

Internalized Heterosexism, Religious Coping, and Psychache in Lesbian, Gay, and Bisexual
Young Adults

A Dissertation Presented for the
Doctor of Philosophy
Degree
The University of Tennessee, Knoxville

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August 2016

Dedication

It is with gratitude and admiration that I dedicate my dissertation to a very special teacher, Mr. David Cosey, who has taught me several powerful lessons both inside and outside of the classroom. I wrote my very first paper on social justice and human rights for you, when I had the opportunity to design my own document-based question in AP United States' History. You became the first person ever in my life to affirm me as someone who cares about social justice and human rights. For this I am forever grateful. That may have been the first paper I ever wrote on the subject, but it certainly would not be the last. Thank you for your kindness, patience, and dedication to your students. You are a hero in my eyes.

Acknowledgements

It is with the upmost respect and honest sincerity that I offer thanks to my faculty advisor, Dr. Joseph Miles. I truly believe I won the lottery when you selected me to join your lab. Graduate school is an opportunity that I never dreamed I would get to experience. I would like to also thank my dissertation committee, Drs. Dawn Szymanski, Brent Mallinckrodt, and Mellissa Bartsch, and Ms. Donna Braquet, for their expert guidance and feedback. Additionally, thank you to my undergraduate advisor, Dr. Anne Bizub, who first taught me about therapy, personality, and the social construction of mental illness. A huge debt of gratitude goes out to Dr. Martha Easton who first taught me about the power of social institutions and social change.

A beautiful realization I have made is that it is possible to choose our own families. Shannon Griesing, thank you for consistently being here for me, always willing to provide a laugh, a stroll down memory lane, and a reminder not just of where I come from, but of where I am going; *both* are powerful parts of my narrative. You are a beautiful part of my past, my present, and my future. Nikki Chery, thank you for showing me what *unconditional* love actually looks like; you are strong and beautiful. Herb Piercy IV, thank you for teaching me to question my own beliefs, and to always bet on myself. To my graduate school roommate and lab mate, Joel Muller, I acknowledge you for your genuineness, and for helping me to be the more genuine person that is in line with my essential self. To James Arnett III, thank you for paving the way for me, and always being willing to help me along in my journey. Funmi Obiri, thank you for teaching me that relationships are about communication and give and take; on a side note, thank you for agreeing to the *Gilligan's Island*-themed hot tub party. Daniela Recabarren, *always* bet on yourself, and please continue to show your light to the world; thank you for sharing your knowledge and overwhelming love. Yacob Tekie, thank you for showing me what hard work,

passion, and dedication looks like embodied in a beautiful soul. Trevor Dunn, thank you for saving my life on the rafting trip, and for being a loyal friend each day after. Keri, Renée, Cécile, and Marlene...here's to passing the torch to you; thank you for embracing me this past year.

To my family, Auntie Robin, thank you for the countless hours you spent in the car driving with me to Knoxville, helping me move in, and visiting me. The support you have provided me over the past several years means so much to me. Cousin Mickey, thank you for your generosity and faith in me. When you co-signed my loan to keep me in school, you gave me a chance, without which this whole journey would not even be possible. Mom and Dad, thank you for teaching me the value of doing for and giving to others. Thank you Scott Bourn for allowing me to survive my early childhood, with only a few noticeable physical scars, and loving me as an adult. Amanda Bourn, thank you for your courage to live life by your own rules. Dana White, I appreciate you for the love and generosity you have shown me over the years. Nancy Shaw, I warmly thank you for fulfilling the roll of the grandmother that I never got to know. It has meant so much to me.

Now, to my "Original Peaches," Iiona, Margorie, and Cassie, thank you for showing me that true friendship transcends time and space, and that always and forever *there's no crying in baseball*. Additionally, thank you to all of the amazing volunteers and staff who have shaped my life at Skye Farm Camp over the years. It is within this space that I began to grapple with what it means to be an LGB person and a person of faith, and connecting with supportive people within that space has meant so much to me. Next, thank you to *everyone* who does social justice work. Through your dedication, perseverance, and love may we one day live to see the world truly exist not as it is but as it can be. Finally, I would like to thank my nieces and nephew simply for being just the way they are...that will *always* be enough for me.

Abstract

Psychache, or unbearable psychological pain (Shneidman, 1993, 1999), has been found to be the most proximal predictor of suicidality. There is evidence that heterosexism (Crain-Gully, 2011), including internalized heterosexism (IH; Bourn & Miles, 2015), is related to psychache among lesbian, gay, and bisexual (LGB) individuals. The current study sought to further examine the relationship between IH and psychache, by identifying potential factors that moderate and mediate the relationship between IH and psychache. It was hypothesized that, in a sample of religiously-identified LGB young adults, (a) IH would be significantly, negatively correlated with positive religious coping (PRC) and significantly, positively correlated with negative religious coping (NRC) and psychache, (b) PRC would moderate the relationship between IH and psychache, and (c) NRC would mediate the relationship between IH and psychache. A sample of 617 participants completed an online, self-report survey examining IH, the use of religious coping mechanisms, and psychache. As predicted, IH was significantly, positively correlated with NRC and psychache, but it was also significantly, positively correlated with PRC. While main effects were found for both PRC and IH in the moderation analysis, the interaction was not significant. Finally, NRC mediated the relationship between IH and psychache. Study implications, limitations, and future directions are considered.

Keywords: internalized heterosexism; lesbian, gay, and bisexual; psychache, religious coping

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Chapter 1: Introduction

Because of their status as sexual minorities, LGB individuals face unique stressors from their environment that contribute to the development of negative mental health outcomes. In the United States, LGB individuals face blatant forms of bias or discrimination on interpersonal (e.g., being called derogatory names), cultural (e.g., being misrepresented in the media), and institutional (e.g., lacking federal protection from employment discrimination in the private sector) levels, as well as persistent, subtle, negative, and invalidating messages, known as *microaggressions* (e.g., a lesbian woman being asked by her therapist whether she has a boyfriend; e.g., Shelton & Delgado-Romero, 2013; Sue, 2010). These oppressive experiences reflect the persistence of heterosexism, “an ideological system that denies, denigrates, or stigmatizes any nonheterosexual form of behavior, identity, relationship, or community” (Herek, 1990, p. 316). Heterosexism represents a form of *minority stress*, or “excess stress to which individuals from stigmatized social categories are exposed as a result of their social, often a minority, position” (Meyer, 2003, p. 675).

Like other forms of stress, minority stressors like heterosexism put LGB people at increased risk for mental health problems (e.g., Carter, Mollen, & Smith, 2014; Goldbach, Tanner-Smith, Bagwell, & Dunlap, 2013; Kuyper & Fokkema, 2011; Meyer, 2003; Shilo & Savaya, 2012; Szymanski, Kashubeck-West, & Meyer, 2008), including *psychache* (Crain-Gully, 2011), or intense and intolerable emotional pain (Shneidman, 1999). Psychache has been found to be a more reliable predictor of suicidality than either hopelessness or depression (Pereira, Kroner, Holden, & Flamenbaum, 2010; Ribeiro, Bodell, Hames, Hagan, & Joiner, 2013), but little research has examined risk and protective factors for psychache in LGB individuals. It is crucial that counseling psychologists develop a better understanding of the relationship between

heterosexism and psychache, as well as potential protective factors against the negative effects of heterosexism, in order to develop interventions that may prevent or treat psychache before it can lead to suicidality.

Psychache

According to Shneidman (1993, 1999), death by suicide is the result of one trying to escape from the intolerable suffering represented by psychache. Psychache refers to the hurt, anguish, soreness, aching, psychological pain in the psyche, the mind. It is intrinsically psychological – the pain of excessively felt shame, or guilt, or humiliation, or loneliness, or fear, or angst, or dread of growing old or of dying badly, or whatever. (Shneidman, 1999, pp. 633-634)

Thus, it encompasses a cluster of negative emotions, including guilt, shame, fear, dread, loneliness, angst, humiliation, and anguish (Pereira et al., 2010). According to Shneidman's theory, an individual commits suicide when her or his absolute level of psychache exceeds her or his coping abilities. A growing body of research supports Shneidman's theory, suggesting that psychache may more reliably predict suicidality than either hopelessness or depression (Pereira et al., 2010; Ribeiro et al., 2013). For example, DeLisle and Holden (2009) examined motivation for suicidality and suicidal ideation, psychache, depression, and hopelessness in a sample of 587 undergraduate students. They found that the constructs of psychache, depression, and hopelessness are related, but distinct constructs; and that psychache was most strongly related to suicide criteria. DeLisle and Holden concluded that psychache is "most consistently and clearly indicative of proneness toward self-destruction...[and] is the primary reason that people kill themselves" (p. 58).

Similarly, in a study of over 1,400 undergraduate students, Troister and Holden (2010)

found that psychache was a better predictor of suicidal ideation, suicidal motivation, and suicidal preparation than either depression or hopelessness. In addition, they found that psychache was the only independent variable that significantly predicted suicide attempter status or lifetime number of attempts. Troister and Holden (2012) followed up two years later with participants who had been identified as “high risk” in their original (2010) study, and again administered measures of suicidal ideation, psychache, depression, and hopelessness. They found that two years after their baseline data collection, only changes in psychache contributed unique variance to the prediction of changes in suicidal ideation. Similarly, a study by Pereira et al. supported Shneidman’s theory in both incarcerated offender and undergraduate populations. Among 73 incarcerated male offenders, 80 female undergraduates, and 80 male undergraduates, psychache better predicted self-harm ideation than depression or hopelessness (Pereira et al., 2010). The relationship between psychache and suicidality was not moderated by either criminal offender status or participant sex (Pereira et al., 2010). Further, Flamenbaum and Holden (2007) found that psychache fully mediated the relationship between perfectionism and suicidality. Taken together, the research on psychache shows a clear link between psychache and suicidality, with considerable evidence supporting the theory that psychache is the most proximal predictor of suicidality (e.g., DeLisle & Holden, 2009; Flamenbaum, 2011; Flamenbaum & Holden, 2007; Pereira et al., 2010; Ribeiro et al., 2013; Troister & Holden, 2010, 2012).

Research has begun to examine psychache in a range of populations, including those from vulnerable and/or historically oppressed populations. In addition to Pereira et al.’s (2010) study of psychache in an incarcerated male population, Shneidman’s (1993, 1999) theory that psychache is a proximal predictor of suicidality has been supported in research on homeless men (Patterson & Holden, 2012), and a sample of aging Holocaust survivors (Ohana, Golander, &

Barak, 2014). However, almost no research has examined psychache in LGB individuals. Given the unique stressors faced by these populations (i.e., marginalization, oppression, victimization), a better understanding of the risk and protective factors for psychache in these populations could be important for developing interventions to improve mental health and prevent suicidality. The present study aims to further our understanding of psychache in a sample of religiously-identified LGB young adults, who are at increased risk for negative mental health outcomes, including suicidality (Bolton & Sareen, 2011; Cochran & Mays, 2006; Eisenberg & Resnick, 2006; Haas et al., 2011; King, Semlyen, Tai, Killaspy, Osborn, Popelyuk, & Nazareth, 2008; Woodward, Pantalone, & Bradford, 2013), as a result of experiencing the stress of heterosexism.

Psychache among LGB individuals. Despite the growing body of research on psychache, only two studies were found examining psychache, specifically, in LGB individuals: an unpublished dissertation (Crain-Gully, 2011) and an unpublished master's thesis (Bourn & Miles, 2015). Crain-Gully used a mixed-methods design to explore the relationship between psychache and suicidality in LGB young adults. Consistent with Shneidman's (1993, 1999) theory, and previous research (e.g., DeLisle & Holden, 2009; Flamenbaum, 2011; Flamenbaum & Holden, 2007; Pereira et al., 2010; Troister & Holden, 2010, 2012), her quantitative investigation revealed a strong, positive correlation between psychache and suicidality among LGB young adults. Further, qualitative interviews suggested that suicidality and psychache developed as a result of heterosexism. Unfortunately, Crain-Gully's sample was small, so caution must be taken when interpreting the quantitative results of this study. In addition, further research is needed, including quantitative research, to expand on Crain-Gully's qualitative findings that heterosexism is related to the development of psychache.

Expanding on Crain-Gully's qualitative results suggesting that heterosexism was related to psychache, Bourn and Miles (2015), examined the relationship between IH and psychache among LGB young adults. IH results when an LGB person inwardly directs negative messages about sexual minorities she or he has received in a heterosexist system (Herek, 2004; Szymanski et al., 2008). Instead of expressing anger, shame, and resentment toward the heterosexist system, one experiences IH when these emotions are turned inward, causing potentially hazardous consequences to one's mental and physical health (e.g., Szymanski et al., 2008). Research demonstrates that IH is related to a wide range of negative outcomes, including: increased gender role conflict (Robinson & Brewster, 2014; Szymanski & Ikizler, 2013), increased psychological distress (Carter et al., 2014; Szymanski et al., 2014; Szymanski & Gupta, 2009; Szymanski & Henrichs-Beck, 2014; Velez, Moradi, & DeBlaere, 2015), difficulties in the coming out process (Chow & Cheng, 2010; Szymanski & Sung, 2013), decreased physical health (Mereish, 2015), decreased self-esteem (Szymanski & Gupta, 2009; Velez et al., 2015), increased rates of depression (Szymanski & Ikizler, 2013), decreased job satisfaction (Velez, Moradi, & Brewster, 2013), increased workplace distress (Velez et al., 2013), decreased life satisfaction (Velez et al., 2015), increased interpersonal relationship problems (Frost & Meyer, 2009), increased fear of intimacy (Szymanski & Hilton, 2013), and decreased romantic relationship quality (Frost & Meyer, 2009; Szymanski & Hilton, 2013) (see Szymanski et al., 2008 for a review). Consistent with their hypothesis based on this previous research, Bourn and Miles found a significant relationship between IH and psychache in a sample of LGB young adults.

In addition, because previous research has suggested that spirituality serves as a protective factor against negative mental health outcomes for some populations (e.g., Hirsch, Nsamenang, Chang, & Kaslow, 2014; Taliaferro, Rienzo, Pigg, Miller, & Dodd, 2009), Bourn

and Miles were also interested in whether spirituality (operationalized as “existential well-being”) might mediate any observed relationship between IH and psychache (i.e., serve as a protective factor). Existential well-being includes “one’s perception of life’s purpose and satisfaction apart from any specific religious reference” (Paloutzian & Ellison, 1982, p. 231). Consistent with their hypotheses, Bourn and Miles found that existential well-being served as a partial mediator of this relationship such that IH related to lower existential well-being, which was then related to higher psychache. Thus, IH may relate to psychache through reductions in existential well-being of LGB individuals. Bourn and Miles noted, given that existential well-being does not invoke a specific religious belief or deity, additional research is needed to examine if and how IH relates to specific religious constructs, and if religion relates to psychache. Therefore, the current study examined the role of religion in the relationship between IH and psychache, specifically that of PRC and NRC.

LGB Individuals and Religion

Religion and spirituality represent distinct constructs, though they contain points of similarity. Both religion and spirituality represent patterns of feelings, experiences, behaviors, and thoughts that come from a search for the sacred; “the term ‘search’ refers to attempts to identify, articulate, maintain, or transform. The term ‘sacred’ refers to a divine being, divine object, Ultimate Reality, or Ultimate Truth as perceived by the individual.” (Hill, Pargament, Hood, McCullough, Swyers, Larson, & Zinnbauer, 2000, p. 66). For spirituality, this is an all-inclusive definition. In the case of religion, however, the criteria are more specific. Religion may also entail the search for non-sacred goals (e.g., meaning, health, wellness, belongingness) within a space whose primary purpose is the facilitation of a search for the sacred. A final

defining criterion for religion is that the means and method of the search include an identified group of people, who provide support and validation (Hill et al., 2000).

A 2013 survey of over 1,100 adults in the United States by the Pew Research Center (2013) found that, while fewer lesbian, gay, bisexual, and transgender (LGBT) individuals have a religious affiliation than the general population, just over half of them did (51%, compared to 88% in the general population). This means that religion plays at least some role in the lives of about half of the LGBT people in the United States. Pew reported that 43% of the LGBT adults surveyed claimed that religion was either “somewhat” or “very” important in their lives. In addition, of those LGBT adults who reported being affiliated with a religion, 55% of them reported that there is a conflict between religious beliefs and “homosexuality.” Pew concludes that religion is “difficult terrain” for LGBT people (p. 11). Thus, developing a better understanding of the complexities in the lives of religiously-identified LGB adults, and if and how it relates to mental health is important for counseling psychologists.

Religion and the mental health of LGB people. Although research suggests that religion may serve a protective role against negative psychological outcomes in the general population, particularly for members of social groups experiencing stressful situations, such as the elderly, and people with disabilities or medical illnesses (e.g., Moreira-Almeida, Neto, & Koenig, 2006), there is relatively little attention to these relationships among LGB individuals (Rosario, Yali, Hunter, & Gwadz, 2006). Given the “heterosexism manifested in many religious organizations” (Szymanski et al., 2008, p. 559), it is unclear whether religious identification may serve the same protective function for LGB individuals as it does in the general population (Dahl & Galiher, 2010). For example, while responses of various religious denominations to sexual minorities can range from absolute rejection to absolute acceptance (Yashushko, 2005), Sherkat

(2002) noted that only a handful of religious denominations in the United States actually, “affirm homosexuality as a valid and morally supportive lifestyle; virtually all condemn homosexuality as a sin” (p. 315). Thus, navigating an LGB identity within a religious institution can be a complicated and frustrating endeavor for LGB people (Dahl & Galiher, 2010), potentially resulting in a conflict between sexual orientation and religious identities (Kocet, Sanabria, & Smith, 2011; Shuck & Liddle, 2001; Yakushko, 2005).

Some research does suggest that religious affiliation has positive impacts on the well-being of LGB individuals, while other research suggests negative impacts. For example, with regard to positive impacts, a study by Clingman and Fowler (1976) found that gay men who attended a Gay Metropolitan Church regularly reported higher levels of self-esteem than their non-attending gay male peers. A more recent study conducted by Rosario et al. (2006) examined the relationships between religious identification and gay-related stress, through interviews with 164 self-identified LGB youths, ages 14 to 21. For male interviewees, youths with a current religious identity engaged in fewer risky behaviors, evidenced less emotional distress, and greater emotional support. At the same time, male youths with a current religious identity were three times more likely to experience gay-related stress associated with kin (Rosario et al., 2006). Additionally, Helminiak (2006) found that, while LGB Catholics experience their church’s views toward their sexual orientation as negative, those who attended Dignity (an LGB-affirming Catholic organization) have self-acceptance levels similar to heterosexual Catholics. In addition, Woods, Antoni, Ironson, and Kling (1999) found that religious affiliation predicted improved immune functioning and emotional health in gay men living with HIV.

In another study, Lease, Horne, and Noffsinger-Frazier (2005) investigated the role of affirmative faith group experiences on mental health outcomes of 583 LGB faith group members.

They sought to test two models of psychological health, current faith affirmation experiences, spirituality, and IH. They found that affirming faith experiences were related to psychological health (i.e., increased levels of self-acceptance, autonomy, positive relationships with others, a sense of purpose in life, personal growth, environmental mastery, satisfaction with life, and decreased rates of depression) through IH and spirituality, supporting a fully mediated model. More specifically, current faith group experiences were indirectly related to increased psychological health through decreased levels of IH and higher endorsements of spirituality (Lease et al., 2005). While the detrimental effects of non-affirmative religious experiences have previously been documented for LGB individuals (e.g., conflict between religion and sexual orientation, resulting in shame, depression, and suicidal ideation; Schuck & Liddle, 2001), Lease et al.'s research suggests that affirmative faith group experiences can actually have a positive impact on the psychological health of LGB people. While Lease et al. broadly sampled measures of psychological health, they did not measure psychache as part of their fully mediated model of the relations between psychological health and current faith affirmation experiences.

Although these studies suggest potentially positive relationships between religious affiliation and various mental health outcomes for LGB individuals, other studies are less clear, or suggest negative relationships between religion and mental health. For instance, Rosario et al. (2006) found that although increased religious identification was associated with decreased substance abuse and lower rates of risky sexual experiences for gay and bisexual males (e.g., self-denial), this pattern of results was not seen for lesbian and bisexual females. Additionally, religiously-identified lesbian and bisexual females experienced greater gay-related stress than non-religiously-identified lesbian and bisexual females (Rosario et al., 2006). Similarly, Dahl and Galiher (2010) found that positive affective (i.e., emotional religious experiences) and

cognitive religious experiences (e.g., religious beliefs, images of God) were associated with increased self-esteem. Negative affective and cognitive religious experiences were associated with decreased self-esteem, and higher rates of both depression and sexual orientation conflict, suggesting that religious identification may serve both a positive and negative psychological role in the lives of LGB people (Dahl & Galiher, 2010).

Making the issue of whether or not religion might serve as a protective or risk factor among LGB people more complex is a growing body of research exploring the relationships between religious identification and IH (Barnes & Meyer, 2012; Lease et al., 2005; Szymanski et al., 2008; Walker & Longmire-Avital, 2013). For example, Cimini (1992) found that increased levels of religiosity were associated with increased levels of IH. Similarly, Barnes and Meyer (2012) found that exposure to non-affirming religious dogma was associated with higher levels of IH in a sample of 355 LGB individuals, though they found no main effect of non-affirming religious dogma on mental health outcomes. Walker and Longmire-Avital explored the relations between religious identification, IH, and resiliency in a sample of 175 Black LGB adults, ages 18-25 years old. Given the importance of faith in the Black community (Chatters, Taylor, Jackson, & Lincoln, 2008), Walker and Longmire-Avital examined whether devaluation of LGB identities in religious institutions related to IH. Through hierarchical linear modeling, they found that IH moderated the relationship between religious faith and resiliency, such that for those with higher levels of IH, lack of religious faith plays a larger role in their ability to cope with adversity. This finding conflicts with the idea that LGB identities and religiosity are mutually exclusive identities for members of the Black community. Likewise, Walker and Longmire-Avital warned that, given the dynamic interplay between religious identification, religious institutions, IH, and resiliency, if Black LGB individuals reach out to an unsupportive faith

community, it may result in future vulnerabilities. Finally, in their review of the research on correlates of IH, including religious variables, Szymanski et al. (2008) concluded that research supports the notion that adherence to traditional religious dogma is associated with increased levels of IH (Cimini, 1992; Rowen & Malcolm, 2002), while independent religious decision-making and membership in LGB-affirmative faith organizations are associated with less IH (Lease et al., 2005).

Taken together, studies that have examined relations between religious identification, IH, and mental health provide varying conclusions, where religion can be understood as both a source of resilience and a source of risk for LGB people (e.g., Ream & Savin-Williams, 2005). Given the complex and conflicting nature of the research on religious identification, IH, and mental health of LGB individuals (e.g., Clingman & Fowler, 1976; Dahl & Galiher, 2010; Helminiak, 2006; Kocet et al., 2011; Richards, Bartz, & O'Grady, 2009; Rosario et al., 2006; Sherkat, 2002; Shuck & Liddle, 2001; Woods et al., 1999; Yakushko, 2005) further research is necessary to better understand when and how religious identification may serve as a protective factor versus a risk factor in the lives of LGB individuals. One way to do this is to add theoretical rigor to the conceptualization of religiosity, examining it as a multidimensional construct (Dahl & Galiher, 2010).

Religious Coping

One way to conceptualize religiosity as multidimensional is through *religious coping*. Pargament, Smith, Koenig, and Perez (1998, p. 711) described religious coping as “multidimensional,” stating that it is “design[ed] to assist people in the search for a variety of significant ends in stressful times: a sense of meaning and purpose, emotional comfort, personal control, intimacy with others, physical health, or spirituality.” More generally, religious coping

is the process by which people draw on religious beliefs and practices to understand and deal with life stressors (Pargament, 1997). Research has found that religious coping adds unique variance to the prediction of health and wellness above and beyond the effects of nonreligious coping (Pargament et al., 1998). Additionally, religious coping has been found to mediate the relationship between general religious orientation and the outcomes of major life events (Pargament, 1997).

Pargament et al. (1998) sought to identify patterns of PRC and NRC, and to examine how each pattern impacts one's health and adjustment. Using confirmatory and exploratory factor analysis in samples of elderly hospitalized individuals coping with major medical illnesses, people coping with the Oklahoma City bombing, and college students coping with major life stressors, Pargament et al. (1998) developed the Brief RCOPE, a 14-item measure of positive and negative patterns of religious coping. PRC consisted of benevolent religious reappraisal (e.g., "tried to see how God might be trying to strengthen me in this situation"), religious purification (e.g., "sought help from God in letting go of my anger"), seeking spiritual support (e.g., "sought God's love and care"), religious forgiveness (e.g., "asked forgiveness for my sins"), collaborative religious coping (e.g., "tried to put my plans into action together with God"), and spiritual connection (e.g., "looked for a stronger connection with God"). NRC patterns included interpersonal religious discontent (e.g., "wondered whether my church had abandoned me"), reappraisal of God's power (e.g., "questioned the power of God"), demonic reappraisal (e.g., "decided the Devil made this happen"), spiritual discontent (e.g., "questioned God's love for me"), and punishing God reappraisals (e.g., "felt punished by God for my lack of devotion") (Pargament et al., 1998). PRC and NRC were associated with different mental health outcomes, with PRC resulting in decreased psychological distress, greater spiritual and psychological

growth resulting from the stressor, and higher interviewer ratings of cooperativeness. NRC, on the other hand, was associated with greater emotional distress, including depression, poorer quality of life, and callousness (Pargament et al., 1998).

Further, PRC has been empirically tied to positive mental and physical health outcomes for samples of individuals coping with a broad range of life stressors (Allen, Pérez, Pischke, Tom, Juarez, Ospino, & Gonzalez-Suarez, 2014; Pargament et al., 1998; Rosmarin, Bigda-Peyton, Öngur, Pargament, & Björgvinsson, 2013; Souza, Fonseca, De Pietro Magri, & Magalhaes Mendes, 2013). For example, Allen et al. (2014) explored relationships between religious identification (i.e., PRC and NRC, church participation, active and passive spiritual health locus of control, and religious support) and adherence to age-appropriate cancer screening tests. They found that PRC was associated with adherence to age-appropriate cancer screenings. Similarly, in a study examining patterns of religious coping among patients who experience psychosis, Rosmarin et al. (2013) found that PRC was associated with significant reductions in depression and anxiety, while NRC was associated with increased intensity and frequency of suicidal ideation, and greater depression and anxiety symptoms. They concluded that PRC is a significant resource for the population sampled, and identified NRC as a possible risk factor. Finally, in a study of PRC and NRC among patients living with epilepsy, Souza et al. (2013) identified that patients were more likely to use PRC, which was associated with greater quality of life evaluations.

An additional study by Szymanski and Obiri (2011) explored the potential moderating and mediating roles of PRC and NRC in the relationship between external and internalized racism and African American individuals' psychological distress. Given that research examining race-based external and internalized oppression has consistently documented that experiences of

racist events (Jackson, Brown, Williams, Torres, Sellers, & Brown, 1996; Jones, Cross, & DeFour, 2007; Klonoff, Landrine, & Ullman, 1999) and internalized racism (Carter, 1991; Jones et al., 2007; Szymanski & Gupta, 2009) are related to more psychosocial distress for African Americans; and that religious coping is typically utilized for coping with life stressors (e.g., Pargament et al., 1998), especially in the African American community (e.g., Chatters et al., 2008), Szymanski and Obiri sought to test competing hypotheses. Specifically, these hypotheses were derived from stress-buffering theories and Clark, Anderson, Clark, and Williams' (1999) bio-psycho-social model of racism. In a sample of 269 African American individuals, Szymanski and Obiri found that NRC partially mediated the relationships between racist events and internalized racism, and psychological distress. Further, no support was found for the mediating role of PRC or for the moderating role of PRC or NRC in the relationships between racist events and internalized racism and psychological distress.

Although previous research has suggested the potential benefit of PRC, and potential harm of NRC, in relation to the mental and physical health outcomes of diverse populations (Allen et al., 2014; Lee, Nezu, & Nezu, 2014; Pargament et al., 1998; Rosmarin et al., 2013; Souza et al., 2013), there is relatively little research on religious coping among LGB individuals. In one study examining religious coping among HIV-positive gay men, who display mild symptoms, Woods et al. (1999) explored the relationships between religiosity and current affective and immune status. Participants completed a) the Beck Depression Inventory (BDI; Beck, Steer, & Garbin, 1988), b) the COPE Inventory (Carver, Scheier, & Weintraub, 1989) and c) a measure of self-efficacy. The COPE is the initial version of the RCOPE, and is a questionnaire developed to assess a broad range of coping responses (Carver et al., 1989). Participants also provided a venous blood sample and indicated the amount they had attended

religious services, prayed, read religious texts, and had spiritual conversations in the past thirty days. In regard to the COPE Inventory, analyses were performed on the religious coping and active coping subscales. Factor analysis of the religious coping subscale of the COPE revealed two patterns of religiosity, religious behavior (e.g., having spiritual discussions, reading religious literature) and PRC (e.g., “I put my faith in God,” “I try to find comfort in my religion”). Ultimately, they found that, while religious behavior was associated with better immune functioning, it was unrelated to depression scores. At the same time, PRC was associated with lower BDI scores, but not with immune system functionality markers. Woods et al. concluded that those who used PRC more regularly had decreased depressive symptoms. Thus, Woods et al. found that it was not increased religious behaviors that were associated with decreased depression scores, but increased PRC, suggesting that sheer volume of religious activity is not protective against negative psychological health outcomes, but instead one’s ability to successfully use PRC in times of stress or hardship.

In a more recent study, Hampton, Halkitis, and Mattis (2010) examined differences between HIV-negative and HIV-positive gay and bisexual men in regard to PRC, active coping (e.g., seeking social support, getting advice from a doctor, etc.), illicit drug use, and states of anxiety, depression, and hostility. Hampton et al. found that HIV-positive gay and bisexual men were more likely to engage in PRC and active coping strategies, and to abuse illicit drugs. Participants who reported higher rates of illicit drug use were also more likely to report increased levels of anxiety, depression, and hostility. Hampton et al. concluded that coping strategies are not mutually exclusive, and in the course of the life threatening diagnosis of HIV, some individuals may subscribe to multiple, contradictory coping strategies. Together, these coping strategies (i.e., PRC, active coping, illicit drug use) endorsed more often by HIV-positive gay

and bisexual men may function together to create meaning from their HIV-positive identities. Thus, the little available research examining religious coping among LGB individuals (i.e., Hampton et al., 2010; Woods et al., 2010) demonstrates a positive role for behaviors consistent with PRC on the psychosocial health of LGB people. However, additional research is needed to more comprehensively understand the impact of PRC and NRC on the health and well-being of LGB people.

The Current Study

Research has shown that, as a result of heterosexism, LGB individuals face increased mental health risks (e.g., Carter et al., 2014; Goldbach, Tanner-Smith, Bagwell, & Dunlap, 2013; Kuyper & Fokkema, 2011; Meyer, 2003; Shilo & Savaya, 2012; Szymanski et al., 2008), including risk of suicidality (Bolton & Sareen, 2011; Cochran & Mays, 2006; Eisenberg & Resnick, 2006; Haas et al., 2011; King et al., 2008; Woodward et al., 2013). An empirically-validated model posits psychache as the most proximal predictor of suicidality (Shneidman, 1993, 1999), however little research exists on psychache in the LGB population. Therefore, developing a better understanding of the factors that contribute to or protect one from psychache may be valuable in developing suicide prevention programs and promoting mental health. Some evidence suggests that heterosexism (Crain-Gully, 2011) and IH (Bourn & Miles, 2015) relate to psychache in LGB populations, however additional research is needed on the factors that might mediate or moderate these relationships. Thus, the current study seeks to examine the relationships between IH and psychache in LGB young adults, and two factors that might moderate and mediate this relationship, PRC and NRC, respectively.

Examining religion in the lives of LGB people is important, given that a large percentage of the LGB population identifies as religious (Pew Research Center, 2013). Although religion

may serve a protective role against negative psychological outcomes in the general population, particularly for members of social groups experiencing stressful situations (e.g., the elderly, people with disabilities; e.g., Moreira-Almeida et al., 2006), the same may not be true within the LGB community, due to heterosexism inherent in many religious organizations (Szymanski et al., 2008). While some research suggests positive links between religion and the well-being of LGB individuals (e.g., Clingman & Fowler, 1976; Helminiak, 2006; Lease et al., 2005; Woods et al., 1999), other studies are less clear, or suggest negative relationships between religion and mental health outcomes for LGB individuals (e.g., Dahl & Galiher, 2010; Rosario et al., 2006).

Thus, religion can be understood as both a potential source of resilience and a potential source of risk for LGB people (e.g., Ream & Savin-Williams, 2005). Given the complex and conflicting nature of the current research on the relationships between IH, religion, and the mental health of LGB individuals, further research is necessary to better understand when and how religion may serve as a protective factor versus a risk factor in the lives of LGB individuals. One way to do this is to add theoretical rigor to the conceptualization of religiosity, examining it as a multidimensional construct, through use of *religious coping* (Dahl & Galiher, 2010). Religious coping is the process by which people draw on religious beliefs and practices to understand and deal with life stressors, and represents two distinct patterns (i.e., PRC and NRC; Pargament, 1997).

Research suggests the potential benefit of PRC, and potential harm of NRC in relation to the mental and physical health outcomes of diverse populations (Allen et al., 2014; Lee et al., 2014; Pargament et al., 1998; Rosmarin et al., 2013; Souza et al., 2013). For example, Szymanski and Obiri (2011) found that NRC partially mediated the relationships between racist events and internalized racism, and psychological distress in a sample of African American

participants. Interestingly, they found that PRC neither served as a mediator nor a moderator in the relationship between racist events and internalized racism, and psychological distress.

Research examining religious coping among LGB individuals has, however, demonstrated a positive role for behaviors consistent with PRC on the psychosocial health of LGB people (Hampton et al., 2010; Woods et al., 1999). For example, Woods et al. found that PRC was associated with decreased depressive symptoms. However, additional research is needed to more comprehensively understand the impact of PRC and NRC on the health and well-being of LGB people. Moreover, much is still unknown regarding the effects of religion and PRC on mental and physical health of LGB individuals (Lease et al., 2005; Rosario et al., 2006; Walker & Longmire-Avital, 2012; Woods et al., 1999). This study seeks to fill a void and to help clarify the roles of PRC and NRC in regard to psychache resilience and risk. Based on a review of the literature, the following hypotheses are proposed:

Hypothesis 1: IH will be significantly, negatively correlated with PRC and significantly, positively correlated with NRC and psychache in a sample of religiously-identified LGB young adults.

Hypothesis 2: PRC will moderate the relationship between IH and psychache in a sample of religiously-identified LGB young adults, such that PRC will serve as a buffer in the relationship between IH and psychache.

Hypothesis 3: NRC will mediate (either partially or fully) the relationship between IH and psychache in a sample of religiously-identified LGB young adults, such that NRC will exacerbate the relationship between IH and psychache.

Chapter 2: Methods

Participants

Participants were recruited through announcements posted to email listservs and online LGB-related communities and organizations throughout the United States, and through advertisements placed on Facebook and Reddit. The Facebook advertisements specifically targeted: (a) men who were at least 18 years old, in the United States, and who indicated being “interested in men;” (b) women who were at least 18 years old, in the United States, and who indicated being “interested in women;” and (c) individuals of any gender who were at least 18 years old, and who indicated “LGBT interests” in their personal profile. Upon clicking on a link found in the email or on the Facebook advertisement, participants were directed to an online informed consent document, which stated that participants must be at least 18 years of age and self-identify as lesbian, gay, or bisexual (see Appendix A). Upon providing informed consent, participants were directed to the online survey. Individuals who did not identify as lesbian, gay, or bisexual on the demographic form (see Appendix B) were told that the study was currently interested in the experiences of LGB individuals, and were thanked for their time and directed out of the survey.

Between these recruitment strategies a total of 1,185 initial participants completed the survey. Given that the study is specifically interested in examining the experiences of LGB individuals between the ages of 18 and 24, as research consistently finds that LGB young adults are at increased risk for negative mental health outcomes (Bolton & Sareen, 2011; Crain-Gully, 2011; Cochran & Mays, 2006; Haas et al., 2011; King et al., 2008; Woodward et al., 2013), it was necessary to exclude participants outside of these parameters. Thus, 41 participants who fell outside of the 18-24 age criterion, and 14 participants who did not self-identify as LGB were

excluded from the analyses. Further, because this study is interested in religious coping, analyses only included those participants who endorsed being religiously-identified on the demographic form preceding the survey, leading to the exclusion of data from an additional 149 participants. Data from 364 participants were excluded from the analyses for having more than 10% missing data.

Participants in the final sample of 617 ranged in age from 18 to 24 years ($M = 20.16$, $SD = 1.75$). In terms of gender, 30% identified as female ($n = 183$), 69% identified as male ($n = 424$), 0.3% identified as transgender (male-to-female) ($n = 2$), and 1% identified as transgender (female-to-male) ($n = 8$). In terms of sexual orientation, 59% ($n = 366$) identified as gay men, 15% ($n = 93$) identified as lesbian women, 15% ($n = 92$) identified as bisexual women, and 11% ($n = 66$) identified as bisexual men. In terms of race, 82% ($n = 505$) reported being White or European American, 8% ($n = 52$) reported being Black or African American, 5% of the participants ($n = 28$) reported being Asian, 4% ($n = 25$) reported being Alaska Native or American Indian, 1% ($n = 8$) reported being Native Hawaiian or Pacific Islander, 8% ($n = 48$) reported being multiracial, and 6% ($n = 37$) reported an “other” racial identity (Participants were allowed to select more than one racial category, thus the percentages add to more than 100%). For ethnicity, 13% ($n = 78$) reported identifying as Hispanic or Latino. Regarding marital status, 61% ($n = 375$) identified as single, 5% ($n = 32$) identified as being in a domestic partnership, 2% ($n = 13$) identified as married, 0.2% ($n = 1$) identified as separated, 0.2% ($n = 1$) identified as widowed, and 5% ($n = 32$) identified their marital status as “other,” while 26% ($n = 163$) did not provide an answer.

Current religious affiliations included Agnostic ($n = 154$), Atheist ($n = 7$), Buddhist ($n = 43$), Christian ($n = 335$), Hindu ($n = 8$), Jewish ($n = 21$), Muslim ($n = 5$), Secular ($n = 16$),

Unitarian ($n = 24$), and Wiccan ($n = 66$); all participants in the sample identifying as atheist also identified a second religious faith they subscribe to, indicating the complexity of religiosity, especially in the lives of LGB people (e.g., Hill et al., 2000; Ream & Savin-Williams, 2005). As with race, participants were allowed to select multiple religious affiliations, so frequencies add to greater than 617 (i.e., $n = 679$). In addition to religious affiliation, 74% of participants ($n = 454$) currently identified as spiritual. In terms of religion of origin, affiliations included: Agnostic ($n = 10$), Atheist ($n = 5$), Buddhist ($n = 6$), Christian ($n = 382$), Hindu ($n = 1$), Jewish ($n = 8$), Muslim ($n = 3$), Secular ($n = 7$), Unitarian ($n = 1$), Wiccan ($n = 3$), and No Religious Affiliation ($n = 28$). In this instance, as multiple participants elected to not answer this demographic, the statistic is significantly less than $n = 617$. Finally, in terms of the degree to which their religion of origin was open and affirming to the LGB community, only 3% ($n = 16$) reported growing up in a “church/faith community where there were affirmative LGB role models, and active movement from the church/faith community to support and affirm LGB members.” Conversely, 52% ($n = 323$) reported growing up in a church/faith community without LGB role models and without active movement from the church/faith community to support and affirm LGB members; 6% ($n = 34$) of participants did not identify with either statement as applied to their experience, 13% ($n = 82$) did not grow up as part of a church/faith community, and 26% ($n = 162$) did not provide demographic information on this item.

Measures

Psychache. Psychache was measured via the Psychache Scale (Holden, Mehta, Cunningham, & McLeod, 2001). The Psychache Scale is a 13-item self-report measure, which utilizes two different five-point scales: items one through nine are rated from 1 (*never*) to 5 (*always*), while items ten through thirteen are rated from 1 (*strongly disagree*) to 5 (*strongly*

agree). Sample items include, “I hurt because I feel empty” (item 8), and “My pain is making me fall apart” (item 12).

Based on an alpha reliability value of .94, Holden et al. (2001) reported that the scale is a highly homogenous measure. Further, the Psychache Scale has been reliably utilized in a wealth of studies to support an empirical link between suicidality and psychache amongst diverse populations, including LGB individuals (Crain-Gully, 2011), criminal offenders (Pereira et al., 2010), and undergraduate students (DeLisle & Holden, 2009; Flamenbaum, 2011; Flamenbaum & Holden, 2007; Troister & Holden, 2010). Holden et al. (2001), in the measurement development study, reported that the scale possesses excellent concurrent validity with measures of suicide attempt. For the current sample of LGB young adults, an alpha value of .96 was determined, indicating excellent measurement internal consistency.

Internalized Heterosexism. IH was measured using Martin and Dean’s (1987) Internalized Homophobia Scale (IHP), a nine-item self-report measure. This scale was initially developed for use with gay males utilizing the criteria for ego-dystonic homosexuality in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (Szymanski et al., 2008). Sample items from the measure include, “I have tried to stop being attracted to men in general” (item 2), and “I feel that being gay is a personal shortcoming for me” (item 7). Items are assessed using a five point Likert-type scale, ranging from one (*strongly disagree*) to five (*strongly agree*).

Herek and Glunt (1995) reported that the IHP possesses high internal consistency, at a level of .85 for a gay male sample. Herek, Cogan, Gillis, and Glunt (1998) later modified the IHP to be used with both female and male sexual minority samples. Herek et al. (1998) reported an alpha value of .71 with a lesbian and bisexual female sample, and an alpha score of .83 with a

gay and bisexual male sample. At the same time, in a systematic review of scales that measure attitudes toward gay men (e.g., IH scales and measures of homophobia), Grey, Robinson, Coleman, and Bockting (2013) report that test-retest reliability data is currently unavailable for all IH scales, including the IHP. Herek & Glunt (1995) also report that high IHP scores were correlated with a cluster of negative psychological and social outcomes, including lower self-esteem, a higher likelihood of attributing personal setbacks to antigay prejudice, lower community consciousness, fewer gay identity disclosures, and greater dissatisfaction with the local LGB community.

For the current study, participants who identified as gay men completed an eight-item version of the IHP. Participants who identified as lesbian or bisexual were given a slightly reworded version of the eight-item scale (i.e., “I feel that being gay is a personal shortcoming for me” was recoded as, “I feel that being lesbian is a personal shortcoming for me,” or “I feel that being bisexual is a personal shortcoming for me,” respectively) to ensure a match between participant identity and measurement items. One item, originally worded, “I often feel it best to avoid personal or social contact with other gay men,” was not utilized with any of the participants, as it was deemed that this item would not be appropriate for use with a bisexual sample. It was believed that this item would be particularly ambiguous with a bisexual sample (i.e., for bisexual men, it could read: “I often feel it best to avoid personal or social contact with other bisexual men/gay and bisexual men/men”). Frost and Meyer (2009) used the same eight-item version of the IHP in research with an LGB sample, and reported an alpha value of .86; for the current sample an alpha value of .85 was found, indicating both comparable and good measurement internal consistency.

Religious Coping. The extent to which LGB individuals utilize positive and negative patterns of religious coping was assessed using the Brief RCOPE, a 14-item self-report measure developed by Pargament et al. (1998). PRC consists of such behaviors as: collaborative religious coping, seeking spiritual support, religious forgiveness, benevolent religious reappraisal, religious purification, and spiritual connection. Items are scored using a four point Likert scale ranging from 0 (*not at all*) to 3 (*a great deal*), to indicate the degree to which a respondent employs each religious coping method to deal with a critical life event (Pargament, Feuille, & Burdzy, 2011). Sample items include, “Sought God’s love and care” (item 2), and “Tried to see how God might be trying to strengthen me in this situation” (item 5).

Currently the most commonly used measure of religious coping in the literature, the Brief RCOPE possesses strong internal consistency, across studies with widely differing samples, including patients undergoing cardiac surgery (Ai, Seymour, Tice, Kronfol, & Bolling, 2009), Catholic middle school students (Van Dyke, Glenwick, Cecero, & Kim, 2009), older adults in residential care (Schanowitz & Nicassio, 2006), African American women with a history of intimate partner violence (Bradley, Schwartz, & Kaslow, 2005), cancer patients (Cole, 2005), and residents of Massachusetts and New York City following 9/11 (Meisenhelder & Cassem, 2009). The median alpha value for the PRC subscale was reported at .92 (Pargament et al., 2011). Additionally, a wealth of empirical studies supports the construct validity and incremental validity of the measure. Specifically, regarding predictive validity, PRC has been shown to predict greater well-being (Tsevat, Leonard, Szaflarski, Sherman, Cotton, Mrus, & Feinberg, 2009), and, in terms of incremental validity, there is evidence that PRC predicts well-being even after controlling for age and gender (Lewis, Maltby, & Day, 2005). In the current sample of LGB young adults, an alpha value of .96 was determined for the PRC subscale,

indicating excellent internal consistency. Additionally, an alpha value of .88 was found for the NRC subscale, indicating good measurement internal consistency for this scale.

Procedure

Participants recruited from Facebook were directed to the study from an advertisement posted on the side panel of their individual profile. Interested participants clicked the advertisement and were taken to the online informed consent document. Additionally, study announcements were posted on other social media websites (e.g., Reddit), LGB listservs, and online communities. These contained both a description of the study and a participation invitation. This announcement included a URL that navigated interested participants to an online informed consent document, which described the study and participants' rights. If a potential participant provided consent, she or he was then directed to the demographic form, followed by the survey. Upon completion of all of the measures in the survey, participants had the option to enter into a raffle for one of four small incentive prizes (i.e., electronic gift cards to a well-known online retailer).

Chapter 3: Results

Prior to conducting the analyses, expectation maximization was used in order to appropriately handle missing data, as outlined by Schlomer, Bauman, and Card (2010). Of the 617 participants with less than 10% missing data, thirty-one participants were missing at least one data point at the item level, with only six participants missing two data points at the item level (no participants with less than 10% missing data had greater than two missing data points). Given the small percentage of missing data, and considering that the missing data occurred at the item-level (Parent, 2013), procedures outlined by Schlomer et al. (2010) for expectation maximization were followed to handle these 37 missing data points.

The first hypothesis was that IH would be significantly, negatively correlated with PRC and significantly, positively correlated with both NRC and psychache in a sample of religiously-identified LGB young adults. In order to test the first hypothesis, bivariate correlations among all variables were calculated (see Table 1). Consistent with the first hypothesis, IH was significantly, positively correlated with NRC ($r = .34, p < .01$) and significantly, positively correlated with psychache ($r = .44, p < .01$); however, inconsistent with the first hypothesis, IH was also significantly, positively correlated with PRC ($r = .21, p < .01$).

The second hypothesis was that PRC would moderate the relationship between IH and psychache in a sample of religiously-identified LGB young adults. In order to test this hypothesis, a multiple regression was conducted, where psychache served as the criterion (see Table 2). This analysis followed the procedures for testing moderation outlined by Frazier, Tix, and Baron (2004). Specifically, z-scores for the predictor and moderator variables were calculated (i.e., IH and PRC, respectively), and these z-scores for IH and psychache were multiplied to create an interaction term. The z-scores for the predictor and moderator variables

were entered into the regression in Step 1, and the interaction term corresponding to IH and PRC was entered in Step 2. The results of the regression were significant ($R^2 = .20$), $F(2, 614) = 74.23$, $p < .001$. Significant main effects for both IH ($\beta = .41$, $p < .001$) and PRC were found at Step 1 ($\beta = -.07$, $p < .04$) (see Table 2). IH and PRC accounted for 19% of the variance in psychache at Step 1. The interaction of IH and PRC, however, was not significant.

Finally, it was hypothesized that NRC would mediate the relationship between IH and psychache in a sample of religiously-identified LGB young adults. To test this hypothesis, the *PROCESS* macro for SPSS (Hayes, 2013) was utilized to test for mediation effects. As stipulated by Hayes (2013), the independent variable, intervening/mediating variable, and the outcome variable were entered into a single simultaneous analysis. As Figure 1 illustrates, IH was significantly related to both NRC ($\beta = .34$, $p < .01$) and psychache ($\beta = .35$, $p < .01$), and NRC was significantly related to psychache ($\beta = .25$, $p < .01$).

A bootstrap analysis procedure was utilized to create 10,000 bootstrap re-samples from the dataset with 95% confidence intervals for the indirect effect (Mallinckrodt, Abraham, Wei, & Russell, 2006; Preacher & Hayes, 2008). Bootstrap methods draw many samples from the original empirical dataset, with re-sampling, such that “variability in the distribution of the parameter estimates across the many bootstrap samples accurately models variability in the original research sample to the degree that the original sample accurately represents the population from which it is drawn” (Mallinckrodt et al., p. 374). As Szymanski and Hilton (2013) pointed out, mediation analysis utilizing bootstrapping confidence intervals possesses several advantages, including that: (a) it does not erroneously assume normality in the distribution of the mediated effect, (b) it holds greater power and control over Type I error, and (c) it can be used with confidence when working with smaller sample sizes (Mallinckrodt et al.,

2006; Preacher & Hayes, 2008). Tests for mediation are significant when the calculated confidence interval does not contain zero (Preacher & Hayes, 2008).

Results of the analysis using a bias corrected 95% confidence interval for indirect relations revealed a statistically significant indirect link at $p < .05$. The mean indirect (unstandardized) effect was .09; the standard error of the main indirect effect was .02, and the 95% confidence interval for the main indirect effect was .06 (lower limit) and .14 (upper limit). The standardized indirect effect of IH on psychache through NRC was $\beta = .09$ (i.e., $.34 \times .25$). Further, the path between IH and psychache was significantly reduced when NRC was included in the model ($\beta = .44$ vs. $\beta = .35$); this offers greater support for the claim for partial mediation. Examining absolute values, the total effects of IH on psychache are .25 (direct effects) + .09 (indirect effects) = .34. Therefore, the total effect of IH on psychache is .09/.34; 26.47% is accounted for by the partial mediating influence of NRC. Preacher and Kelley (2011) recommend reporting kappa-squared (κ^2), “the ratio of the obtained indirect effect to the maximum possible indirect effect,” (p.107) as a measure of effect size in mediation analysis. They point out that “The benefits of using κ^2 are that it is standardized, in the sense that its value is not wedded to the particular scale used in the mediation analysis; it is on an interpretable metric (0 to 1); it is insensitive to sample size; and with bootstrap methods, it allows for the construction of confidence intervals” (p. 107). In the current study, $\kappa^2 = .09$ with the 95% confidence interval ranging from .06 to .13. Preacher and Kelley suggest that interpretation of κ^2 such that .01 is a small effect size, .09 is a medium effect size, and .25 is a large effect size.

Finally, a *t*-test analysis was initially planned to determine the impact of participants’ experiences with their religion of origin (i.e., whether participants came from LGB affirmative faith communities). However, only 3% ($n = 16$) of participants reported growing up in a

“church/faith community where there were affirmative LGB role models, and active movement from the church/faith community to support and affirm LGB members.” Conversely, 52% ($n = 323$) reported growing up in a church/faith community without LGB role models and without active movement from the church/faith community to support and affirm LGB members. Given this major discrepancy, and an extremely low number of participants reporting affirmative experiences, this analysis was deemed inappropriate. To further clarify the percentage of results, 6% ($n = 34$) of participants did not identify with either statement as applied to their experience, 13% ($n = 82$) did not grow up as part of a church/faith community, and 26% ($n = 162$) did not provide information in regard to this item.

Chapter 4: Discussion

LGB people are at greater risk of mental health problems, including psychache, because of systems of oppression that operate through heterosexism (e.g., Crain-Gully, 2011; Herek, 1990; Meyer, 2003; Sue, 2010). Psychache is especially troubling because it is a proximal predictor of suicidality (DeLisle & Holden, 2009; Flamenbaum, 2011; Flamenbaum & Holden, 2007; Pereira et al., 2010; Ribeiro et al., 2013; Troister & Holden, 2010, 2012). Previous research suggests that heterosexism (Crain-Gully, 2011) and IH (Bourn & Miles, 2015) relate to psychache in LGB populations, and this study sought to better understand psychache among LGB people, and to identifying potential factors that moderate and mediate the relationship between IH and psychache. Identifying moderators and mediators can help inform best practices for counseling psychologists and other allied professionals who work with LGB young adults struggling with immense mental pain (i.e., psychache). Therefore, a goal of this study was to examine the relationships between IH and psychache, and the role of PRC and NRC to moderate and mediate, respectively, this relationship.

This study thus extended the work of Crain-Gully (2011) and Bourn and Miles (2015), the two known previous studies to explore the role of psychache among LGB individuals. Specifically, within a sample of religiously-identified LGB young adults it was hypothesized that: (1) IH would be significantly, negatively correlated with PRC, and significantly, positively correlated with NRC and psychache; (2) PRC would moderate the relationship between IH and psychache, such that PRC would serve as a buffer in the relationship between IH and psychache; and (3) NRC would mediate the relationship between IH and psychache, such that NRC would facilitate the relationship between IH and psychache.

Consistent with Hypothesis 1, IH was significantly, positively correlated with NRC and

significantly, positively correlated with psychache. This finding is consistent with Bourn and Miles (2015) who likewise identified a significant, positive correlation between IH and psychache. Further, as NRC is associated with greater emotional distress, including depression, lower quality of life, and callousness (i.e., Pargament, 1998), and psychache by definition entails pervasive emotional distress (i.e., guilt, shame, fear, dread, loneliness, angst, humiliation, and anguish; Shneidman, 1993, 1999), it makes sense that NRC and psychache are significantly, positively correlated. However, inconsistent with Hypothesis 1, IH was also significantly, *positively* correlated with PRC. Though this finding was unpredicted, it seems to be in line with a similar pattern of results found by Hampton et al. (2010), who concluded that for gay and bisexual men living with HIV, coping strategies (i.e., PRC, illicit drug use, active coping) were not mutually exclusive, and in the course of the life threatening diagnosis of HIV, some individuals may subscribe to multiple, contradictory coping strategies.

For Hypothesis 2, IH did independently predict psychache, with higher levels of IH predicting higher levels of psychache, consistent with Meyer (2003) who concluded that heightened levels of IH likely results in negative mental health consequences. However, PRC did not moderate the relationship between IH and psychache (i.e., it did not serve as a buffer against the negative effects of IH in relation to psychache).

Further, both of the unexpected findings (i.e., the significant, *positive* correlation between IH and PRC, and the lack of a moderating effect of PRC) could make sense within the context of a heterosexist environment (e.g., Herek, 1990). Examining the participants' lived experiences, very few grew up in an open and affirming church/faith community ($n = 16$, or 3%), based on the responses to the demographic questionnaire. Instead, many of the individuals' experiences were likely marked by rejection and hostility by their church/faith community of origin. Growing up

in an oppressive context results in the experience of IH, placing participants at risk for increased mental health problems (e.g., Carter et al., 2014; Goldbach, Tanner-Smith, Bagwell, & Dunlap, 2013; Kuyper & Fokkema, 2011; Meyer, 2003; Shilo & Savaya, 2012; Szymanski et al., 2008). As the vast majority of participants grew up in heterosexist churches/faith communities, they were likely subjected to a high number of negative, hostile messages regarding the LGB community. Further, PRC and NRC were significantly, positively correlated in the current sample ($r = .40, p < .01$). Thus, if an individual used one form of religious coping, it may be likely that she or he is also using the other form as well. PRC does not seem to have the positive buffering effect hypothesized, but NRC does have a negative function in facilitating the link between IH and psychache. Thus, given the heterosexist context, marked by such features as microaggressions, prejudice, and discrimination (e.g., Shelton & Delgado-Romero, 2013; Sue, 2010), the current pattern of results might be expected. The findings regarding NRC and PRC are also consistent with the results of Szymanski and Obiri (2011), who found that NRC mediated the relationship between racist events and internalized racism, but that PRC did not moderate or mediate the link between racist events and internalized racism.

Further, studies that have examined relations between religion, IH, and mental health have referred to religion as both a source of resilience and a source of risk for LGB people (e.g., Ream & Savin-Williams, 2005). Simultaneously holding LGB and religious identities can be complicated and frustrating for LGB people (Dahl & Galiher, 2010). This may have been the case for this sample of LGB young adults. Given that so few participants described growing up in an actively LGB affirming religious environment, religion may not have served the same protective function in this LGB sample, as it might in the general (predominantly heterosexual) population (e.g., Dahl & Galiher, 2010, Szymanski et al., 2008). Thus, most of the sample, for

whom both their religious and LGB identities were salient, grew up in a religious community that presented either a “null environment” (Betz, 1989) in relation to LGB individuals and issues (i.e., one that “neither encourages nor discourages [LGB] individuals,” [Betz, 1989, p. 136]), or presented an outwardly hostile climate toward LGB individuals; either of these environments can be considered heterosexist. Given this heterosexism, and the lack of positive affirmations, it may be no wonder that a buffering effect was not found between IH and psychache, for the PRC behaviors were rooted within oppressive systems.

Finally, consistent with Hypothesis 3, mediation analyses revealed that NRC partially mediated the relationship between IH and psychache. Specifically, IH was positively related to NRC, which in turn was positively related to psychache. So, higher IH related to higher NRC, which related to higher levels of psychache. This finding is consistent with Szymanski and Obiri (2011) who found that NRC partially mediated the relationships between racist events and internalized racism, and psychological distress among African American people. The majority of the current sample identified as growing up in a church/faith community of origin that was *not* actively affirming to LGB people. LGB people who grew up in heterosexist faith environments who experience IH may feel inferior to their heterosexual peers and believe they deserve their oppressed status, which may drive the use of NRC behaviors that are consistent with this negative self-schema (Szymanski & Obiri, 2011). Use of these NRC behaviors may then drive the experience of psychache.

Practice Implications

These results can help inform best practices for counseling psychologists (and allied professionals) who work with LGB young adults struggling with psychache. First, counseling psychologists should consider the heterosexist context of LGB clients’ lives by asking about

experiences of heterosexism. Just as Szymanski and Obiri (2011) suggested that counseling psychologists should help clients of color to connect their experiences of racism to their presenting concerns, counseling psychologists should also help LGB clients to connect experiences with heterosexism, including IH, to their presenting concerns. Counseling psychologists can help clients to understand the nature of the heterosexist contexts in which they have developed, and to explore the ways in which they may have internalized this heterosexism, as a means to help de-pathologize clients. Counseling psychologists can also help clients to explore (and gently challenge) IH that may manifest itself in the therapy room, and help empower clients to advocate for themselves and confront (rather than internalize) heterosexism in their lives.

Counseling psychologists should also attend to the dynamic intersection of religion and sexual orientation among LGB clients of faith. Therapy can be a supportive and encouraging environment for LGB people to explore their sexual orientation identity, their religious identity, and the intersection of these two identities. Counseling psychologists can facilitate dialogues about an LGB client's thoughts and feelings about their religion, how the person's coming out process was (or continues to be) impacted by their religious identity, what one's religious journey has looked like over time, and how one interacts with their faith community. They can also help LGB clients understand how their experiences of IH may impact their use of NRC, thereby increasing their psychological pain (i.e., psychache). Further, counseling psychologists can help facilitate change by lessening the impact of IH on LGB young adults' mental health by helping to decrease their use of NRC. This can be a particularly powerful intervention, especially considering that religion can be a source of resilience or a source of risk in the lives of LGB people of faith (e.g., Ream & Savin-Williams, 2005).

Further, given that negative mental health outcomes (e.g., psychache) result from life in a heterosexist system (e.g., Crain-Gully, 2011; Meyer, 2003), and that the current results revealed positive correlations between IH and psychache, it is essential that counseling psychologists and allied professionals target systemic interventions to counteract this relationship (e.g., Fouad, Gerstein, & Toporek, 2006; Vera & Speight, 2003). Vera and Speight (2003) argue for a commitment to social justice within the field of counseling psychology, which entails an expansion of roles beyond that of psychotherapist in order to effect social change. On a systemic level and applied to heterosexism, this can take many forms, for example: educating the LGBT community about resources available to meet their needs, conducting trainings for police officers on working with the LGBT community, leading inter-group dialogues on sexual orientation in the community, collaborating with the community to start an LGBT organization, engaging in public policy activities at the local, state, or national level on behalf of the LGBT community. This is not an exhaustive list. On a related note, given that only 3% (i.e., $n = 16$) of the sample reported coming from an open and affirming church/faith community, counseling psychologists active in religious communities should take steps to make their religious communities more open and affirming of the LGBT community, if doing so is safe. This activism could take several forms, including: holding an LGBT support group at the place of worship, speaking to the congregation about LGBT rights issues, and distributing and making available pamphlets about LGBT health. By making the context more affirming, counseling psychologists can make an impact in the lives of LGB young adults dealing with psychache.

Limitations

It is necessary to attend to certain limitations within the study. First, the majority of the sample identified as White. The relative lack of racial diversity may have skewed the results,

with White participants not having to contend with additional minority stressors (e.g., Meyer, 2003) like various forms of racism. This, in turn, could have impacted the experience and endorsement of IH, PRC, NRC, and psychache. The majority of the sample also identified as Christian, which could have similarly impacted the results, with LGB people identifying as Christian also not having to contend with additional minority stressors that people from a minority religious group (e.g., Jewish, Muslim, etc.) would have to contend with.

Further, utilizing a young adult sample of LGB people for this study is appropriate in that this age group most consistently reports increased levels of psychache and suicidality (e.g., Eisenberg & Resnick, 2006; Haas et al., 2011; Szymanski et al., 2008). Even though this was an appropriate decision, it is currently unknown how well these results will generalize to the entire LGB community. Finally, the sample lacked diversity in regard to their religious community of origin's stance toward the LGB community. Only 3% ($n = 16$) of participants reported growing up in a "church/faitth community where there were affirmative LGB role models, and active movement from the church/faitth community to support and affirm LGB members," compared to 52% ($n = 323$) who grew up in a non-affirming church/faitth community. This large statistical difference made it inappropriate to run a *t*-test analysis to determine the impact of participants' experiences with their religion of origin (i.e., whether participants came from LGB affirmative religious communities).

Future Directions

A primary focus for this study was to better understand the risk and protective factors related to psychache in LGB young adults, in order to aid counseling psychologists in developing prevention and other interventions. Since NRC was found to be a partial mediator of the relationship between IH and psychache, counseling psychologists can target interventions at

NRC use by religiously-identified LGB young adults. Future research should address the efficacy of these interventions.

Since few participants reported experiencing an open and affirming faith community of origin ($n = 16$), it is also necessary to distinguish how well these results hold true for LGB adults who *did* experience open and affirming faith communities of origin. It is possible that PRC may serve as a protective factor against psychache for this specific population, whose experience may have been marked by greater support and less heterosexism manifested by their faith community of origin. Further, given the additional questions regarding generalizability elucidated above (i.e., regarding age, race, and religion), future research should address IH, PRC, NRC, and psychache with national samples of LGB participants of different ages; this will hopefully yield a more diverse sample in terms of race and religious background as well.

At the same time, as research concerning psychache in LGB communities is still very new (e.g., Bourn & Miles, 2015; Crain-Gully, 2011), there is considerable opportunity and need to identify additional potential protective factors against psychache. Thus, future research should examine the extent to which factors that have been found to protect individuals against psychache and suicidality in other diverse populations also serve as protective factors for LGB young adults. A large-scale project examining the applicability of multiple LGB young adult psychache protective factors, utilizing a longitudinal design, as well as a diverse national sample of LGB young adults would allow for optimal exploration. Pursuing these research areas will continue to inform best practices for counseling psychologists and other helping professionals who work with LGB young adults experiencing the maelstrom of mental pain that psychache inherently entails.

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Appendices

Table 1
Variable Means and Standard Deviations, and Correlations Between Variables

Variables	Mean	SD	Variables			
			1	2	3	4
1. Positive Religious Coping	9.17	7.24	--	.40**	.02	.21**
2. Negative Religious Coping	5.81	5.63		--	.37**	.34**
3. Psychache	1.92	.91			--	.44**
4. Internalized Heterosexism	1.92	.81				--

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

Table 2

Testing PRC as a Moderator of the Relationship Between IH and Psychache

Step and variable	<i>B</i>	<i>SE B</i>	95% <i>CI</i>	<i>R</i> ²
Step 1				
IH	.41	.03	.34, .48	
PRC	-.07	.03	-.14, -.01	.20**
Step 2				
IH × PRC	.01	.03	-.05, .08	.20

Note. CI = Confidence Interval. IH = Internalized Heterosexism. PRC = Positive Religious Coping. * $p < .01$. ** $p < .001$.

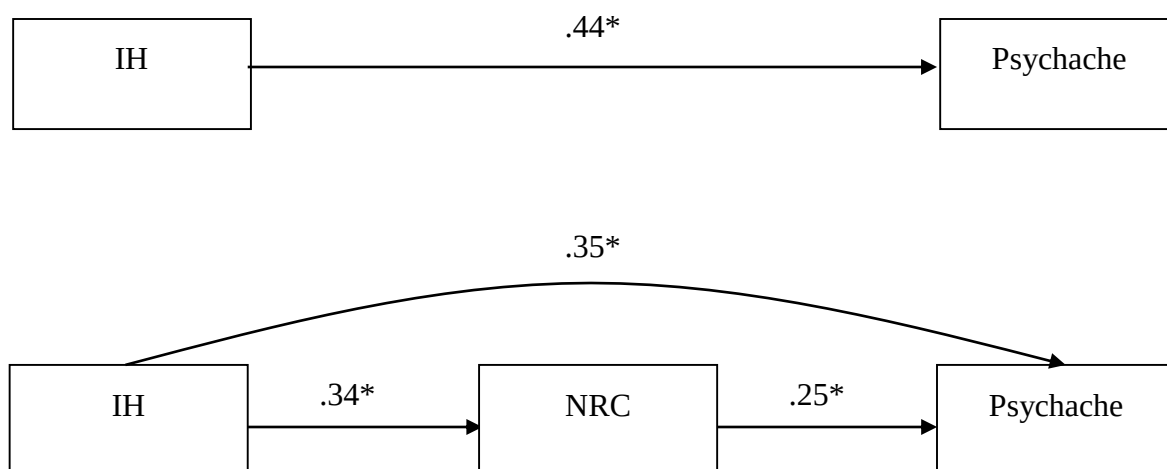


Figure 1. Relations among variables for direct effect of internalized heterosexism on psychache, and for the mediation of the relationship between internalized heterosexism and psychache by negative religious coping. $*p < .01$. IH = internalized heterosexism, NRC = negative religious coping.

Appendix A

Informed Consent

INTRODUCTION

If you identify as a gay, bisexual, lesbian undergraduate or graduate student, and are at least 18 years of age, you are invited to participate in a research project examining the unique factors related to the career development and well-being of undergraduate students identified of LGB persons. This research is being conducted by James Arnett and Jon Bourn, graduate students in counseling psychology at the University of Tennessee, and Joseph Miles, Assistant Professor in the Department of Psychology at the University of Tennessee.

INFORMATION ABOUT YOUR INVOLVEMENT IN THE STUDY

If you provide consent to participate in this study, you will be directed to a brief survey that will ask you to provide demographic information, and to answer questions regarding your experiences as a sexual minority person, your career development process, your religion and spirituality, and your relationships. The survey should take approximately 15-20 minutes to complete.

RISKS

The risks in this study are minimal and may include discomfort in answering questions about your experiences as a sexual minority individual, your career development process, and/or your relationships; or the possibility of a breach of confidentiality. You are able to withdraw your consent and discontinue your participation at any time in the course of the study, without penalty (i.e., you may still be entered in the raffle should you withdraw your consent).

To minimize the risk of a breach of confidentiality, you will not be asked to provide your name or other unique identifying information at any point on the survey measures, other your email address, should you wish to enter the raffle. Your email address will be used only for the purposes of the raffle, will in no way be connected to your survey data, and will be deleted upon completion of the raffle. In addition, the survey will be hosted by www.surveymonkey.com, which has secure servers and data encryption. Only the researchers will have access to the Survey Monkey account. Data will be stored in password protected computer files in the laboratory of the researchers and will be accessible only to the researchers.

BENEFITS

There are no direct benefits to you specifically for participating in the research. Potential benefits to society, however, include a better understanding of the unique factors that relate to the career development process and well-being in LGB individuals.

CONFIDENTIALITY

Your name and other identifying information will not be collected on any of the survey

measures. However, if you choose to be entered into the raffle, you will be asked to provide an e-mail address. You will be contacted through this same e-mail address you should win a raffle prize. Your email address will be used solely for the purpose of contacting you. Email addresses collected will be stored separately from the data in a separate computer. The raffle entries and survey are separate and not connected or linked in any way, and no attempts will be made to find a relationship between the entries and the questionnaire responses or IP addresses. Additionally, email information will be deleted upon completion of the raffle drawing.

Data will be stored securely and will be made available only to the researchers. Data will be used for aggregate (i.e., group-level) analyses only, and individuals will not be individually identifiable. No reference will be made in oral or written reports that could link participants to the study.

INCENTIVE

All persons will be asked whether or not they would like to be entered into a raffle for a chance to win one of four \$25 Amazon.com gift cards. Should you choose to enter the raffle, you will be asked to provide an email address. Winners of the raffle will be selected randomly from the list of emails provided, and winners will be contacted via email. Email addresses will be collected separately from the survey, and will be stored separately from survey responses. Emails will not be connected in anyway to the information that you provide in the survey itself. Email addresses will only be used for the purposes of the raffle, and will be deleted upon completion of the raffle. No additional identifying information will be collected in the course of the study. You do not have to participate in the study in order to be considered for the raffle.

CONTACT INFORMATION

If you have questions at any time about the study or the procedures, would like to receive a copy of this informed consent form for your records, (or you experience adverse effects as a result of participating in this study,) you may contact the researcher, Joseph Miles (joemiles@utk.edu), at 410C Austin Peay, and (865) 974-4183, or James Arnett (jarnett3@utk.edu) If you have questions about your rights as a participant, contact the Office of Research Compliance Officer (blawson@utk.edu) at (865) 974-3466.

PARTICIPATION

Your participation in this study is voluntary; you may decline to participate without penalty. If you decide to participate, you may withdraw from the study at anytime. However, you will only be able to enter the raffle upon completion of the survey. If you exit the survey without completing it, your responses will be deleted.

CONSENT

By clicking “yes” below, you indicate that you have read the above information, and that you consent to participate in this study. You may print or save a copy of this informed consent statement for your records, or a copy of the informed consent statement may also be obtained by

emailing James Arnett at jarnett3@utk.edu.

- ☐ Yes, I consent to participate in this study (by selecting this option, you will be directed to the survey)
- ☐ No, I do not wish to participate in this study (by selecting this option, you will be directed out of the survey)

Appendix B

Demographic Questionnaire

What is your age?

What is your gender?

- ☐ Female
- ☐ Male
- ☐ Transgender Male-To-Female
- ☐ Transgender Female-To-Male
- ☐ Other (please specify)

Do you consider yourself to be Hispanic or Latino?

- ☐ Yes
- ☐ No
- ☐ Prefer Not to Answer

Please select one or more of the following racial categories to describe yourself:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White or European American
- ☐ Multiracial
- ☐ Other
- ☐ Prefer Not to Answer

Do you identify as spiritual?

- ☐ Yes
- ☐ No

Do you identify as religious?

- ☐ Yes
- ☐ No

Please indicate your religious affiliation:

- ☐ Agnostic
- ☐ Atheist
- ☐ Buddhist
- ☐ Christian
- ☐ Hindu
- ☐ Islam
- ☐ Judaism
- ☐ Secular
- ☐ Unitarian
- ☐ Wiccan
- ☐ Not Applicable/No Religious Affiliation

Other (please specify)

Which of the following categories best describes how you would identify your sexual orientation and gender?

- ☐ Gay Man
- ☐ Bisexual Man
- ☐ Bisexual Woman
- ☐ Lesbian Woman
- ☐ Heterosexual Man
- ☐ Heterosexual Woman

What was your religion of origin (i.e., the religious faith that you were raised in), if applicable?

- ☐ Agnostic
- ☐ Atheist
- ☐ Buddhist
- ☐ Christian
- ☐ Hindu
- ☐ Islam
- ☐ Judaism
- ☐ Secular
- ☐ Unitarian
- ☐ Wiccan
- ☐ Not Applicable/No Religious Affiliation

Other (please specify) | _____

Which of the following best describes your religious experience while growing up?

- ☐ I grew up in a church/faith community where there were affirmative LGB role models, and active movement from the church/faith community to support and affirm LGB members
- ☐ I grew up in a church/faith community with no known LGB role models, and no active movement from the church/faith community to support and affirm LGB members
- ☐ Neither of these describes my church/faith community growing up. Please provide a narrative description here: | _____
- ☐ Not applicable

What is your current marital status?

- ☐ Single
- ☐ Married
- ☐ Domestic Partnership
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Other

Vita

Jon Raymond Bourn was born in Glens Falls, NY, to the parents of Shirley and Guy Bourn. He was raised in Granville, NY, and graduated valedictorian from Granville Jr./Sr. High School. He enrolled at Elmira College on a full tuition scholarship, where he was able to nurture his passion for the social sciences. While at Elmira College, he became very active in social justice, leading an LGBTQ+ advocacy group and serving in an all-affirming religious group. Jon earned a Bachelor of Arts degree from Elmira College in June 2011 in Psychology, Human Services, and Sociology/Anthropology, graduating summa cum laude.

Inspired by the Scientist-Practitioner-Advocate training model offered, Jon next enrolled in the Counseling Psychology doctoral program at the University of Tennessee, Knoxville, studying under Joseph Miles, Ph.D. While in the program, Jon taught classes in General Psychology and Abnormal Psychology, emphasizing the social construction of mental illness and a multicultural view on psychopathology. In addition to leading intergroup dialogues exploring social class and classism, sexual orientation and heterosexism, and gender and sexism, he co-authored a book chapter on the use of intergroup dialogue to explore intersections of conservative Christianity and sexual orientation. During his doctoral training, Jon provided therapy at a university counseling center, a residential substance abuse treatment center, a veterans' shelter, and a community mental health center. He completed a Social Justice Practicum addressing barriers to domestic violence services faced by the LGBT community, which entailed educating the LGBT community about healthy relationships and domestic violence, and offering workshops to service providers and police officers about working effectively with the LGBT community. Jon's research interests focus on LGBT mental health, psychache/suicidality in the LGBT community, and protective factors in these domains.