Centrality of Religiosity scores and scale scores were calculated by dividing the total score by the number of items and dividing scale scores by the number of scale score items. On the CRS-15, a score of 1-2 denotes "not-religious," 2.1 to 3.9 denotes "religious," and 4.0 to 5 indicates membership into the "highly-religious" category. The average religiosity score was 2.98 (*SD* = 1.09), indicating that the sample was religious. The sample was also religious across the intellect (*M* = 3.03, *SD* = .93) ideology (*M* = 3.66, *SD* = 1.25), public practice (*M* = 2.58, *SD* =1.35), private practice (*M* = 2.92, *SD* = 1.4) and experience (*M* = 2.72, *SD* = 1.22) subscales. The CES-D mean score was 21.24 (*SD* = 11.63). A score of 16 or above is indicative of meeting the criteria for depression symptomology, and scores range from 0 to 60. MINI suicidality scores range from 0 to 33. A score greater than 10 indicates a high suicide risk, 6 to 9 points indicates moderate risk, and 1-5 points indicates low risk. A low, moderate, or high score is calculated if the participant answers yes to one or more suicidality prompts. The mean MINI score for the sample was 5.23 (*SD* = 7.71). When categorized into suicide risk groups, 32 individuals (14%) were at low suicide risk, 35 (15.6%) were at moderate risk, and 48 (21.4%) experienced high suicide risk. Mean scores for depression, suicidality, and religiosity scales were also captured by sexual orientation (Table 6).

Transgender congruence scores were recorded for the 11 individuals in the sample. The mean transgender congruence was 39.45 (*SD* = 8.64). Scores range from 0 to 60, with higher scores representing higher levels of congruence. Internalized homophobia (IHP) scores were collected for all individuals identifying as bisexual and gay men or women (N = 80). IHP scores range from 1 to 5, with higher scores indicating higher levels of self-stigma. The mean IHP score

was 1.88 (*SD* = .95). Women (*N* = 61, *M* = 1.79, *SD* = .89) displayed lower scores than men (*N* = 19, *M* = 2.15, *SD* = 1.11). The Daily Heterosexist Experiences Questionnaire (DHEQ) was completed for all non-heterosexual individuals for isolation (*M* = 8.50, *SD* = 4.03), victimization (*M* = 4.39, *SD* = 1.46), harassment and discrimination (*M* = 8.5, *SD* = 4.00), family of origin (*M* = 9.43, *SD* = 4.91) and vigilance subscales (*M* = 11.62, *SD* = 5.91). Higher scores indicate higher levels of distress related to each experience covered in the subscale. Isolation and victimization scales have a maximum score of 20, and harassment and discrimination, family of origin, and vigilance subscales have a maximum score of 30. Reliability was also collected for applicable scales and subscales (Table 8). Reliability for the DHEQ victimization subscale was low.

Table 8

Cronbach's Alpha for Scales and Subscales

Scale	α
CES-D	.92
CRS-15	.96
CRS Intellect subscale	.76
CRS Ideology subscale	.92
CRS Public Practice subscale	.93
CRS Private Practice subscale	.96
CRS Experience subscale	.93
DHEQ Isolation subscale	.80
DHEQ Victimization subscale	.60
DHEQ Harassment and Discrimination subscale	.79
DHEQ Family of Origin subscale	.78
DHEQ Vigilance	.86
IHP-R	.87
IHP-R (men)	.90
IHP-R (women)	.86
MINI Suicidality	.71
Transgender Congruence Scale	.81

Note: Scales reported are the CES-D (Center for Epidemiological Studies Depression) scale, CRS-15 (Centrality of Religiosity) scale and subscales, Daily Heterosexist Experiences Questionnaire (DHEQ) scale and subscales, IHP-R (Internalized Homophobia Revised) scales scores for the total sample, men, and women, and Transgender Congruence scores.

3.6 Plan of Analysis

1. **Is there a difference between religious importance/experience and suicidal ideation and suicide attempt among GSM?**

   Following cleaning and screening procedures, t-tests were used to examine suicidality and depression scores across gender and sexual minority and straight, cisgender groups. Additionally, relationships between suicide, depression, and religiosity scores were observed for the GSM population.

2. **Are individuals exposed to religion more likely to experience factors of internalized self-hatred, victimization, and discrimination (minority stress), compared to those not exposed to religion?**

   A correlation was used to compare religiosity and minority stress measures.

3. **Are there significant differences in reported suicidal ideation between demographic groups?**

   Analysis of odds ratios was done to observe the association between suicide attempts, suicidal ideation, and religion's importance across demographic characteristics (religion, sexual orientation, gender identity).

4. **What experiences and needs do gender and sexual minorities express across Social-ecological domains?**

   Open-ended questions were included to explore the specific needs and experiences of gender and sexual minorities across socioecological levels (see below). Individuals endorsed how they perceive religion has impacted their mental health. Responses were

coded via thematic analysis by two coders. Results display a thematic map of social-ecological barriers and assets that impact GSM individuals in religious settings.

CHAPTER 4

RESULTS

4.1 Quantitative Results

The first research question was aimed at exploring the relationship between religious experience and suicidal ideation, and attempt for gender and sexual minorities. Due to the low number of agender, genderqueer or genderfluid, nonbinary, and transgender individuals in the sample, direct comparisons cannot be drawn between cisgender individuals and those who identified as gender minorities. However, in fitting with the research scope, which is aimed at gender and sexual minorities, all individuals who identified as agender, transgender, genderqueer or genderfluid, nonbinary, questioning, and those who self-described as another gender, and individuals who selected more than one gender were combined with all individuals who did not select straight/heterosexual on the survey to form a sample of gender and sexual minorities. Recoding individuals into a larger gender and sexual minority group guarantees independence of observations; otherwise, gender minority individuals would be counted in both the straight/heterosexual and gender minority groups. Boxcox charting was used to determine outliers for analyses. Five extreme outliers were removed from both analyses, and cases were excluded listwise.

An independent samples t-test was observed to compare group means on the MINI suicidality scale between gender and sexual minorities and straight, cisgender individuals. There was a significant difference between GSM individuals (M = 6.20, SD = 7.66) and others (M = 3.39, SD = 6.60; t (204) = 2.82, $p < .01$, two-tailed; Levene's = .09) on the MINI suicidality scale. Gender and sexual minorities displayed higher means on the suicidality scale than straight, cisgender identified individuals. The magnitude of differences between the means (mean

difference = 2.81, 95% *CI*: .85 to 4.77) was small (eta squared =.038). State mental distress was also analyzed using CES-D depression scores, and similar findings existed between groups. Straight, cisgender individuals had significantly lower (*M* = 19.18, *SD* = 11.44) mean depression scores than gender and sexual minorities (*M* = 23.48, *SD* = 11.05; *t* (205) = 2.75, p<.01., two-tailed). There was homogeneity of variances (Levene's = .65). The magnitude of differences between the means (mean difference = 4.30, 95% *CI*: 1.21 to 7.38) was also small (eta squared = .036). For the gender and sexual minority subset of the sample, The MINI suicidality score and CES-D scores displayed a medium positive correlation (r_s = .45, p<.001, *N* = 102). There was not a significant association between CRS-15 scale scores and MINI suicidality and CES-D scores, indicating a lack of relationship between religiosity and negative mental health outcomes (Table 9).

Table 9

Spearman's Rho Correlations Between CRS-15 Scale Score, MINI Total Score, and CES-D Total Score for GSM Individuals

Scale	1	2	3
1. CRS-15	—		
2. MINI suicidality	.007	—	
3. CES-D	.000	.446*	—

Note: MINI (Mini International Neuropsychiatric Interview) Suicidality mean scores represent total scores, CES-D (Center for Epidemiological Studies Depression) means represent total scores, CRS (Centrality of Religiosity) mean scores represent the total score divided by the number of scale/subscale items.

** *p* <.01

Since religiosity was not correlated directly to suicidality (MINI suicidality) and depression (CES-D), Spearman's rho correlations were completed for minority stress subscales

and suicide and depression measures (Table 10). Results displayed that DHEQ isolation had a medium, positive correlation with the CES-D ($r_s = .35$, $p < .01$). The DHEQ victimization scale showed a medium, positive correlation to the suicidality measure ($r_s = .30$, $p < .01$), and the DHEQ vigilance scale displayed a positive medium correlation with the CES-D measure ($r_s = .33$, $p < .05$).

Table 10

Spearman's Rho Correlations Between DHEQ Victimization, Vigilance, and Isolation Scales, Internalized Homophobia, Depression, and Suicidality

	1	2	3	4	5	6
1. MINI Suicidality	—					
2. CES-D	.49**	—				
3. IHP-R	-0.02	0.08	—			
4. DHEQ isolation	0.21	.35**	.33**	—		
5. DHEQ victimization	.30**	0.12	-0.04	.30**	—	
6. DHEQ vigilance	0.19	.33**	.41**	.42**	0.08	—

Note: Scales reported are the CRS-15 (Centrality of Religiosity) scale and subscales, Daily Heterosexist Experiences Questionnaire (DHEQ) isolation, victimization, and vigilance subscales, and the IHP-R (Internalized Homophobia Revised) scale. Listwise $N = 78$

*p < .05. **p < .01.

The following research question examined the relationship between religious experience, religiosity, and minority stressors. To address this question, minority stress scales (DHEQ and IHP-R) were compared to CRS-15 subscales. Shapiro-Wilks was significant at the .05 level for CRS-15 total score items and minority stress items, indicating that the assumption of normality was breached. As the sample was halved to analyze only gender and sexual minorities, the lower *N* would make testing less robust regarding the assumption of normality. Additionally, listwise deletion was utilized to observe scores for the individuals who completed IHP-R and DHEQ subscales ($N = 78$) as the DHEQ measures were given to the total gender and sexuality minority sample, and IHP-R was given to those who identified specifically as men or women who had experienced attraction to their same gender. Additionally, Q-Q plots also displayed that variables were moderately positively skewed, with individuals being less likely to endorse more extreme scores. Thus, the Pearson product-movement correlation would be inappropriate.

Spearman's rho correlation was used to analyze relationships between CRS-15 Scores (intellect, ideology, public practice, private practice, experience, and CRS-15 score), and minority stressors of internalized homophobia (IHP-R), and Daily Heterosexist Experience Questionnaire (DHEQ) subscales (isolation, victimization, harassment and discrimination, family of origin, and vigilance subscales). CRS-15 subscale scores were calculated by dividing the total subscale score by the number of subscale items to put the items on a comparable scale.

Table 11

Spearman's Rho Correlations for Centrality of Religiosity, Daily Heterosexist Experiences, and Internalized Homophobia Scales

Scale	1	2	3	4	5	6	7	8	9	10	11	12
1. CRS-15	—											
2. CRS intellect	.67**	—										
3. CRS ideology	.85**	.44**	—									
4. CRS public practice	.86**	.68**	.60**	—								
5. CRS private practice	.91**	.48**	.70**	.75**	—							
6. CRS experience	.89**	.42**	.83**	.63**	.82**	—						
7. DHEQ isolation	.16	.24*	0.10	.25*	.08	.05	—					
8. DHEQ victimization	.12	.11	.12	.11	.08	.12	.30**	—				
9. DHEQ harassment and discrimination	.00	.03	-.06	.09	-.03	-.03	0.21	.39**	—			
10. DHEQ family of origin	.28*	.21	.15	.36**	.11	.15	.21	.24*	.31**	—		
11. DHEQ vigilance	.18	.37**	.01	.24*	0.15	0.04	.42**	.08	.26*	.42**	—	
12. IHP-R	.53**	.42**	.38**	.50**	.51**	.37**	.33**	-.04	.03	.12	.41**	—

Note: Scales reported are the CRS-15 (Centrality of Religiosity) scale and subscales, Daily Heterosexist Experiences Questionnaire (DHEQ) subscales, and the IHP-R (Internalized Homophobia Revised) scale. Listwise $N = 78$

*$p < .05$. **$p < .01$.

with the total CRS score. The resulting correlation matrix indicated significant relationships between scale and subscale scores (Table 11). Spearman's rho correlation analyses displayed a strong, positive correlation between internalized homophobia and CRS-15 scores (r_s = .53, n = 78, p<.01). There was also a large, positive correlation between internalized homophobia scores and CRS public practice (r_s = .50, n = 78, p <.01) and private practice subscales (r_s = .51, n = 78, p <.01). A medium positive correlation was identified between internalized homophobia scores and CRS-15 intellect (r_s = .42, n = 78, p <.01), ideology (r_s = .38, n = 78, p <.01), and experience scales (r_s = .37, n = 78, p <.01). Additionally, the IHP-R displayed a medium positive relationship with DHEQ isolation (r_s = .33, n = 78, p <.01) and vigilance subscales (r_s = .41, n = 78, p <.01). DHEQ vigilance had a positive relationship with the CRS intellect subscale (r_s = .37, n = 78, p <.01). Lastly, DHEQ family of origin had a positive moderate relationship with CRS public practice scores. (r_s = .36, n = 78, p <.01).

Results from the correlational analysis indicate that there was a relationship between aspects of religiosity and family of origin, vigilance, and internalized homophobia. Internalized homophobia was associated with all CRS-15 domains. A high positive correlation between CRS public practice, private practice, and homophobia suggested that higher levels of publicly and privately displayed religion were associated with higher levels of internalized homophobia. Additionally, there were significant positive correlations between internalized homophobia and CRS-15 intellect, ideology, experience, and isolation subscales, indicating that as the centrality of religion increases, feelings of internalized homophobia may as well. The DHEQ family of origin subscale (which observes distress regarding expected and actual family rejection) was correlated with the CRS-15 public practice subscale. This shows that individuals experiencing rejection have higher levels of publicly displayed religion (perceived importance of a religious

community and frequency of attending religious services). Vigilance and CRS intellect subscales were also related, indicating that as, level of distress relating to concealing GSM identity increases, so did intellectual thought regarding religious news and issues. Additionally, internalized homophobia related to isolation and vigilance scores, indicating that as internalized homophobia increased, distress related to isolation and vigilance due to sexual orientation or gender identity also increased. Overall, these findings indicate a relationship between religiosity scores and internalized homophobia and distress related to family beliefs about one's gender and sexual minority status.

Race and ethnicity were recategorized into White American and Non-White American groups to examine the relationship between race/ethnicity and GSM-associated minority stress factors. Non-Americans (international individuals) were not included in this sample due to the low number. Initial observance of means differences for scales and subscales indicated a difference between White American and Non-White Americans on the DHEQ vigilance subscale (mean difference = -1.9) and DHEQ family of origin scales (mean difference = -1.54). Due to uneven sample sizes between groups (60 White Americans and 36 Non-White Americans), a Mann-Whitney U test was performed. There was no statistically significant difference between White and Non-White Americans on the vigilance (U = 1,138, z = 128.81, p = .50) and family of origin (U = 1,233.5, z =1.22, p =.22) subscales.

The last research question was aimed at exploring demographic factors as they related to suicidality. Religiosity, gender, and sexual minority status, and race were observed as predictors for lifetime suicide contemplation (*Have you ever seriously considered suicide in your life?).* Race and ethnicity were again recategorized into White non-Hispanic American and Other American categories. Non-Americans (international individuals) were removed from the sample

because there were too few for a separate ethnicity category. The total sample for the model included 201 individuals after Non-Americans and individuals with missing data were removed. Linearity of the continuous variable (CRS score) was analyzed using the Box-Tidwell procedure (Box & Tidwell, 1962). The interaction term between the CRS-15 score and its logit was not significant, and the model met the assumption of linearity (p =.42). Omnibus Tests of Model Coefficients indicated that the model was statistically significant at the p <.005 level (X^2 (3) = 16.105). Additionally, the Homer and Lemeshow goodness of fit test was not significant, indicating that the model was not a poor fit (p =.92). The Nagellerke R^2 value indicated that the model accounted for 10.5 percent of the variability in the dependent variable. The percentage accuracy classification value was 63.7 percent. Percentage correct was 79%, and specificity was 39%. The positive predictive value for the model was 67.59%, and the negative predictive value was 53.57%. Thus, the model was better at accurately predicting the occurrence of ever contemplating suicide. The Wald test indicated that only the variable of gender and sexual minority identity significantly contributed to the model. Specifically, the model, composed of roughly half gender and sexual minorities and half straight, cisgender groups, displayed that individuals who were gender and sexual minorities were 3.21 times more likely to have contemplated suicide than others who were not gender and sexual minorities, when holding all other variables constant (Table 12). This indicates that gender and sexual minorities are at increased risk for suicidal ideation throughout their lifetimes.

Table 12

Logistic Regression Predicting Lifetime Suicide Contemplation based on Gender and Sexual Minority Identity, CRS-15 Total Score, and Ethnicity Category

	B	*SE*	Wald	*df*	*p*	Odds Ratio	95% C.I.for Odds Ratio	
							Lower	Upper
Ethnicity Category	-.411	.32	1.71	1	.191	.663	.358	1.227
CRS-15 Total Score	.123	.15	.70	1	.403	1.130	.848	1.506
Gender and Sexual Minority Status	1.165	.31	13.78	1	.000	3.206	1.733	5.932
Constant	-.242	.50	.24	1	.625	.785		

Note: Race is for Other American Ethnicities compared to White Non-Hispanic Americans. Gender and Sexual Minority status denotes gender and sexual minorities compared to others.

4.2 Qualitative Results

Open-ended prompts regarding the subjective impact of religion (at the peer/family, personal, and religious institution level) on mental health were provided to address research question four. Themes were organized in a manner to describe the mechanisms through which religion impacted mental health. Seventy-three participants responded to the personal religiosity impact prompt, 70 responded to the family and peer religiosity prompt, and 69 responded to the institutional impact prompt. Despite categorization into separate social groups and institutions, individuals endorsed similar experiences across categories. Additionally, participants discussed a variety of religious experiences and beliefs. Thus, themes represent broad experiences. These qualitative prompts were analyzed using thematic analysis as outlined by Braun and Clarke (2006). In this process, the researcher reviewed the data, generated initial codes, synthesized codes into possible themes, reviewed and revised themes by comparing them to the codes and raw data, and developed definitions and names for the following themes (Figure 2). Following this process, a second coder was consulted to assure interrater reliability.

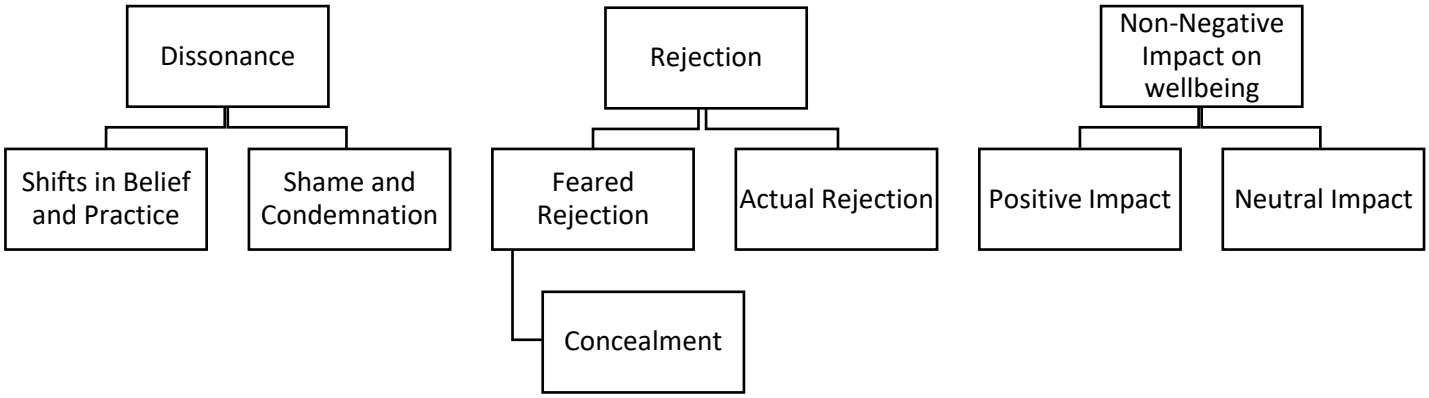


Figure 2. Thematic Map of Religious Factors Perceived as Impacting Mental Well-Being

4.2.1 Dissonance

Dissonance was defined as a perceived conflict between one's gender identity or sexual orientation and the religious teachings and practices of religious institutions, peers and family, or personal religious beliefs. For example, one individual stated, “There is a conflict with how I identify and how my church views people who identify as I do.” Another participant described feeling “nearly unbearable dissonance.” A participant discussed the process they underwent to resolved dissonance caused by childhood religion: “It took me a long time to sort out my personal religious beliefs from those that I was taught as a child and to mesh them with my identity. The turmoil in the in-between made me often wish I was not who I am.” Another participant described that the cognitive dissonance between being raised as a member of The Church of Jesus Christ of Latter-Day Saints and being a sexual minority caused them to experience depression symptoms and thoughts of self-harm:

> Growing up Mormon, even though I have left the religion, has left a lasting impact on how I view my worth. As a child/teen/young adult/married woman, I was highly religious and also knew I was not totally heterosexual. I tried to hide from that side of me that was

not totally straight and the cognitive dissonance it caused created such pain in my life I struggled with depression and thoughts of wanting to harm myself for years.

Shame and condemnation and shifts in belief and practice are subthemes of dissonance related to practices and beliefs that may arise as the result of one's personal attributes failing to align with the teachings and practices within one's religious group. Individuals might express. Qualitative findings indicated that individual's reactions to anti-GSM religious experiences exist along a continuum of feeling like one is morally bad or wrong to either rejecting these religious practices or forming a personal belief system more aligned to their identity.

4.2.2 Shame and Condemnation

The subtheme of shame and condemnation was defined as the individuals feeling morally incorrect, bad, or sinful due to their sexual orientation or gender identity. An individual described experiencing diminished mental health when they were younger due to shame: “My personal religious beliefs and practices were much more impactful when I was younger, and it caused a lot more shame, but as I have gotten older and developed a more individual perspective of my own religious beliefs and it has affected my mental health much less, if at all.”

Participants experienced expectations or fears about being condemned to hell because of their identities or experienced others expressing condemnation. One said, “The short of it is, I thought I was going to hell for a very long time. I assumed that because of who I am l, that I was less than and therefore unworthy of real love.” Another stated, “I'm terrified of going to hell, even though I've accepted Jesus as my Savior.” Additionally, one participant said that they, “thought I was bad, evil, hopeless, condemned because I was gay and raised Mormon.” One individual described feeling traumatized after having sex for the first time, stating, “Believing

being gay is wrong when I was younger, my first-time having sex was traumatizing because I felt I was dirty and shameful afterwards…".

4.2.3 Shifts in Belief and Practice

Shifts in belief and practice occurred when an individual resolves dissonance surrounding their identity through changing or assimilating their personal religious beliefs with that of a religious belief system, rejecting a belief system due to its anti-GSM stance, or choosing an affirming belief system. Some individuals experienced a learning process to discover a system or practice that aligned with their personal beliefs. One participant said, "I am learning for myself what Christianity is really about, so currently, my own religious beliefs have a positive effect on my mental health, but it didn't use to always be this way." A participant discussed taking an individual perspective to religion, "My personal religious beliefs and practices were much more impactful when I was younger and it caused a lot more shame, but as I have gotten older and developed a more individual perspective of my own religious beliefs and it has affected my mental health much less, if at all." Another endorsed seeking out a religion that aligned with their personal belief system.

> I've been searching recently for a different belief system that matches more closely with my own personal dogma and haven't found any named religion yet. Currently, I'm comfortable labeling myself as spiritual, but I have not shared this change with anyone outside of my peer group. But the process has helped me be more independent and confident in myself where I was lacking before.

A participant described how shifting to a GSM affirming religion helped to repair their self-esteem and lead to them feeling worthy of God's love.

> My current religious practices are very accepting to my orientation and encourage everyone to come as they are because God loves everyone, and they teach that everyone is important to God. We believe that everyone who strives to do good and live a life of service and lifting of our fellow men will be blessed. We believe that everyone has a place in heaven as long as they are good in heart and do no harm to others. This religious belief has started to repair my self-esteem that I am a good person, and I do good things, so I am worthy of God's love.

Other individuals endorse that not practicing religion improved mental health or that they rejected religion altogether. One said, “I don't personally believe in much anymore, and I don't willingly practice Catholicism. Therefore, my personal religious beliefs are better for me mentally than what they were growing up”. Another stated that an institution's anti-GSM stance pushed them away from religious services and practices. Others rejected religion altogether, “Grew up in, one could argue, a cult. Now potentially, one might label me as anti-religion. I have a significant amount of trauma centered from my religious upbringing”.

4.2.4 Rejection

Feared or actual rejection was defined as disclosure of an experience where a participant was rejected by a religious leader or institution, peer, or family member or feared that they would be rejected due to their gender and sexual minority status. Regarding feared rejection, individuals endorsed feeling lonely, isolated, or rejected as the result of their identities. In an example of feared rejection, an individual described not applying to a Catholic hospital due to their gender and sexual minority status, saying, “The hospital I was planning on applying to after graduation is a Catholic hospital. I don't know how happy they would be to have me. I've since reconsidered for fear of backlash.”

Actual rejection occurred when an individual experienced a perceived lack of acceptance of their gender identity or sexuality by peers, family, or their religious institution. For example, an individual stated, “Some family members have ceased contact due to religious reasons concerning my gender identity, increasing my depression and anxiety.” This theme also exemplified in a statement provided by an individual with LDS (Latter-Day Saint) family members who described being cut off from some siblings:

> Most of my family are LDS/Mormon. And they believe that it is a personal choice to be LGBTQ+ and that giving in to the feelings and not following the prophet will ultimately be my downfall and that my life will not be blessed. Some of my siblings refuse to have me at their home or around their children because they believe that I will be a bad example to them or do something bad.

Within the theme of feared or actual rejection, a subtheme of rejection of a romantic partner or romantic relationship was observed. One person stated, “I feel like I can't hang out with church people with my partner.” Another individual stated, “My grandparents refused to acknowledge a same-sex partner as a partner but they're dead now so that was devastating. Also, people I grew up going to church and youth group with speaking about queer people and how they reacted to me coming out after I left the church.”

> My grandfather, upon hearing about my then girlfriend (now fiancée), sent me a letter saying that I am straying from God's path and that he can help me. It was all very patronizing. I told him to his face about how excited I was about this relationship because I trusted him, and he was too much of a coward to say anything to my face. I used to love my grandfather, and now I'm trying to figure out how I can ask my grandmother to not

bring him to my wedding. I don't want to see him, and I don't want him there to taint my future wife and I's day.

4.2.5 Concealment

A subtheme defined as hiding or concealing one's gender or sexual orientation out of fear of religious persecution or rejection was defined as concealment. Individuals were aware of either other GSM individuals who had experienced rejection or anticipated rejection from their own peers and family member; thus, they decided to conceal their identity. Participants mentioned fear of rejection by religious leaders and family among their reasons for hiding their identities. One person indicated, “Hiding who you are in general is taxing but hiding it from your religious leader out of fear of rejection is depressing.” Another stated, “My birth family is still highly religious. I cannot be open with them regarding my LGBTQ identity because I am afraid of how they will react. I feel sad and angry that I cannot be open with my mother especially. I am worried it would hurt her too much.” Another stated, “My mother's family (grandmother and aunt/her children) has cut ties with me over my identity and with my family for supporting me.” One participant described that concealing their identity caused them to feel lonely and delayed in dating experience compared to their peers. Additionally, this individual discusses feeling daily anxiety symptoms:

My family's religious beliefs have impacted my mental health significantly, I believe. I have not come out to my family because of their beliefs and knowledge that they would likely shun or disown me if I did. I have decided to wait until I am in a financially stable enough position to be okay if I were to be completely cut off. It has caused a lot of loneliness because I can't date or pursue any relationships because it's such a small town. I feel like I am falling quickly behind my other friends and family members with where they are in developing lives

with partners because I have been stunted in this stage. There is just the everyday anxiety and stress of them ever finding out before I am ready and all the complications that could follow that.

4.2.6 Non-Negative Impact on Well-being

To gain a perspective of the prevalence of perceived positive or neutral impact on mental well-being, responses that explicitly indicated positive or no impact were quantified. Several individuals endorsed experiencing a positive impact on their mental well-being as the result of religious experience. Specifically, 17 individuals reported a positive of their personal religious practice on their mental health, four individuals endorsed a positive impact of peer or family religious beliefs or practices, and five indicated that a religious institution had a positive impact. In contrast, five respondents endorsed no perceived impact of personal religious beliefs on mental well-being, four endorsed no impact of family religious practices and beliefs, and ten endorsed no perceived impact of institutional factors on mental well-being. Nine respondents reported being non-religious. Other respondents described a variety of negative experiences that they perceived as causing negative impact to their mental health.

Respondents who reported a positive impact expressed unconditional acceptance, using spirituality as a coping mechanism, and feelings of confidence due to their religious involvement. One person wrote, “I am spiritual as I believe something out there is controlling us all, and that gives me peace of mind more than anything. Turning to whomever is in charge when I'm going through hardships about being gay gives me hope that whoever it is loves me no matter what.” Another stated, “I believe that there is a higher power, and they accept me no matter what, so that gives me some peace of mind.” This finding indicated that, for some GSM individuals, religion could foster self-acceptance and a means for dealing with minority stressors.

For individuals reporting no impact on mental health, most endorsed either being non-religious or experiencing “none” or “no impact.”

CHAPTER 5

DISCUSSION

Overall, the current study established a connection between religiosity and minority stress. The study also supports previous literature observing increased suicidality among gender and sexual minority individuals (Gibbs & Goldbach, 2015). Due to the small sample size, a causal relationship could not be established between smaller demographic categories, like race category and sexual orientation category, on minority stress, depression, and suicidality. However, the thematic analysis provided some insight into the mechanisms underlying religious-specific minority stress. Specifically, some individuals disclosed experiencing internalized homophobia and expectations of rejection as a result of religious experience. However, many individuals disclosed positive or neutral impacts of religion on their mental wellbeing. These findings support the necessity for gender and sexual minority-specific suicide and depression interventions. Additionally, the findings warrant further examination of the interplay between religious factors and GSM mental health.

5.1 Qualitative Findings

Qualitative prompts sought to identify the impacts of personal religious beliefs and practices, family/peer religious beliefs, and practices institution or organization on individual perceived well-being. Many individuals described the positive or neutral impact of religious experiences on their lives. Positive experiences revolved around using religion as a means of coping or acceptance. Many also listed that there was no impact on their mental well-being caused by religion. Within those who expressed negative religious experiences, a clear connection to the minority stressors of internalized homophobia, concealment, and expectations of rejection were observed. Minority stress theory postulates that minorities experience unique,

persistent stressors as the result of their membership in a socially stigmatized group (Meyer, 2003).

Meyer (1995) proposed three processes of minority stress: theactual experiences of prejudice and discrimination, expectations of rejection and discrimination, and internalized homophobia and concealment. These stressors lie on a continuum of more proximal objective stress factors to more subjective distal factors. Proximal stressors, like internalized homophobia and concealing of one's sexual orientation, are defined by the individual holding negative self - attitudes toward gender and sexual minorities. Conversely, distal stressors are objectively damaging to people within the minority group but may not directly impact the individual. For example, news coverage regarding transgender athletes may impact all gender minorities regardless of their desire to play sports. Qualitative findings indicated that both distal and proximal stressors were perceived to have impacted well-being.

The theme of rejection was defined as feared or actual incidents of isolation caused as the result of religious experiences spanned across the minority stress continuum. Within this theme, the subtheme of actual rejection was characterized as a distal, objectively negative experience. For example, being rejected for a same-sex partner or being shunned by family aligns with distal stress processes. Feared rejection (analogous to expectations of rejection in Meyer's 2003 model) was a more proximal stressor. Feared rejection was exemplified by narratives of individuals feeling like they would not be accepted if their peers or family members became aware of their identity. Fears of rejection may result in individuals concealing their identity from religious-affiliated peers and institutions. The theme of concealment was identified as hiding or concealing one's gender or sexual orientation out of fear of rejection. This was displayed through

individuals disclosing that they hide their identities out of fear of being shunned or upsetting others.

Dissonance developed as a theme defined by the existence of conflict between identity and religious expectation. This theme was divided by subthemes of shifts in belief and practice or shame and condemnation. The proximal minority stressor of internalized homophobia is more closely related to the subtheme of shame and condemnation as individuals experiencing shame and condemnation expressed a negative attribution of their gender identity or sexuality as the result of religious experiences. Additionally, the subtheme of shifts in belief may represent behaviors directed at resolving the dissonance between GSM status and religion.

Since the prompts were focused on mental well-being, concepts related to harassment and violence may have been less likely to be revealed. Future analysis of experiences with violence at the hands of religious-affiliated individuals may be warranted. It could be that the existence of anti-queer principles and practices within families, peer groups, and greater religious institutions is comparable to distal stressors of harassment, discrimination, and vigilance as they cause exposure to proximal minority stressors of internalized homophobia and expectations of rejection.

Some individuals also reported being negatively impacted by gender roles and expectations and purity myth teachings in religious contexts. For example, participants discussed women being forbidden from holding leadership positions in church institutions, experiencing shame regarding their bodies, sexual feelings, or behaviors. These disclosures suggest that some religious groups are opposed to sexual deviance and include gender and sexual minority status existing under a larger umbrella of sexually inappropriate behaviors. Thus, a broader analysis might prove necessary to examine the connection between these beliefs and sexual well-being.

Analyzing the impact of strict gender roles promoted by many institutions on gender dysphoria among trans and nonbinary individuals may also be a potential avenue for future research.

5.2 Quantitative Findings

The theoretical model postulated that religious experiences of personal religiosity and exposure to a religious environment would expose gender and sexual minorities to minority stressors which would manifest in the increased likelihood of depression and suicidality. Within the current study, this model could not be substantiated. The first research question observed whether there was a difference between religious experience, religiosity, and suicidality among gender and sexual minorities. Compared to the straight, cisgender identified subset of the sample, gender and sexual minorities displayed significantly higher suicidality and depression scores. However, the CRS-15 religiosity, which observes public practice, private practice, intellect, ideology, and experience domains, was not correlated with the MINI suicidality or CES-D scale. This indicates that religiosity could not be connected to suicidality or depression scores. Regarding religious demographics, discernment between current and childhood religious denominations in accordance with the previously indicated religious subgroups was not possible.

The next research goal was to observe the relationship between minority stressors and religious experiences. For this purpose, minority stress scales were correlated with the religiosity measure. This analysis displayed that internalized homophobia was significantly, positively correlated to total CRS-15 religiosity scores. There was also a relationship between internalized homophobia and CRS-15 public and private practice scales, illustrating that individuals who take part in prayer and religious services may be at increased risk for developing internalized homophobia. Internalized homophobia was also correlated with intellect, ideology, and experience domains. This indicates that increasing internalized homophobia was associated with

increased religiosity. However, further correlational analyses displayed that this association may not be a contributor to suicide and depression, as proposed in the model. These findings are somewhat related to the previous research that found a link between non-affirming religion and internalized homophobia but did not establish a link between non-affirming religion and mental health outcomes of psychological well-being, self-esteem, and depression (also measured with the CES-D) (Barnes & Meyer, 2012). The authors of the aforementioned study suggested that internalized homophobia may not be a direct contributor to mental health and instead that internalized homophobia diminishes the potential mitigative effect of religion on mental health outcomes. The last question addressed demographic factors in a binary logistic model to observe demographic causes for suicidal contemplation. The CRS-15 was used as a demographic measure for religion, as it covers multiple domains and captures those who do not practice religion as well. Race category and CRS-15 score were not significant contributors to the model; however, gender and sexual minorities had threefold odds for contemplating suicide compared to their cisgender, straight peers. Overall, quantitative observed a potential link between internalized homophobia and religiosity. Further investigation is needed to determine if there is a causal relationship between internalized homophobia, religiosity, and outcomes related to well-being. Qualitative findings observed that individuals experienced a variety of positive, negative, and neutral impact of religion. Those individuals with negative experiences described experiences analogous to the minority stress model, further supporting some interplay between minority stress and religion.

5.3 Limitations

There were several limitations to the qualitative analysis. First, many respondents endorsed Catholic, Latter-Day Saints (Mormon), Islamic, and Christian belief systems. Thus, it

cannot be assumed is likely not representative of the entire GSM population. Future research should be aimed at examining a broader scope of experiences beyond the Abrahamic traditions. Secondly, it could be that GSM individuals more adversely impacted by the religious factors were more likely to share their experiences. Further, for each ecological domain observed (personal, peer/family, and institutional levels), 69-77 short responses were generated. Responses were not easily attributable to the social-ecological domains and instead reflected broad negative religious experiences, so the utility of targeted intervention based on a specific level cannot be observed—additionally, the most prominent limitation of the qualitative analysis in the study related to sample size. The pre-Covid plan to visit churches, GSM-oriented organizations, and other religious institutions to collect surveys and complete interviews may have allowed access to and representation of a subset of people who are less likely to use the internet. Lastly, bias caused by researcher characteristics might have impacted data collection. Despite being an online survey, most data were collected in Kansas and Georgia, residences of the researcher. Data may have been different if collected from other regions or states. Additionally, the researcher's own personal identity as a queer Ex-Mormon and the second coder's identity as a cisgender, heterosexual could have introduced bias. In the future, member checking or may help address this bias.

Quantitative limitations aligned with limitations discussed previously. Namely, selection and sample bias also arose in this area of the study. Firstly, religious denominations, racial and ethnic groups, and each sexual orientation and gender identity are vastly diverse groups. This necessitates representation from several categories and perspectives to truly be able to generalize findings. Additionally, transgender and gender-nonconforming individuals are often underrepresented in research, despite being at the highest risk for suicidality. Findings could not

gain a full perspective of the impact of religion on mental health for these individuals. This study was conducted online, and convenience sampling was used to collect data. Those in demographic groups similar to the author were more likely to complete the survey (LDS/Mormon people, people from Kansas, and people from Georgia). Additionally, the survey was shared on a university campus, which may have skewed demographics. Survey participants were also made aware that the study covered sensitive topics; thus, people who were sensitive to the topics of religion and suicide may have abstained from the survey.

Additionally, on the CRS-15 religiosity measure, a coding error occurred, and a 8-point survey item had to be recoded to a 6-point item (item 3). Regarding the DHEQ heterosexist experiences measure, select subscales from the study were used instead of the full measure, which was deemed an acceptable practice by the author; however, the overarching construct of distress caused by stressors other than heterosexism could not be analyzed as a whole. The DHEQ examines isolation, vigilance, and victimization, which are more distal, external stressors than internalized homophobia. These scales were correlated with mental health measures. Future research might observe the total scale in relation to depression and suicide scales.

5.3.1 COVID-19 Impact on Suicide and Depression

Data for this study were collected from January to March 2021 during the COVID-19 pandemic. Thus, indicators of well-being (depression and suicidality score) scores may have been elevated across groups. A study completed in August 2020 for an international sample (United Kingdom, India, China, Vietnam) reported depression prevalence at 25% compared to 3.44% in 2017 (Bueno-Notivol et al., 2021). In a United States sample, the prevalence was three times higher (from 8.5% to 27.8%) during the COVID-19 pandemic than before (Ettman et al., 2020). In this study, depression symptomology was associated with having lower income and

higher exposure to COVID-19 specific stressors (like family member illness or losing employment). Since the CES-D scale measures depression symptomology for the week up to completing the measure, results indicate depression state for a short period and may be suspectable to life events. Additionally, the majority of the sample identified as women and women tend to display higher rates of depression than men. The MINI Suicidality scale observes suicide risk for the month up to data collection and thus may have been associated with COVID-19 related events as well.

5.4 Future Directions and Implications

Future research should attempt to address the generalizability of the factors in the study to be more representative of the US population and the gender and sexual minority population in the United States. For this to occur, a wider range of religious denominations and racial and ethnic minorities should be observed. In addition, the qualitative analysis indicated that many individuals had experienced former conflict between their sexual orientation and religious beliefs. It may benefit the field to examine the impact on religious factors and depression and suicidality, specifically in GSM youth populations. Longitudinal analyses of gender and sexual minority children may be able to provide perspective on the development of religion-specific internalized homophobia and other minority stressors. Additionally, differences between the religious denominations regarding GSM acceptance, ordination, and teachings/scripture may indicate that LGBT experiences may need to be addressed within each individual institution. Several individuals indicated that they experienced the dissonance between their identity and their religion at one point in their lives. It could be the case that certain religious or social-economic factors are more likely to cause this dissonance than others. In the future, qualitative interviews could be conducted with individuals experiencing this phenomenon in an attempt to

determine the etiology and impact of distress. Additionally, gathering a larger sample of ethnic minorities and examining ethnic minority stressors, in conjunction with gender and sexuality minority stressors, could better indicate the potential existence of the intersection of minority stress and religion.

Internalized homophobia may suppress the potential benefit that religious experience may have on the population (Barnes & Meyer, 2012). Due to the low number of gender and sexual minority participants, we could not quantitatively examine the differences between individuals from self-described affirming religions, tolerating, or non-accepting religions to align with previous literature, which found that GSM individuals who experienced affirming religious groups have lower internalized homophobia and more positive mental health outcomes than their peers in discriminatory religions groups (Lease et al., 2005). Qualitative findings in the current study did indicate that many GSM individuals perceived their religious experiences as contributing positively to their mental health. This finding indicates that there may be institutional, peer, personal, and family characteristics that foster positive well-being for these individuals. Future analysis to discover environmental components that allow foster acceptance and well-being may prove necessary for the community. Those who experienced these positive religious impacts discussed feeling accepted and welcomed rather than rejected like others. For those who experienced actual or feared rejection, most individuals described being shunned by family or having a fear of being rejected by family members. Accessible educational interventions for parents and families in workplaces, religious institutions, and other locations may be implemented to educate the public about the cost of discrimination on the gender and sexual minority population. Specifically, interventions that build parental autonomy and

encourage parents to choose their child's mental health over the opinions of institutions should be fostered.

Culturally specific programing targeted to exposing religious individuals to affirming religions should be examined as a means for reducing the potential impact of harmful experiences. Conversely, investigation of potential benefits of non-religious affiliated substitutes via programming or education should be observed for their mitigative impact on GSM religious persecution. The qualitative analysis displayed that some individuals experienced a shift in their own personal religious beliefs that aided in resolving the dissonance caused by religious exposure. The utility of programming and therapeutic resources targeted at aiding individuals through the process may be necessary. Importantly, initiatives aimed at addressing the causes of stigma, harassment, and discrimination toward gender and sexual minorities should be embedded in policy and practice. For example, conversion therapies or sexual orientation change efforts are often perpetuated by religious leaders or institutions, and regulatory boards for psychotherapy practice could prohibit the practice (Drescher et al., 2016; Mallory et al., 2019). Furthermore, analysis of the mental health impact of this and other discriminatory policies that are proposed or in existence (e.g., transgender sports and bathroom bans, and religious freedom exemptions in schools, healthcare, foster care).

5.5 Conclusion

Suicide rates continue to rise in the US and internationally. Researchers and practitioners must address all factors, minute and large, that lead to increased symptomology, especially for our most vulnerable populations. It is suggested that future research should be aimed not only at psychopathology and personality factors that relate to mental health for groups who experience oppression. Instead, further examination about enduring social institutions and their impact on

minority well-being should be addressed. In American society, where almost half of transgender people endorse attempting suicide at some point in their lives, reducing minority stress could be revolutionary (James et al., 2016). Changing exclusionary religious doctrine and practices may be the most difficult area for intervention. However, actors and stakeholders outside of these institutions might mediate the impact of internalized stigma and suicidality.

REFERENCES

REFERENCES

Agoramoorthy, G., & Hsu, M. J. (2017). The suicide paradigm: Insights from ancient Hindu scriptures. *Journal of Religion and Health, 56*(3), 807–816. https://doi.org/10.1007/s10943-015-0178-3

Alderson, K. G. (2003). The ecological model of gay male identity. *The Canadian Journal of Human Sexuality*, *12*(2), 75+. https://link.gale.com/apps/doc/A114049356/AONE?u=ksstate_wichita&sid=AONE&xid=7fb8b010

Alipour, M. (2017). Islamic shari'a law, neotraditionalist Muslim scholars and transgender sex-reassignment surgery: A case study of Ayatollah Khomeini's and Sheikh al-Tantawi's fatwas. *International Journal of Transgenderism*, *18*(1), 91–103. https://doi.org/10.1080/15532739.2016.1250239

American Baptist Churches. (n.d.). *American Baptist Churches USA: responses/actions pertaining to homosexuality*. Religious Institute. http://religiousinstitute.org/denom_statements/american-baptist-churches-usa-responsesactions-pertaining-to-homosexuality/

Assemblies of God. (2014). *Homosexuality, Marriage, and Sexual Identity*. Ag.Org. https://ag.org/beliefs/position-papers/homosexuality-marriage-and-sexual-identity

Balsam, K. F., Beadnell, B., & Molina, Y. (2013). The daily heterosexist experiences questionnaire: measuring minority stress among lesbian, gay, bisexual, and transgender adults. *Measurement and Evaluation in Counseling and Development*, *46*(1), 3–25. https://doi.org/10.1177/0748175612449743

Barnes, D. M., & Meyer, I. H. (2012). Religious affiliation, internalized homophobia, and mental health in lesbians, gay men, and bisexuals. *American Journal of Orthopsychiatry*, *82*(4), 505–515. https://doi.org/10.1111/j.1939-0025.2012.01185.x

Barringer, M. N. (2020). Lesbian, gay, and bisexual individuals' perceptions of american religious traditions. *Journal of Homosexuality*, *67*(9), 1173–1196. https://doi.org/10.1080/00918369.2019.1582221

Blackwood, E. (2005). Transnational sexualities in one place: Indonesian readings. *Gender & Society*, *19*(2), 221–242. https://doi.org/10.1177/0891243204272862

Blaine, B. E., Trivedi, P., & Eshleman, A. (1998). Religious belief and the self-concept: Evaluating the implications for psychological adjustment. *Personality and Social Psychology Bulletin*, *24*(10), 1040–1052. https://doi.org/10.1177/01461672982410002

Bostock v. Clayton County, 590 U.S. ___ (2019), (2019).

Box, G. E. P., & Tidwell, P. W. (1962). Transformation of the independent variables. *Technometrics*, *4*(4), 531–550. https://doi.org/10.1080/00401706.1962.10490038

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Brewster, M. E., Velez, B. L., Foster, A., Esposito, J., & Robinson, M. A. (2016). Minority stress and the moderating role of religious coping among religious and spiritual sexual minority individuals. *Journal of Counseling Psychology*, *63*(1), 119–126. https://doi.org/10.1037/cou0000121

Bueno-Notivol, J., Gracia-García, P., Olaya, B., Lasheras, I., López-Antón, R., & Santabárbara, J. (2021). Prevalence of depression during the COVID-19 outbreak: A meta-analysis of community-based studies. *International Journal of Clinical and Health Psychology*, *21*(1), 100196. https://doi.org/10.1016/j.ijchp.2020.07.007

Burke, D. (2020, January 17). The Methodist Church will probably split in two over homosexuality, and that's bad for all of us. *CNN Religion*. https://www.cnn.com/2020/01/17/us/united-methodist-church-split-christianity/index.html

Byard, E., Kosciw, J., & Bartkiewicz, M. (2013). Schools and LGBT-parent families: Creating change through programming and advocacy. In A. E. Goldberg & K. R. Allen (Eds.), *LGBT-Parent Families* (pp. 275–290). Springer New York. https://doi.org/10.1007/978-1-4614-4556-2_18

Cadge, W., Day, H., & Wildeman, C. (2007). Bridging the denomination-congregation divide: Evangelical Lutheran church in America congregations respond to homosexuality. *Review of Religious Research*, *48*(3), 245–259. http://www.jstor.org/stable/20447442

Calabrese, S. K., Meyer, I. H., Overstreet, N. M., Haile, R., & Hansen, N. B. (2015). Exploring discrimination and mental health disparities faced by Black sexual minority women using a minority stress framework. *Psychology of Women Quarterly*, *39*(3), 287–304. https://doi.org/10.1177/0361684314560730

Canady, R. B., Stommel, M., & Holzman, C. (2009). Measurement Properties of the centers for epidemiological studies depression scale (CES-D) in a Sample of African American and Non-Hispanic White Pregnant Women. *Journal of Nursing Measurement*, *17*(2), 91–104. https://doi.org/10.1891/1061-3749.17.2.91

Cash, S. J., & Bridge, J. A. (2009). Epidemiology of youth suicide and suicidal behavior. *Current Opinion in Pediatrics*, *21*(5), 613–619. https://doi.org/10.1097/MOP.0b013e32833063e1

Centers for Disease Control and Prevention (2016). Sexual identity, sex of sexual contacts, and health-related behaviors among students in grades 9–12—United states and selected sites. *Surveillance Summaries*, *65*(9). https://www.cdc.gov/mmwr/volumes/65/ss/pdfs/ss6509.pdf

Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (2017). *WISQARS Injury Data*. CDC.Gov. https://www.cdc.gov/injury/wisqars/

Ching, T. H. W., Lee, S. Y., Chen, J., So, R. P., & Williams, M. T. (2018). A model of intersectional stress and trauma in Asian American sexual and gender minorities. *Psychology of Violence*, *8*(6), 657–668. https://doi.org/10.1037/vio0000204

Cho, S., Crenshaw, K. W., & McCall, L. (2013). Toward a field of intersectionality studies: Theory, applications, and praxis. *Signs: Journal of Women in Culture and Society, 38*(4), 785-810. https://doi-org/10.1086/669608

Clarke, J. M., Brown, J. C., & Hochstein, L. M. (1989). Institutional religion and gay/lesbian oppression. *Marriage & Family Review*, *14*(3–4), 265–284. https://doi.org/10.1300/J002v14n03_13

Clayton, R. R., & Gladden, J. W. (1974). The five dimensions of religiosity: Toward demythologizing a sacred artifact. *Journal for the Scientific Study of Religion*, *13*(2), 135. https://doi.org/10.2307/1384375

Clements-Nolle, K., Marx, R., & Katz, M. (2006). Attempted suicide among transgender persons: The influence of gender-based discrimination and victimization. *Journal of Homosexuality*, *51*(3), 53–69. https://doi.org/10.1300/J082v51n03_04

Colucci, E., & Martin, G. (2008). Religion and spirituality along the suicidal path. *Suicide and Life-Threatening Behavior*, *38*(2), 229–244. https://doi.org/10.1521/suli.2008.38.2.229

Compendium of the Catechism of the Catholic Church. (2015). Libreria. http://www.vatican.va/archive/compendium_ccc/documents/archive_2005_compendium-ccc_en.html

Congregation for the Clergy. (2016). *The Gift of the Priestly Vocation*. clerua.va. http://www.clerus.va/content/dam/clerus/Ratio%20Fundamentalis/The%20Gift%20of%20the%20Priestly%20Vocation.pdf

Consolacion, T. B., Russell, S. T., & Sue, S. (2004). Sex, race/ethnicity, and romantic attractions: Multiple minority status adolescents and mental health. *Cultural Diversity and Ethnic Minority Psychology*, *10*(3), 200–214. https://doi.org/10.1037/1099-9809.10.3.200

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

Dahl, A. L., & Galliher, R. V. (2010). Sexual minority young adult religiosity, sexual orientation conflict, self-esteem and depressive symptoms. *Journal of Gay & Lesbian Mental Health*, *14*(4), 271–290. https://doi.org/10.1080/19359705.2010.507413

Dervic, K., Oquendo, M. A., Grunebaum, M. F., Ellis, S., Burke, A. K., & Mann, J. J. (2004). Religious affiliation and suicide attempt. *American Journal of Psychiatry*, *161*(12), 2303–2308. https://doi.org/10.1176/appi.ajp.161.12.2303

Diaz, R. M., Ayala, G., Bein, E., & Henne, J. (2001). The impact of homophobia, poverty, and racism on the mental health of gay and bisexual Latino men: Findings from 3 US cities. *American Journal of Public Health*, *91*(6), 927–932. https://doi.org/10.2105/AJPH.91.6.927

Dodor, B. A., Robinson, M. A., Watson, R., Meetze, D., & Whicker, R. (2018). The impact of religiosity on substance abuse and obesity in African Americans. *Journal of Religion and Health*, *57*(4), 1315–1328. https://doi.org/10.1007/s10943-017-0501-2

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

Drescher, J., Schwartz, A., Casoy, F., McIntosh, C. A., Hurley, B., Ashley, K., Barber, M., Goldenberg, D., Herbert, S. E., Lothwell, L. E., Mattson, M. R., McAfee, S. G., Pula, J., Rosario, V., & Tompkins, D. A. (2016). The Growing regulation of conversion therapy. *Journal of Medical Regulation*, *102*(2), 7–12. https://doi.org/10.30770/2572-1852-102.2.7

Drinan, R. F., & Huffman, J. I. (1993). The religious freedom restoration act: A legislative history. *Journal of Law and Religion*, *10*(2), 531. https://doi.org/10.2307/1051146

English, D., Rendina, H. J., & Parsons, J. T. (2018). The effects of intersecting stigma: A longitudinal examination of minority stress, mental health, and substance use among Black, Latino, and multiracial gay and bisexual men. *Psychology of Violence*, *8*(6), 669–679. https://doi.org/10.1037/vio0000218

Ettman, C. K., Abdalla, S. M., Cohen, G. H., Sampson, L., Vivier, P. M., & Galea, S. (2020). Prevalence of depression symptoms in us adults before and during the COVID-19 pandemic. *JAMA Network Open*, *3*(9), e2019686. https://doi.org/10.1001/jamanetworkopen.2020.19686

Finlay, B., & Walther, C. S. (2003). The relation of religious affiliation, service attendance, and other factors to homophobic attitudes among university students. *Review of Religious Research*, *44*(4), 370. https://doi.org/10.2307/3512216

Florence, C., Haegerich, T., Simon, T., Zhou, C., & Luo, F. (2015). *Estimated lifetime medical and work-loss costs of emergency department–treated nonfatal injuries—United States, 2013*. Morbidity and Mortality Weekly Report 2015. *64* (38), 1074–1077. https://www.cdc.gov/mmwr/pdf/wk/mm6438.pdf

Gibbs, J. J., & Goldbach, J. (2015). Religious conflict, sexual identity, and suicidal behaviors among LGBT young adults. *Archives of Suicide Research*, *19*(4), 472–488. https://doi.org/10.1080/13811118.2015.1004476

Goldblum, P., Testa, R. J., Pflum, S., Hendricks, M. L., Bradford, J., & Bongar, B. (2012). The relationship between gender-based victimization and suicide attempts in transgender people. *Professional Psychology: Research and Practice*, *43*(5), 468–475. https://doi.org/10.1037/a0029605

Goldhammer, H., Krinsky, L., & Keuroghlian, A. S. (2019). Meeting the behavioral health needs of LGBT older adults. *Journal of the American Geriatrics Society*, *67*(8), 1565–1570. https://doi.org/10.1111/jgs.15974

Golub, S. A., Walker, J. J., Longmire-Avital, B., Bimbi, D. S., & Parsons, J. T. (2010). The role of religiosity, social support, and stress-related growth in protecting against HIV risk among transgender women. *Journal of Health Psychology*, *15*(8), 1135–1144. https://doi.org/10.1177/1359105310364169

Gonzalez, K. A., Ramirez, J. L., & Galupo, M. P. (2018). Increase in GLBTQ Minority Stress Following the 2016 US Presidential Election. *Journal of GLBT Family Studies*, *14*(1–2), 130–151. https://doi.org/10.1080/1550428X.2017.1420849

Griffin, L. C. (2015). A word of warning from a woman: arbitrary, categorical, and hidden religious exemptions threaten LGBT rights. *Scholarly Works*, 97–128 https://scholars.law.unlv.edu/facpub/986

Grubbs, J. B., Wilt, J., Stauner, N., Exline, J. J., & Pargament, K. I. (2016). Self, struggle, and soul: Linking personality, self-concept, and religious/spiritual struggle. *Personality and Individual Differences*, *101*, 144–152. https://doi.org/10.1016/j.paid.2016.05.365

Haas, A. P., Lane, A., & on behalf of the Working Group for Postmortem Identification of SO/GI. (2015). Collecting sexual orientation and gender identity data in suicide and other violent deaths: A step towards identifying and addressing lgbt mortality disparities. *LGBT Health*, *2*(1), 84–87. https://doi.org/10.1089/lgbt.2014.0083

Halkitis, P. N., Mattis, J. S., Sahadath, J. K., Massie, D., Ladyzhenskaya, L., Pitrelli, K., Bonacci, M., & Cowie, S.-A. E. (2009). The meanings and manifestations of religion and spirituality among lesbian, gay, bisexual, and transgender adults. *Journal of Adult Development*, *16*(4), 250–262. https://doi.org/10.1007/s10804-009-9071-1

Hall, W. J. (2018). Psychosocial risk and protective factors for depression among lesbian, gay, bisexual, and queer youth: A systematic review. *Journal of Homosexuality*, *65*(3), 263–316. https://doi.org/10.1080/00918369.2017.1317467

Hatchel, T., Ingram, K. M., Mintz, S., Hartley, C., Valido, A., Espelage, D. L., & Wyman, P. (2019). Predictors of suicidal ideation and attempts among LGBTQ adolescents: the roles of help-seeking beliefs, peer victimization, depressive symptoms, and drug use. *Journal of Child and Family Studies*, *28*(9), 2443–2455. https://doi.org/10.1007/s10826-019-01339-2

Hatzenbuehler, M. L. (2009). How does sexual minority stigma "get under the skin"? A psychological mediation framework. *Psychological Bulletin*, *135*(5), 707–730. https://doi.org/10.1037/a0016441

Hayes, J. A., Chun-Kennedy, C., Edens, A., & Locke, B. D. (2011). Do double minority students face double jeopardy? Testing minority stress theory. *Journal of College Counseling*,*4*(2), 117–126. https://doi.org/10.1002/j.2161-1882.2011.tb00267.x

Hedgegaard, H., Curtin, S. C., & Warner, M. (2018). *Suicide rates in the United States continue to increase.* (No. 309). National Center for Health Statistics. https://www.cdc.gov/nchs/products/databriefs/db309.htm

Herek, G. M. (2004). Beyond "Homophobia": Thinking about sexual prejudice and stigma in the twenty-first century. *Sexuality Research and Social Policy*, *1*(2), 6–24. https://doi.org/10.1525/srsp.2004.1.2.6

Herek, G. M., Cogan, J. C., Gillis, J. R., & Glunt, E. K. (1997). Correlates of internalized homophobia in a comunity sample of lesbians and gay men. *Journal of the Gay and Lesbian Medical Association*, *2*(1), 17–25.

Herek, G. M., Gillis, J. R., & Cogan, J. C. (2009). Internalized stigma among sexual minority adults: Insights from a social psychological perspective. *Journal of Counseling Psychology*, *56*(1), 32–43. https://doi.org/10.1037/a0014672

Hodges, S. (2020, January 3). *Diverse leaders' group offers separation plan*. UM News. https://www.umnews.org/en/news/diverse-leaders-group-offers-separation-plan

Holdcroft, B. B. (2006). What is religiosity? *Journal of Catholic Education*, *10*(1). https://doi.org/10.15365/joce.1001082013

Hopkinson, R. A., Keatley, E., Glaeser, E., Erickson-Schroth, L., Fattal, O., & Nicholson Sullivan, M. (2017). Persecution experiences and mental health of LGBT Asylum seekers. *Journal of Homosexuality*, *64*(12), 1650–1666. https://doi.org/10.1080/00918369.2016.1253392

Hoy-Ellis, C. P., & Fredriksen-Goldsen, K. I. (2017). Depression among transgender older adults: general and minority stress. *American Journal of Community Psychology*, *59*(3–4), 295–305. https://doi.org/10.1002/ajcp.12138

Human Rights Campaign (2018). *Stances of faith on LGBTQ issues*. HRC.org. https://www.hrc.org/resources/stances-of-faiths-on-lgbt-issues

Huber, S., & Huber, O. W. (2012). The centrality of religiosity scale (CRS). *Religions*, *3*(3), 710–724. https://doi.org/10.3390/rel3030710

Huynh, K. D., Sheridan, D. J., & Lee, D. L. (2020). Assessing the internalized homophobia scale for gender invariance. *Measurement and Evaluation in Counseling and Development*, 1–11. https://doi.org/10.1080/07481756.2020.1735202

Igartua, K. J., Gill, K., & Montoro, R. (2003). Internalized homophobia: a factor in depression, anxiety, and suicide in the gay and lesbian population. *Canadian Journal of Community Mental Health*, *22*(2), 15–30. https://doi.org/10.7870/cjcmh-2003-0011

Intahchomphoo, C. (2018, June). Social media and youth suicide: a systematic review. Twenty-Sixth European Conference on Information Systems (ECIS2018).

Irwin, J. A., Coleman, J. D., Fisher, C. M., & Marasco, V. M. (2014). Correlates of suicide ideation among LGBT Nebraskans. *Journal of Homosexuality*, *61*(8), 1172–1191. https://doi.org/10.1080/00918369.2014.872521

James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *Report of the 2015 U.S. Transgender Survey*. National Center for Transgender Equality. https://www.ustranssurvey.org/

Ji, C.-H. C., Perry, T., & Clarke-Pine, D. (2011). Considering personal religiosity in adolescent delinquency: The role of depression, suicidal ideation, and church guideline. *Journal of Psychology and Christianity*, *30*(1), 3-15. Gale Academic OneFile.

Jim, H. S. L., Pustejovsky, J. E., Park, C. L., Danhauer, S. C., Sherman, A. C., Fitchett, G., Merluzzi, T. V., Munoz, A. R., George, L., Snyder, M. A., & Salsman, J. M. (2015). Religion, spirituality, and physical health in cancer patients: A meta-analysis. *Cancer*, *121*(21), 3760–3768. https://doi.org/10.1002/cncr.29353

Kalibatseva, Z., Bathje, G. J., Wu, I. H. C., Bluestein, B. M., Leong, F. T. L., & Collins-Eaglin, J. (2020). Minority status, depression and suicidality among counseling center clients. *Journal of American College Health*, 1–10. https://doi.org/10.1080/07448481.2020.1745810

King, S. R., Hampton, W. R., Bernstein, B., & Schichor, A. (1996). College students' views on suicide. *Journal of American College Health*, *44*(6), 283–287. https://doi.org/10.1080/07448481.1996.9936856

Kleiman, E. M., & Liu, R. T. (2014). Prospective prediction of suicide in a nationally representative sample: Religious service attendance as a protective factor. *British Journal of Psychiatry*, *204*(4), 262–266. https://doi.org/10.1192/bjp.bp.113.128900

Kosciw, J. G., Greytak, E. A., & Diaz, E. M. (2009). Who, what, where, when, and why: Demographic and ecological factors contributing to hostile school climate for lesbian, gay, bisexual, and transgender youth. *Journal of Youth and Adolescence*, *38*(7), 976–988. https://doi.org/10.1007/s10964-009-9412-1

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

Kozee, H. B., Tylka, T. L., & Bauerband, L. A. (2012). Measuring transgender individuals' comfort with gender identity and appearance: Development and validation of the transgender congruence scale. *Psychology of Women Quarterly*, *36*(2), 179–196. https://doi.org/10.1177/0361684312442161

Kralovec, K., Fartacek, C., Fartacek, R., & Plöderl, M. (2014). Religion and suicide risk in lesbian, gay and bisexual Austrians. *journal of religion and health*, *53*(2), 413–423. https://doi.org/10.1007/s10943-012-9645-2

Kuper, L. E., Adams, N., & Mustanski, B. S. (2018). Exploring cross-sectional predictors of suicide ideation, attempt, and risk in a large online sample of transgender and gender nonconforming youth and young adults. *LGBT Health*, *5*(7), 391–400. https://doi.org/10.1089/lgbt.2017.0259

Lapinski, J., & McKirnan, D. (2013). Forgive me father for I have sinned: The role of a Christian upbringing on lesbian, gay, and bisexual identity development. *Journal of Homosexuality*, *60*(6), 853–872. https://doi.org/10.1080/00918369.2013.774844

Lawrence, R. E., Brent, D., Mann, J. J., Burke, A. K., Grunebaum, M. F., Galfalvy, H. C., & Oquendo, M. A. (2016). Religion as a risk factor for suicide attempt and suicide ideation among depressed patients. *The Journal of Nervous and Mental Disease*, *204*(11), 845–850. https://doi.org/10.1097/NMD.0000000000000484

Lease, S. H., Horne, S. G., & Noffsinger-Frazier, N. (2005). Affirming Faith experiences and psychological health for Caucasian Lesbian, gay, and bisexual individuals. *Journal of Counseling Psychology*, *52*(3), 378–388. https://doi.org/10.1037/0022-0167.52.3.378

Ledet, R. (2017). Competing claims: Religious affiliation and African Americans' Intolerance of Homosexuals. *Journal of Homosexuality*, *64*(6), 786–803. https://doi.org/10.1080/00918369.2016.1236580

Lester, D., & Walker, R. L. (2017). Religiosity is a protective factor for suicidal ideation in European American students but not in African American students. *OMEGA - Journal of Death and Dying*, *74*(3), 295–303. https://doi.org/10.1177/0030222815598452

Lomash, E. F., Brown, T. D., & Galupo, M. P. (2019). "A whole bunch of love the sinner hate the sin": LGBTQ microaggressions experienced in religious and spiritual context. *Journal of Homosexuality*, *66*(10), 1495–1511. https://doi.org/10.1080/00918369.2018.1542204

Luxton, D. D., June, J. D., & Fairall, J. M. (2012). Social media and suicide: A public health perspective. *American Journal of Public Health*, *102*(S2), S195–S200. https://doi.org/10.2105/AJPH.2011.300608

Lytle, M. C., Blosnich, J. R., De Luca, S. M., & Brownson, C. (2018). Association of religiosity with sexual minority suicide ideation and attempt. *American Journal of Preventive Medicine*, *54*(5), 644–651. https://doi.org/10.1016/j.amepre.2018.01.019

Mallory, C., Brown, T. N. T., & Conron, K. (2019). *Conversion Therapy and LGBT Youth: Update*. UCLA School of Law, Williams Institute.

Masini, B. E., & Barrett, H. A. (2008). Social support as a predictor of psychological and physical well-being and lifestyle in lesbian, gay, and bisexual adults aged 50 and over. *Journal of Gay & Lesbian Social Services*, *20*(1–2), 91–110. https://doi.org/10.1080/10538720802179013

McCarthy, M. A., Fisher, C. M., Irwin, J. A., Coleman, J. D., & Pelster, A. D. K. (2014). Using the Minority stress model to understand depression in lesbian, gay, bisexual, and transgender individuals in Nebraska. *Journal of Gay & Lesbian Mental Health*, *18*(4), 346–360. https://doi.org/10.1080/19359705.2014.908445

McKinney, W. (1998). Mainline Protestantism 2000. *The ANNALS of the American Academy of Political and Social Science*, *558*(1), 57–66. https://doi.org/10.1177/0002716298558001006

McLaren, S. (2016). The Interrelations Between Internalized Homophobia, Depressive Symptoms, and Suicidal Ideation Among Australian Gay Men, Lesbians, and Bisexual Women. *Journal of Homosexuality*, *63*(2), 156–168. https://doi.org/10.1080/00918369.2015.1083779

McLeroy, K. R., Bibeau, D., Steckler, A., & Glanz, K. (1988). An Ecological Perspective on Health Promotion Programs. *Health Education Quarterly*, *15*(4), 351–377. https://doi.org/10.1177/109019818801500401

Meanley, S., Pingel, E. S., & Bauermeister, J. A. (2016). Psychological well-being among religious and spiritual-identified young gay and bisexual men. *Sexuality Research and Social Policy*, *13*(1), 35–45. https://doi.org/10.1007/s13178-015-0199-4

Melton, J. G. (2005). *Encyclopedia of Protestantism*. Infobase Publishing.

Mereish, E. H., O'Cleirigh, C., & Bradford, J. B. (2014). Interrelationships between LGBT-based victimization, suicide, and substance use problems in a diverse sample of sexual and gender minorities. *Psychology, Health & Medicine*, *19*(1), 1–13. https://doi.org/10.1080/13548506.2013.780129

Meyer, I. H. (1995). Minority Stress and Mental Health in Gay Men. *Journal of Health and Social Behavior*, *36*(1), 38. https://doi.org/10.2307/2137286

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

Moody, C., & Smith, N. G. (2013). Suicide protective factors among trans adults. *Archives of Sexual Behavior*, *42*(5), 739–752. https://doi.org/10.1007/s10508-013-0099-8

Moscardini, E. H., Douglass, R. P., Conlin, S. E., & Duffy, R. D. (2018). Minority stress and life meaning among bisexual adults: The role of religiosity. *Psychology of Sexual Orientation and Gender Diversity, 5*(2), 194–203. https://doi.org/10.1037/sgd0000284

Mustanski, B., & Liu, R. T. (2013). A longitudinal study of predictors of suicide attempts among lesbian, gay, bisexual, and transgender youth. *Archives of Sexual Behavior*, *42*(3), 437–448. https://doi.org/10.1007/s10508-012-0013-9

National Baptist Convention Admin. (2014). *Policy Statement and Guidelines to Chaplains Regarding Same-Gender Couples*. https://www.nationalbaptist.com/policy-statement-guidelines-chaplains-regarding-gender-couples

National Center for Transgender Equality. (2016, July 9). *Understandig transgender people: The basics*. Transequality.Org. https://transequality.org/issues/resources/understanding-transgender-people-the-basics

Neeleman, J., Halpern, D., Leon, D., & Lewis, G. (1997). Tolerance of suicide, religion and suicide rates: An ecological and individual study in 19 Western countries. *Psychological Medicine*, *27*(5), 1165–1171. https://doi.org/10.1017/S0033291797005357

Neeleman, J., Wessely, S., & Lewis, G. (1998). Suicide acceptability in African and White Americans: The Role of religion. *The Journal of Nervous &amp Mental Disease*, *186*(1), 12–16. https://doi.org/10.1097/00005053-199801000-00003

Nkansah-Amankra, S., Diedhiou, A., Agbanu, S. K., Agbanu, H. L. K., Opoku-Adomako, N. S., & Twumasi-Ankrah, P. (2012). A longitudinal evaluation of religiosity and psychosocial determinants of suicidal behaviors among a population-based sample in the United States. *Journal of Affective Disorders*, *139*(1), 40–51. https://doi.org/10.1016/j.jad.2011.12.027

Nock, M. K., Hwang, I., Sampson, N. A., & Kessler, R. C. (2010). Mental disorders, comorbidity and suicidal behavior: Results from the national comorbidity survey replication. *Molecular Psychiatry*, *15*(8), 868–876. https://doi.org/10.1038/mp.2009.29

Office of the General Council. (2015, July 28). *Memo on same sex ruling*. Cogic.Org. https://www.cogic.org/blog/memo-on-same-sex-ruling/

Olson, K. R., Durwood, L., DeMeules, M., & McLaughlin, K. A. (2016). Mental Health of transgender children who are supported in their identities. *Pediatrics*, *137*(3), e20153223. https://doi.org/10.1542/peds.2015-3223

Parra, L. A., Benibgui, M., Helm, J. L., & Hastings, P. D. (2016). Minority stress predicts depression in lesbian, gay, and bisexual emerging adults via elevated diurnal cortisol. *Emerging Adulthood*, *4*(5), 365–372. https://doi.org/10.1177/2167696815626822

Parsons, G. (2014). *A message from the stated clerk Gary Parsons 221st General Assembly*. Office of the General Assembly. https://oga.pcusa.org/section/ga/ga221/message-stated-clerk-grady-parsons-marriage/

Pereira, H., & Rodrigues, P. (2015). Internalized homophobia and suicidal ideation among LGB youth. *Journal of Psychiatry*, *18*(2). https://doi.org/10.4172/Psychiatry.1000229

Perez-Brumer, A., Hatzenbuehler, M. L., Oldenburg, C. E., & Bockting, W. (2015). Individual- and structural-level risk factors for suicide attempts among transgender adults. *Behavioral Medicine*, *41*(3), 164–171. https://doi.org/10.1080/08964289.2015.1028322

Pew Research Center. (2015). *America's changing religious landscape.* Pew Research Center. https://www.pewforum.org/2015/05/12/americas-changing-religious-landscape/

Pirutinsky, S., Rosmarin, D. H., & Holt, C. L. (2012). Religious coping moderates the relationship between emotional functioning and obesity. *Health Psychology*, *31*(3), 394–397. https://doi.org/10.1037/a0026665

Puckett, J. A., Woodward, E. N., Mereish, E. H., & Pantalone, D. W. (2015). Parental rejection following sexual orientation disclosure: Impact on internalized homophobia, social support, and mental health. *LGBT Health*, *2*(3), 265–269. https://doi.org/10.1089/lgbt.2013.0024

Radloff, L. S. (1977). The CES-D Scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement, 1*(3), 385–401. https://doi.org/10.1177/014662167700100306

Radloff, L. S. (1991). The use of the center for epidemiologic studies depression scale in adolescents and young adults. *Journal of Youth and Adolescence*, *20*(2), 149–166. https://doi.org/10.1007/BF01537606

Rahman, M. (2010). Queer as intersectionality: Theorizing gay Muslim identities. *Sociology*, *44*(5), 944–961. https://doi.org/10.1177/0038038510375733

Raifman, J., Moscoe, E., Austin, S. B., & McConnell, M. (2017). Difference-in-differences analysis of the association between state same-sex marriage policies and adolescent suicide attempts. *JAMA Pediatrics*, *171*(4), 350. https://doi.org/10.1001/jamapediatrics.2016.4529

Ramirez, J. L., & Galupo, M. P. (2019). Multiple minority stress: The role of proximal and distal stress on mental health outcomes among lesbian, gay, and bisexual people of color. *Journal of Gay & Lesbian Mental Health*, *23*(2), 145–167. https://doi.org/10.1080/19359705.2019.1568946

Rasic, D. T., Belik, S.-L., Elias, B., Katz, L. Y., Enns, M., & Sareen, J. (2009). Spirituality, religion and suicidal behavior in a nationally representative sample. *Journal of Affective Disorders*, *114*(1–3), 32–40. https://doi.org/10.1016/j.jad.2008.08.007

Ream, G. L. (2020). An Investigation of the LGBTQ+ youth suicide disparity using national violent death reporting system narrative data. *Journal of Adolescent Health*, *66*(4), 470–477. https://doi.org/10.1016/j.jadohealth.2019.10.027

Remafedi, G., French, S., Story, M., Resnick, M. D., & Blum, R. (1998). The relationship between suicide risk and sexual orientation: Results of a population-based study. *American Journal of Public Health*, *88*(1), 57–60. https://doi.org/10.2105/AJPH.88.1.57

Roaldset, J. O., Linaker, O. M., & Bjørkly, S. (2012). Predictive validity of the mini suicidal scale for self-harm in acute psychiatry: A prospective study of the first year after discharge. *Archives of Suicide Research*, *16*(4), 287–302. https://doi.org/10.1080/13811118.2013.722052

Robins, A., & Fiske, A. (2009). Explaining the Relation between Religiousness and Reduced Suicidal Behavior: Social Support Rather Than Specific Beliefs. *Suicide and Life-Threatening Behavior*, *39*(4), 386–395. https://doi.org/10.1521/suli.2009.39.4.386

Robinson, J. A., Bolton, J. M., Rasic, D., & Sareen, J. (2012). Exploring the relationship between religious service attendance, mental disorder, adn suicidality among different ethnic groups: Results from a nationally representative survey: Research article: Ethnic and religious differences in mental health. *Depression and Anxiety*, *29*(11), 983–990. https://doi.org/10.1002/da.21978

Rodriguez, E. M., & Etengoff, C. (2016). Religious workplaces: The Joys, trials and tribulations of LGBT clergy. In T. Köllen (Ed.), *Sexual Orientation and Transgender Issues in Organizations* (pp. 181–196). Springer International Publishing. https://doi.org/10.1007/978-3-319-29623-4_11

Romijnders, K. A., Wilkerson, J. M., Crutzen, R., Kok, G., Bauldry, J., Lawler, S. M., & the Montrose Center. (2017). Strengthening social ties to increase confidence and self-esteem among sexual and gender minority youth. *Health Promotion Practice*, *18*(3), 341–347. https://doi.org/10.1177/1524839917690335

Rood, B. A., Reisner, S. L., Surace, F. I., Puckett, J. A., Maroney, M. R., & Pantalone, D. W. (2016). Expecting rejection: Understanding the minority stress experiences of transgender and gender-nonconforming individuals. *Transgender Health*, *1*(1), 151–164. https://doi.org/10.1089/trgh.2016.0012

Rowatt, W. C., LaBouff, J., Johnson, M., Froese, P., & Tsang, J.-A. (2009). Associations among religiousness, social attitudes, and prejudice in a national random sample of American adults. *Psychology of Religion and Spirituality*, *1*(1), 14–24. https://doi.org/10.1037/a0014989

Rushing, N. C., Corsentino, E., Hames, J. L., Sachs-Ericsson, N., & Steffens, D. C. (2013). The relationship of religious involvement indicators and social support to current and past suicidality among depressed older adults. *Aging & Mental Health*, *17*(3), 366–374. https://doi.org/10.1080/13607863.2012.738414

Ryan, C., Russell, S. T., Huebner, D., Diaz, R., & Sanchez, J. (2010). Family acceptance in adolescence and the health of LGBT young adults: Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing*, *23*(4), 205–213. https://doi.org/10.1111/j.1744-6171.2010.00246.x

Ryan, C., Toomey, R. B., Diaz, R. M., & Russell, S. T. (2020). Parent-initiated sexual orientation change efforts with LGBT adolescents: Implications for young adult mental health and adjustment. *Journal of Homosexuality*, *67*(2), 159–173. https://doi.org/10.1080/00918369.2018.1538407

Salway, T., Plöderl, M., Liu, J., & Gustafson, P. (2019). Effects of Multiple forms of information bias on estimated prevalence of suicide attempts according to sexual orientation: an application of a Bayesian misclassification correction method to data from a systematic review. *American Journal of Epidemiology*, *188*(1), 239–249. https://doi.org/10.1093/aje/kwy200

Sander, W. (2017). Religion, religiosity, and happiness. *Review of Religious Research*, *59*(2), 251–262. https://doi.org/10.1007/s13644-017-0285-6

Savin-Williams, R. C., & Ream, G. L. (2003). Suicide attempts among sexual-minority male youth. *Journal of Clinical Child & Adolescent Psychology*, *32*(4), 509–522. https://doi.org/10.1207/S15374424JCCP3204_3

Schnabel, L. (2016). Gender and homosexuality attitudes across religious groups from the 1970s to 2014: Similarity, distinction, and adaptation. *Social Science Research*, *55*, 31–47. https://doi.org/10.1016/j.ssresearch.2015.09.012

Seelman, K. L. (2016). Transgender adults' access to college bathrooms and housing and the relationship to suicidality. *journal of Homosexuality*, *63*(10), 1378–1399. https://doi.org/10.1080/00918369.2016.1157998

Seybold, K. S., & Hill, P. C. (2001). The role of religion and spirituality in mental and physical health. *Current Directions in Psychological Science*, *10*(1), 21–24. https://doi.org/10.1111/1467-8721.00106

Shangani, S., Gamarel, K. E., Ogunbajo, A., Cai, J., & Operario, D. (2020). Intersectional minority stress disparities among sexual minority adults in the USA: The role of race/ethnicity and socioeconomic status. *Culture, Health & Sexuality*, *22*(4), 398–412. https://doi.org/10.1080/13691058.2019.1604994

Sheehan, D., Janavs, J., Baker, R., Harnett-Sheehan, K., Knapp, E., Sheehan, M., Lecrubier, Y., Weiller, E., Hergueta, P., Amorim, P., Bonora, L. I., & Lepine, J. P. (2002). *M.I.N.I. Mini international neuropsychiatric interview: English Version 5.0.0*.

Shilo, G., & Savaya, R. (2011). Effects of family and friend support on LGB youths' mental health and sexual orientation milestones. *Family Relations*, *60*(3), 318–330. https://doi .org/10.1111/j.1741-3729.2011.00648.x

Simmons, B. W. (2017). *Coming out Mormon: An examination of religious orientation, spiritual trauma, and PTSD among Mormons and ex-Mormon LGBTQQA adults (Doctoral dissertation)*. https://getd.libs.uga.edu/pdfs/simmons_brian_w_201712_phd.pdf

Simpson, M. E., & Conklin, G. H. (1989). Socioeconomic development, suicide and religion: a test of Durkheim's theory of religion and suicide. *Social Forces*, *67*(4), 945. https://doi.org/10.2307/2579709

Slomowitz, A., & Feit, A. (2015). Does God Make Referrals? Orthodox Judaism and Homosexuality. *Journal of Gay & Lesbian Mental Health*, *19*(1), 100–111. https://doi.org/10.1080/19359705.2014.975583

Snapp, S. D., Watson, R. J., Russell, S. T., Diaz, R. M., & Ryan, C. (2015). Social support networks for LGBT young adults: Low cost strategies for positive adjustment. *Family Relations*, *64*(3), 420–430. https://doi.org/10.1111/fare.12124

Southern Baptist Convention. (2012). *On "same-sex marriage" and civil rights rhetoric*. SBC.net. https://www.sbc.net/resource-library/resolutions/on-same-sex-marriage-and-civil-rights-rhetoric/

Southern Baptist Convention. (2014). *On transgender identity*. SBC.net http://www.sbc.net/resolutions/2250/on-transgender-identity

Spencer, R. J., Ray, A., Pirl, W. F., & Prigerson, H. G. (2012). Clinical correlates of suicidal thoughts in patients with advanced cancer. *The American Journal of Geriatric Psychiatry*, *20*(4), 327–336. https://doi.org/10.1097/JGP.0b013e318233171a

Stack, S. (1983a). The Effect of the Decline in Institutionalized Religion on Suicide, 1954-1978. *Journal for the Scientific Study of Religion*, *22*(3), 239. https://doi.org/10.2307/1385968

Stack, S. (1983b). The Effect of Religious Commitment on Suicide: A Cross-National Analysis. *Journal of Health and Social Behavior*, *24*(4), 362. https://doi.org/10.2307/2136402

Standley, C. J. (2020). Expanding our paradigms: Intersectional and socioecological approaches to suicide prevention. *Death Studies*, 1–9. https://doi.org/10.1080/07481187.2020.1725934

Stokols, D., Allen, J., & Bellingham, R. L. (1996). The social ecology of health promotion: Implications for research and practice. *American Journal of Health Promotion*, *10*(4), 247–251. https://doi.org/10.4278/0890-1171-10.4.247

Sumner, S. A., Galik, S., Mathieu, J., Ward, M., Kiley, T., Bartholow, B., Dingwall, A., & Mork, P. (2019). Temporal and geographic patterns of social media posts about an emerging suicide game. *Journal of Adolescent Health*, *65*(1), 94–100. https://doi.org/10.1016/j.jadohealth.2018.12.025

Szymanski, D. M. (2005). Heterosexism and sexism as correlates of psychological distress in lesbians. *Journal of Counseling & Development*, *83*(3), 355–360. https://doi.org/10.1002/j.1556-6678.2005.tb00355.x

Szymanski, D. M., Kashubeck-West, S., & Meyer, J. (2008). Internalized heterosexism: a historical and theoretical overview. *The Counseling Psychologist*, *36*(4), 510–524. https://doi.org/10.1177/0011000007309488

Tebbe, E. A., & Moradi, B. (2016). Suicide risk in trans populations: An application of minority stress theory. *Journal of Counseling Psychology*, *63*(5), 520–533. https://doi.org/10.1037/cou0000152

The Church of Jesus Christ of Latter-Day Saints. (2010). *Handbook 2: administering the church*. https://www.churchofjesuschrist.org/bc/content/shared/content/english/pdf/language-materials/08702_eng.pdf?lang=eng

Turban, J. L., Beckwith, N., Reisner, S. L., & Keuroghlian, A. S. (2020). Association between recalled exposure to gender identity conversion efforts and psychological distress and suicide attempts among transgender adults. *JAMA Psychiatry*, *77*(1), 68. https://doi.org/10.1001/jamapsychiatry.2019.2285

Turecki, G., & Brent, D. A. (2016). Suicide and suicidal behaviour. *The Lancet*, *387*(10024), 1227–1239. https://doi.org/10.1016/S0140-6736(15)00234-2

Umar, M. (2020). *Homosexuality in Islam: Clarifying the boundaries*. Fiquhcouncil.Org. http://fiqhcouncil.org/homosexuality-in-islam-clarifying-the-boundaries-2/

U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. (2012). *2012 National strategy for suicide prevention: Goals and objectives for action*. US Department of Health and Human Services, Office of the Surgeon General. https://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full-report.pdfpdf icon

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2019). *National Survey on Drug Use and Health 2018 (NSDUH-2016-DS0001)*. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. https://www.samhsa.gov/data/report/2018-nsduh-detailed-tables

VanderWeele, T. J., Li, S., Tsai, A. C., & Kawachi, I. (2016). Association between religious service attendance and lower suicide rates among US women. *JAMA Psychiatry*, *73*(8), 845. https://doi.org/10.1001/jamapsychiatry.2016.1243

Walker, R. L., & Bishop, S. (2005). Examining a model of the relation between religiosity and suicidal ideation in a sample of African American and White college students. *Suicide and Life-Threatening Behavior*, *35*(6), 630–639. https://doi.org/10.1521/suli.2005.35.6.630

Wang, K., & Pachankis, J. E. (2016). Gay-related rejection sensitivity as a risk factor for condomless sex. *AIDS and Behavior*, *20*(4), 763–767. https://doi.org/10.1007/s10461-015-1224-6

Waters, E., Jindasurat, C., & Wolfe, C. (2016). *Lesbian, gay, bisexual, transgender, queer, and hiv-affected hate violence in 2015*. National Coalition of Anti-Violence Programs (NCAVP). https://avp.org/wp-content/uploads/2017/04/ncavp_hvreport_2015_final.pdf

White Hughto, J. M., Reisner, S. L., & Pachankis, J. E. (2015). Transgender stigma and health: A critical review of stigma determinants, mechanisms, and interventions. *Social Science & Medicine*, *147*, 222–231. https://doi.org/10.1016/j.socscimed.2015.11.010

Whitley, B. E. (2009). Religiosity and attitudes toward lesbians and gay men: A meta-analysis. *International Journal for the Psychology of Religion*, *19*(1), 21–38. https://doi.org/10.1080/10508610802471104

Williams, S. L., Mann, A. K., & Fredrick, E. G. (2017). Proximal minority stress, psychosocial resources, and health in sexual minorities. *Journal of Social Issues*, *73*(3), 529–544. https://doi.org/10.1111/josi.12230

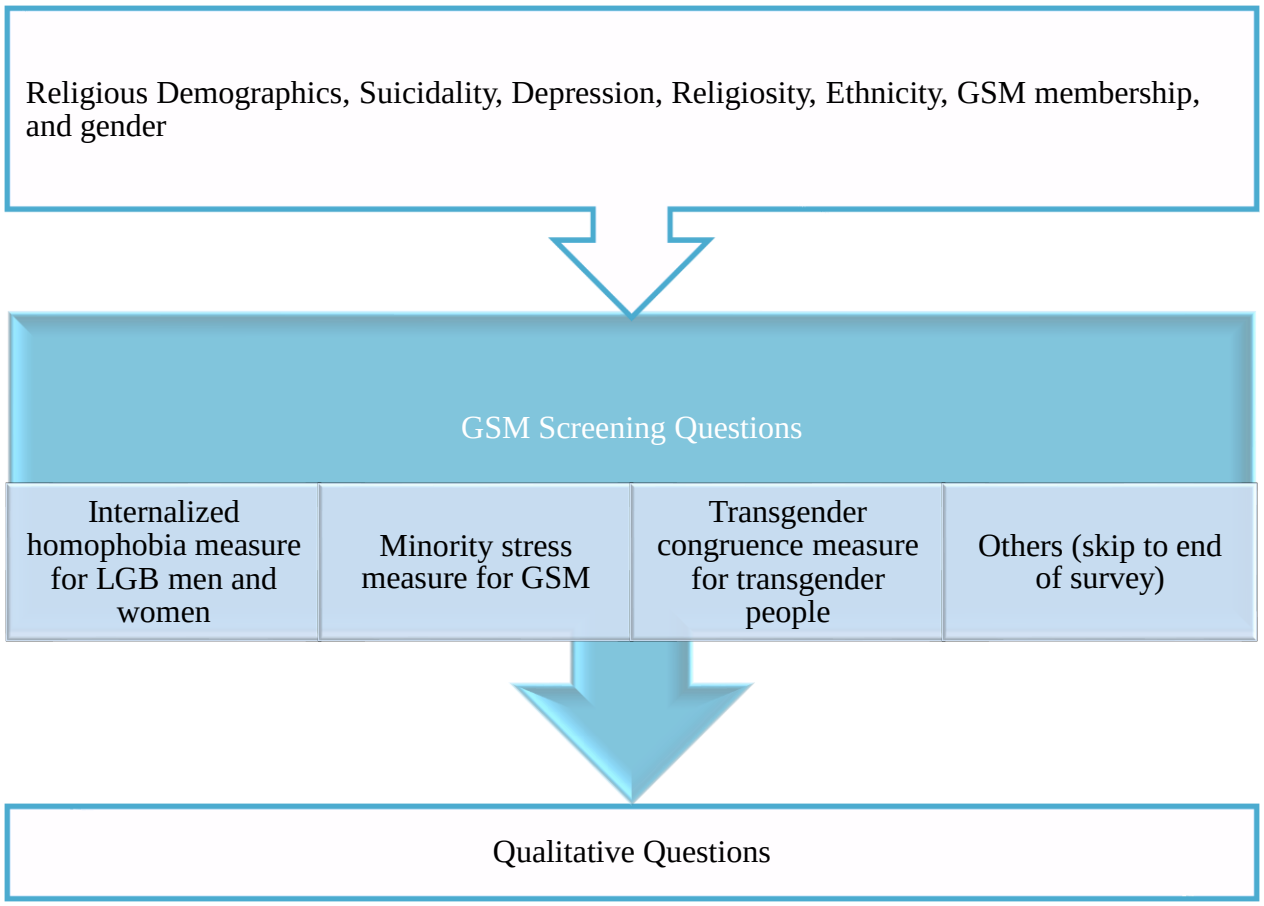
World Health Organization. (2017). *Depression and other common mental disorders: Global health estimates*. World Health Organization. https://www.who.int/mental_health/management/depression/prevalence_global_health_estimates/en/

Worthen, M. G. F., Lingiardi, V., & Caristo, C. (2017). The roles of politics, feminism, and religion in attitudes toward LGBT individuals: A cross-cultural study of college students in the USA, Italy, and Spain. *Sexuality Research and Social Policy*, *14*(3), 241–258. https://doi.org/10.1007/s13178-016-0244-y

APPENDICES

APPENDIX A

Survey Flow



APPENDIX B

Survey

Informed Consent

We are researchers from the Wichita State University Community Psychology Program. We are contacting you because you are 18 years or older and have access to the internet for participation in an online survey. We are recruiting research participants to help us observe whether there is a connection between religion and suicidal thoughts and behaviors for both LGBTQIA+ individuals and straight, cisgender individuals. Participation involves completing a survey that will take about 25-35 minutes. In addition to the survey questions, we will request information regarding your gender, sexual orientation, religious denomination, income, and age. There is some risk in participating in this study due to sensitive topics like suicide, internalized homophobia, and depression. However, if you feel uncomfortable with a question, you may skip it. Participation is voluntary, and you can stop taking the survey at any time. We will work to make sure that no one sees your survey responses without approval. But, because we are using the internet, there is a chance that someone could access your online responses without permission. In some cases, this information could be used to identify you. If you have any questions, please contact Rhonda Lewis at Wichita State University, Jabara Hall 437, 1845 Fairmount Street, Wichita, KS 67260; 316-978-3695; or rhondalewis@wichita.edu or Keyondra Brooks at Wichita State University, Jabara Hall 425, 1845 Fairmount Street, Wichita KS 67260 or klbrooks2@shockers.edu. For questions about the rights of research participants, you may contact the Office of Research and Technology Transfer at Wichita State University, 1845 Fairmount Street, Wichita, KS 67260-0007, and telephone (316) 978-3285. You are under no obligation to participate in this study.

By selecting "Yes" below, you are indicating that:

- You have read (or someone has read to you) the information provided above,
- You are aware that this is a research study,
- You have voluntarily decided to participate.

I have read the statement above and agree to participate in the survey.

Yes

No

I am age 18 or over.

Yes

No

Religious Demographics

The following questions ask about your current religious denomination. Please answer the following to the best of your abilities.

Do you currently identify as a member of a religion or spirituality?
- Yes
- No

Do you identify as a Christian?
- Yes
- No

What is your religious denomination?
- Jewish
- Muslim
- Christian Protestant
- Orthodox Christian
- Catholic
- Buddhist
- Hindu
- Jehovah's Witness
- Latter Day Saint (Mormon)
- Non-denominational Christian
- Other Christian religion (please describe below):
  _____
- Another Non-Christian religion (please describe below):
  _____

Which Protestant denomination are you a part of?
- Baptist
- Lutheran
- Methodist
- African Methodist Episcopal
- Presbyterian
- Seventh Day Adventist
- Pentecostal
- Anglican
- Other (please describe below): _____

Which best describes your religion?
- Evangelical Protestant (Southern Baptist Convention, Nondenominational, Assemblies of God, etc.)
- Mainline Protestant (United Methodist Church, American Baptist Churches USA, etc.)
- Historically Black Protestant (National Baptist Convention, A.M.E., C.O.G.I.C, etc.)
- Neither of these

Which Jewish denomination are you a part of?

Orthodox Judaism
Conservative Judaism
Reform Judaism
Other (please describe)

Have you ever experienced conversion therapy (therapy/counseling intended to change an individual's sexuality or gender identity)?

Yes
No

How would you describe your religious institution?

Accepting/affirming of LGBTQIA+ individuals
Tolerating of LGBTQIA+ individuals
Non-accepting of LGBTQIA+ individuals

Why do you choose to remain in a religion that is not accepting of LGBTQIA+ individuals?

_____

On a scale from 1-10 (1 being non-religious and 10 being very religious) how religious are your family members currently?

On a scale from 1-10 (1 being non-religious and 10 being very religious) how religious is your peer group currently?

On a scale from 1-10 (1 being unaccepting and 10 being accepting) how accepting are your family members towards LGBTQIA+ individuals?

On a scale from 1-10 (1 being unaccepting and 10 being accepting) how accepting is your peer group towards LGBTQIA+ individuals?

The following questions ask about your religious denomination during childhood. Please answer the following to the best of your abilities.

Were you raised in a religious household? (did your parents raise you to be a particular religion?)

Yes
No

What was your primary religion during childhood?

- Jewish
- Muslim
- Christian Protestant
- Orthodox Christian
- Catholic
- Buddhist
- Hindu
- Jehovah's Witness
- Latter Day Saint (Mormon)
- Non-denominational Christian
- Other Christian religion: _____
- Another Non-Christian religion: _____

Which Protestant denomination were you a part of?

- Baptist
- Lutheran
- Methodist
- African Methodist Episcopal
- Presbyterian
- Seventh Day Adventist
- Pentecostal
- Anglican
- Other (please describe): _____

Which best describes your childhood religion?

- Evangelical Protestant (Southern Baptist Convention, Nondenominational, Assemblies of God, etc.)
- Mainline Protestant (United Methodist Church, American Baptist Churches USA, etc.)
- Historically Black Protestant (National Baptist Convention, A.M.E., C.O.G.I.C.,etc.)
- Neither of these

Which Jewish denomination were you a part of?

- Orthodox Judaism
- Conservative Judaism
- Reform Judaism
- Other (please describe): _____

On a scale from 1-10 (1 being non-religious and 10 being very religious) how religious were your family members during your childhood?

On a scale from 1-10 (1 being non-religious and 10 being very religious) how religious was your peer group during your childhood?

Suicidality

Have you ever seriously considered attempting suicide at some point in your life?
Yes
No

During the past 12 months, have you seriously considered attempting suicide?
Yes
No

How many times in your life have you attempted suicide?

_____

How many of these attempts occurred in the past 12 months?

_____

MINI Suicidality

In the past month did you:

Think that you would be better off dead or wish you were dead?
No
Yes

Want to harm yourself?
No
Yes

Think about suicide?
No
Yes

Have a suicide plan?
No
Yes

Attempt suicide?
No
Yes

In your lifetime:

Did you ever make a suicide attempt?
- No
- Yes

CRS-15

How often do you think about religious issues?
- Very often
- Often
- Occasionally
- Rarely
- Never

To what extent do you believe that God, deities or something divine exists?
- Very much so
- Quite a bit
- Moderately
- Not very much
- Not at all

How often do you take part in religious services? (Note: this is the question that contained the coding error)
- More than once a week
- Once a week
- One to three times a month
- A few times a year
- Less often
- Never

How often do you pray?
- Several times a day
- Once a day
- More than once a week
- Once a week
- One to three times a month
- A few times a year
- Less often
- Never

How often do you experience situations in which you have the feeling that God, deities or something divine intervenes in your life?

Very often
Often
Occasionally
Rarely
Never

How often do you experience situations in which you have the feeling that God, deities or something divine allows for an intervention in your life? (alternate version for Muslim individuals)

Very often
Often
Occasionally
Rarely
Never

How interested are you in learning more about religious topics?

Very much so
Quite a bit
Moderately
Not very much
Not at all

To what extent do you believe in an afterlife—e.g. immortality of the soul, resurrection of the dead or reincarnation?

Very much so
Quite a bit
Moderately
Not very much
Not at all

How important is to take part in religious services?

Very much so
Quite a bit
Moderately
Not very much
Not at all

How important is personal prayer for you?

Very much so
Quite a bit
Moderately
Not very much
Not at all

How often do you experience situations in which you have the feeling that God, deities, or something divine wants to communicate or to reveal something to you?

- Very often
- Often
- Occasionally
- Rarely
- Never

How often do you experience situations in which you have the feeling that God, deities, or something divine lets something be communicated or revealed to you? (alternate version for Muslim individuals)

- Very often
- Often
- Occasionally
- Rarely
- Never

How often do you keep yourself informed about religious questions through radio, television, internet, newspapers, or books?

- Very often
- Often
- Occasionally
- Rarely
- Never

In your opinion, how probable is it that a higher power really exists?

- Very much so
- Quite a bit
- Moderately
- Not very much
- Not at all

How important is it for you to be connected to a religious community?

- Very much so
- Quite a bit
- Moderately
- Not very much
- Not at all

How often do you pray spontaneously when inspired by daily situations?

- Several times a day
- Once a day
- More than once a week
- Once a week
- One to three times a month
- A few times a year
- Less often
- Never

How often do you experience situations in which you have the feeling that God, deities, or something divine is present?

- Very often
- Often
- Occasionally
- Rarely
- Never

CES-D

Below is a list of the ways you might have felt or behaved. Please tell me how often you have felt this way during the past week.

During the past week

	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
1. I was bothered by things that usually don't bother me.	○	○	○	○
2. I did not feel like eating; my appetite was poor.	○	○	○	○
3. I felt that I could not shake off the blues even with help from my family or friends.	○	○	○	○
4. I felt I was just as good as other people.	○	○	○	○
5. I had trouble keeping my mind on what I was doing.	○	○	○	○
6. I felt depressed.	○	○	○	○
7. I felt that everything I did was an effort.	○	○	○	○
8. I felt hopeful about the future.	○	○	○	○
9. I thought my life had been a failure.	○	○	○	○
10. I felt fearful.	○	○	○	○

Below is a list of the ways you might have felt or behaved. Please tell me how often you have felt this way during the past week.

During the past week

	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
11. My sleep was restless.	○	○	○	○
12. I was happy.	○	○	○	○
13. I talked less than usual.	○	○	○	○
14. I felt lonely.	○	○	○	○
15. People were unfriendly.	○	○	○	○
16. I enjoyed life.	○	○	○	○
17. I had crying spells.	○	○	○	○
18. I felt sad.	○	○	○	○
19. I felt that people dislike me.	○	○	○	○
20. I could not get “going.”	○	○	○	○

Demographics

Where do you currently live?

- I do not reside in the United States
- Prefer not to answer
- Alabama
- Alaska
- Arizona
- Arkansas
- California
- Colorado
- Connecticut
- Delaware
- District of Columbia
- Florida
- Georgia
- Hawaii
- Idaho
- Illinois
- Indiana
- Iowa
- Kansas
- Kentucky
- Louisiana
- Maine
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Mississippi
- Missouri
- Montana
- Nebraska
- Nevada
- New Hampshire
- New Jersey
- New Mexico
- New York
- North Carolina
- North Dakota
- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- Puerto Rico
- Rhode Island

South Carolina
South Dakota
Tennessee
Texas
Utah
Vermont
Virginia
Washington
West Virginia
Wisconsin
Wyoming

What year were you born?

_____

What is your marital status?

Living with a steady partner
Single
Married
Divorced
Widowed
Separated

What is your gender? (Choose all that apply)

Agender
Woman
Man
Non-binary
Gender queer or gender fluid
Intersex
Questioning
Prefer not to say
Prefer to self-describe/identity not listed (please describe below):
_____

Do you identify as trans or transgender?

Yes
No
Prefer not to say

Which best describes your sexual orientation?

- Asexual
- Gay
- Straight (heterosexual)
- Lesbian
- Queer
- Bisexual
- Pansexual
- Questioning
- Prefer not to say
- Prefer to self-describe/identity not listed:

_____

What is your race/ethnicity? (Choose all that apply)

- Euro-American/White
- Middle Eastern or North African American/Middle Eastern or North African
- African American/Black
- Hispanic American/Latinx
- Asian/Asian American
- Native Hawaiian or other Pacific Islander
- Indigenous American/American Native/Alaskan Native
- I am not American (describe nationality below):

_____

- Other/Prefer to self-describe (please describe below):

_____

What is your annual income? (In dollars)

- Less than $10,000
- $10,000 - $19,999
- $20,000 - $29,999
- $30,000 - $39,999
- $40,000 - $49,999
- $50,000 - $59,999
- $60,000 - $69,999
- $70,000 - $79,999
- $80,000 - $89,999
- $90,000 - $99,999
- $100,000 - $149,999
- More than $150,000

What is the highest level of education you have completed?

- Less than a high school diploma
- High school degree or equivalent
- Some college
- Associate's degree
- Bachelor's degree
- Master's degree
- Doctorate
- Professional Degree (Example: MD, Nurse Practitioner)

The following questions are about internalized homophobia and transgender congruence. Please select the option that best describes how you identify:

- I identify as a woman that is attracted to other women or both women and men
- I identify as a man that is attracted to men or both men and women
- I do not identify as either of these

IHP-R
Men's Version

I wish I weren't gay/bisexual.

- Strongly agree
- Agree
- Neither disagree or agree
- Disagree
- Strongly disagree

I have tried to stop being attracted to men in general.

- Strongly agree
- Agree
- Neither disagree or agree
- Disagree
- Strongly disagree

If someone offered me the chance to be completely heterosexual, I would accept the chance.

- Strongly agree
- Agree
- Neither disagree or agree
- Disagree
- Strongly disagree

I feel that being gay/bisexual is a personal shortcoming for me.
Strongly agree
Agree
Neither disagree or agree
Disagree
Strongly disagree

I would like to get professional help in order to change my sexual orientation from gay/bisexual to straight.
Strongly agree
Agree
Neither disagree or agree
Disagree
Strongly disagree

Women's Version

I wish I weren't lesbian/bisexual.
Strongly agree
Agree
Neither disagree or agree
Disagree
Strongly disagree

I have tried to stop being attracted to women in general.
Strongly agree
Agree
Neither disagree or agree
Disagree
Strongly disagree

If someone offered me the chance to be completely heterosexual, I would accept the chance.
Strongly agree
Agree
Neither disagree or agree
Disagree
Strongly disagree

I feel that being lesbian/bisexual is a personal shortcoming for me.
Strongly agree
Agree
Neither disagree or agree
Disagree
Strongly disagree

I would like to get professional help in order to change my sexual orientation from lesbian/bisexual to straight.

Strongly agree
Agree
Neither disagree or agree
Disagree
Strongly disagree

Daily Heterosexist Experiences Questionnaire (DHEQ)

The following is a list of experiences that LGBT people sometimes have. Please read each one carefully, and then respond to the following question:
How much has this problem distressed or bothered you during the past 12 months?

	0 = Did not happen/not applicable to me	1 = It happened, and it bothered me NOT AT ALL	2 = It happened, and it bothered me A LITTLE BIT	3 = It happened, and it bothered me MODERATELY	4 = It happened, and it bothered me QUITE A BIT	5 = It happened, and it bothered me EXTREMELY
1. Difficulty finding a partner because you are LGBT	○	○	○	○	○	○
2. Difficulty finding LGBT friends	○	○	○	○	○	○
3. Having very few people you can talk to about being LGBT	○	○	○	○	○	○
15. Feeling like you don't fit in with other LGBT people	○	○	○	○	○	○
11. Family members not accepting your partner as a part of the family	○	○	○	○	○	○

12. Your family avoiding talking about your LGBT identity	○	○	○	○	○	○
25. Being rejected by your mother for being LGBT	○	○	○	○	○	○
26. Being rejected by your father for being LGBT	○	○	○	○	○	○
27. Being rejected by a sibling or siblings because you are LGBT	○	○	○	○	○	○
28. Being rejected by other relatives because you are LGBT	○	○	○	○	○	○

	0 = Did not happen/not applicable to me	1 = It happened, and it bothered me NOT AT ALL	2 = It happened, and it bothered me A LITTLE BIT	3 = It happened, and it bothered me MODERATELY	4 = It happened, and it bothered me QUITE A BIT	5 = It happened, and it bothered me EXTREMELY
43. Being punched, hit, kicked, or beaten because you are LGBT	○	○	○	○	○	○
44. Being assaulted with a weapon because you are LGBT	○	○	○	○	○	○
45. Being raped or sexually assaulted because you are LGBT	○	○	○	○	○	○
46. Having objects thrown at you because you are LGBT	○	○	○	○	○	○
Being called names such as "fag" or "dyke"	○	○	○	○	○	○
19. People staring at you when you are out in public because you are LGBT	○	○	○	○	○	○

29. Being verbally harassed by strangers because you are LGBT	○	○	○	○	○	○
30. Being verbally harassed by people you know because you are LGBT	○	○	○	○	○	○
31. Being treated unfairly in stores or restaurants because you are LGBT	○	○	○	○	○	○
32. People laughing at you or making jokes at your expense because you are LGBT	○	○	○	○	○	○
4. Watching what you say and do around heterosexual people	○	○	○	○	○	○
16. Pretending that you have an opposite-sex partner	○	○	○	○	○	○
17. Pretending that you are heterosexual	○	○	○	○	○	○

18. Hiding your relationship from other people	○	○	○	○	○	○
34. Avoiding talking about your current or past relationships when you are at work	○	○	○	○	○	○
35. Hiding part of your life from other people	○	○	○	○	○	○

Transgender Congruence

Do you identify as trans or transgender?

Yes

No

Instructions: Gender identity is defined as the gender(s) that you experience yourself as; it is not necessarily related to your assigned gender at birth. For the following items, please indicate the response that best describes your experience over the past 2 weeks.

My outward appearance represents my gender identity.

Strongly disagree
Somewhat disagree
Neither agree nor disagree
Somewhat agree
Strongly agree

I experience a sense of unity between my gender identity and my body.

Strongly disagree
Somewhat disagree
Neither agree nor disagree
Somewhat agree
Strongly agree

My physical appearance adequately expresses my gender identity.
- Strongly disagree
- Somewhat disagree
- Neither agree nor disagree
- Somewhat agree
- Strongly agree

I am generally comfortable with how others perceive my gender identity when they look at me.
- Strongly disagree
- Somewhat disagree
- Neither agree nor disagree
- Somewhat agree
- Strongly agree

My physical body represents my gender identity.
- Strongly disagree
- Somewhat disagree
- Neither agree nor disagree
- Somewhat agree
- Strongly agree

The way my body currently looks does not represent my gender identity.
- Strongly disagree
- Somewhat disagree
- Neither agree nor disagree
- Somewhat agree
- Strongly agree

I am happy with the way my appearance expresses my gender identity.
- Strongly disagree
- Somewhat disagree
- Neither agree nor disagree
- Somewhat agree
- Strongly agree

I do not feel that my appearance reflects my gender identity.
- Strongly disagree
- Somewhat disagree
- Neither agree nor disagree
- Somewhat agree
- Strongly agree

I feel that my mind and body are consistent with one another.
- Strongly disagree
- Somewhat disagree
- Neither agree nor disagree
- Somewhat agree
- Strongly agree

I am not proud of my gender identity.
- Strongly disagree
- Somewhat disagree
- Neither agree nor disagree
- Somewhat agree
- Strongly agree

I am happy that I have the gender identity that I do.
- Strongly disagree
- Somewhat disagree
- Neither agree nor disagree
- Somewhat agree
- Strongly agree

I have accepted my gender identity.
- Strongly disagree
- Somewhat disagree
- Neither agree nor disagree
- Somewhat agree
- Strongly agree

In your opinion, has religion impacted your mental health
- Yes
- No

Qualitative Questions

Please describe how your experiences with the following impacted your mental health/wellbeing:

Personal religious beliefs and practices

_____

_____

_____

Family/peer religious beliefs and practices

_____

_____

_____

Religious beliefs/practices of a religious institution or organization

_____

_____

_____

Other

_____

_____

_____