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An Inconsistent God: Attachment to God and Minority Stress among Sexual Minority Christians

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I am submitting herewith a thesis written by Adam David Anthony Maughan entitled "An Inconsistent God: Attachment to God and Minority Stress among Sexual Minority Christians." I have examined the final electronic copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Arts, with a major in Psychology.

Joseph R. Miles, Major Professor

We have read this thesis and recommend its acceptance:

Joseph R. Miles, Kirsten A. Gonzalez, Patrick R. Grzanka

Accepted for the Council:
Dixie L. Thompson

Vice Provost and Dean of the Graduate School

(Original signatures are on file with official student records.)

An Inconsistent God: Attachment to God and Minority Stress among Sexual Minority Christians

A Thesis Presented for the

Master of Arts

Degree

The University of Tennessee, Knoxville

Adam David Anthony Maughan

December 2020

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Abstract

Having a secure Attachment to God (ATG) has been found to be related to better mental health and well-being for Christian individuals and has been shown to have a buffering effect against stressful life events for this population. However, the ATG literature has failed to examine the experiences of Christians who also identify as sexual minorities (lesbian, gay, bisexual, queer, pansexual, same-sex attracted, or another non-exclusively heterosexual identity). Sexual minority Christians (SMCs) experience unique minority stressors related to prejudice, discrimination, and stigma associated with their sexual identities, and this minority stress has negative implications for their mental health and well-being. The current study sought to examine whether ATG moderates the association between minority stress and mental health and well-being of SMCs. The anxiety dimension of ATG was found to be negatively associated with mental health and well-being, such that individuals whose attachment relationship with God was characterized with greater anxiety were found to report significantly worse mental health and well-being. However, contrary to our hypothesis, ATG did not moderate the relation between minority stress and mental health and well-being among SMCs.

TABLE OF CONTENTS

1. Introduction

Minority Stress Theory as conceptualized by Meyer (2003) suggests that disparities in mental health among sexual minorities (those who identify as lesbian, gay, bisexual, pansexual, queer, same-sex attracted, or another non-exclusively heterosexual identity) can be explained through examining unique experiences of stigma, prejudice, and discrimination related to these identities. Within Christian contexts where sexual minority identities are traditionally vilified, sexual minority Christians (SMCs) consistently face additional minority stressors that have real consequences for their mental health and well-being (Barnes & Meyer, 2012; Gibbs & Goldbach, 2015; Syzmanski et al., 2008). SMCs have been observed to use religion as a way to cope with these minority stressors (Brewster et al., 2016), suggesting that religious constructs may play a role in reducing the impacts of minority stress on mental health and well-being among SMCs. Among the broader population, the type of attachment relationship individuals have with God (referred to as Attachment to God, or ATG; Kirkpatrick, 1992, 2005) has been observed to moderate the impacts of stressful life events on mental health and well-being (Ellison et al., 2012). Given ATG's role in ameliorating the impacts of stress among the broader Christian population, it is surprising that none of the ATG literature to date has examined how this construct works in the lives of SMCs. The complex role of religion in the lives of SMCs as both a safe haven and place of discrimination and abandonment highlights the importance of examining how ATG functions in relation to the minority stress that SMCs face both within their religious spheres and the world beyond. The current study seeks to address this gap in the literature, examining whether ATG buffers the impacts of minority stress on the mental health and well-being of SMCs.

Minority Stress

Research has suggested that sexual minorities experience more mental health difficulties than their heterosexual peers (Meyer, 2003). The Minority Stress Model, proposed by Meyer (2003), suggests that these disparities can be understood by examining the role of unique stressors that sexual minorities experience above and beyond the general population. These additional stressors, referred to by Meyer (2003) as minority stress, include prejudice, discrimination, and stigma that individuals encounter related to their sexual identity. Greater experiences of minority stress have been found to relate to worse mental health and well-being for sexual minorities (e.g., Brown et al., 2016; McCarthy et al., 2014). Minority stress can be experienced both proximally (e.g., internalized feelings that stigmatize sexual minorities as evil/bad, referred to as internalized heterosexism) as well as distally (e.g., expectations/experience of harassment and discrimination for being a sexual minority). For example, exposure to violence towards sexual minorities, lack of self-acceptance, discrimination, and exposure to heterosexist events are all minority stressors observed to be related to shame, internalized homonegativity, depression, anxiety, and PTSD (Brown et al., 2016; McCarthy et al., 2014).

Religion and Minority Stress

Minority stress is especially salient in the lives of sexual minorities who also identify as Christian. A majority of Christian denominations preach that same-sex romantic and sexual behavior is immoral in the eyes of God (Kashubeck-West et al., 2017; Levy, 2014). Sexual minorities who are coming to terms with their sexual identity within such a context often experience severe conflicts between their sexual and religious identities, feeling that they have to choose one or the other (Dahl & Galliher, 2009; Schuck & Liddle, 2001). 43% of sexual

minorities report that they have experienced this conflict between their religious and sexual identities (Gibbs & Goldbach, 2015). Religious sexual minorities experiencing this conflict report greater internalized heterosexism (i.e., proximal minority stress) than their non-religious peers (Gibbs & Goldbach, 2015). Furthermore, in Gibbs and Goldbach's sample of 2,949 sexual minorities, those experiencing religious and sexual identity conflict reported more suicidal ideation than their non-religious peers. Those who reported leaving their religion to resolve this conflict were more likely to report a suicide attempt within the past year (Gibbs & Goldbach, 2015). This is especially distressing, as leaving one's religion of origin has been found to be the most common form of resolution seeking among sexual minorities experiencing this conflict (Scheitle & Wolf, 2017). In addition to greater internalized heterosexism and suicidality, sexual minorities who grew up religious environments report greater experiences of discrimination (i.e., distal minority stress) than their non-religious peers (Barnes & Meyer, 2012; Syzmanski et al., 2008). Greater experiences of both proximal and distal minority stress place these sexual minorities at greater risk for other mental health difficulties, including greater depression, anxiety, PTSD symptoms, shame, and lower self-esteem (Brown et al., 2016; McCarthy et al., 2014; Meyer, 2003; Syzmanski et al., 2008).

Religion as Moderator for Minority Stress

Interestingly, some sexual minority Christians (SMCs) have reported using religion as a way to cope with minority stress. Brewster et al. (2016) found that positive religious coping among religious and spiritual sexual minorities moderated the relation between internalized heterosexism and psychological well-being, in that greater positive religious coping buffered the impact of internalized heterosexism on psychological well-being. Positive religious coping, as measured by Pargament et al.'s (2011) R-COPE, includes items such as, "Looked for a stronger

connection with God," "Sought God's love and care," and "Sought help from God in letting go of my anger." Negative religious coping, however, was not found to moderate this relationship, and is characterized in the R-COPE by statements such as, "Wondered whether God had abandoned me," "Felt punished by God for my lack of devotion," and "Questioned God's love for me," (Brewster et al., 2016; Pargament et al., 2011). It is relevant to note that these statements of positive religious coping draw upon themes of trust, love, and proximity seeking with God, while themes related to negative religious coping include fears of abandonment, and questioning God's love, which are themes reminiscent of those found in the construct of Attachment to God.

Attachment to God

Attachment to God (ATG) as a construct has its roots in Bowlby's (1969) Attachment Theory as well as Ainsworth's (1978) expansion on Bowlby's research on relationships between infants and their caregivers. Ainsworth identified three patterns of attachment between the infant and their caregiver: secure, anxious-ambivalent, and avoidant attachment, with a fourth attachment pattern, disorganized attachment, being identified by Main and Solomon (1986). Growing research on attachment has suggested that these attachment patterns tap into two separate dimensions of attachment, specifically anxiety and avoidance in attachment relationships (Cameron et al., 2012). Research has since examined the impact of attachment on a number of different types of relationships, including romantic relationships (Hazan & Shaver, 1987), adolescent friendships (Diamond & Dubé, 2002), and therapeutic relationships (Mallinckrodt et al., 1995). In addition to examining these human relationships, attachment research has extended to relationships between individuals and non-human entities, such as an

individual's attachment to their workplace (Feeney et al., 2020) and, as being discussed here, attachment relationships between individuals and God (Kirkpatrick, 1992; 2005).

According to Kirkpatrick (1992; 2005), a leader in ATG research, attachment to God meets Ainsworth's (1985) criteria for attachment relationships. First, in an attachment relationship, the attached person seeks proximity to the attachment figure in times of distress (Ainsworth, 1985; Kirkpatrick, 2005). Second, the attached person relies on the attachment figure for safety and protection (Ainsworth, 1985; Kirkpatrick, 2005). Third, the attached person experiences feelings of trust/security with the attachment figure (Ainsworth, 1985; Kirkpatrick, 2005). Fourth, when the attached person experiences real or threatened separation from the attachment figure they experience anxiety (Ainsworth, 1985; Kirkpatrick, 2005). Finally, the loss of the attachment figure results in distress and grief for the attached person (Ainsworth, 1985; Kirkpatrick, 2005). Because God is portrayed to be a safe haven; a secure base; and an omniscient, omnipresent, and omnipotent guardian, God has the potential to act as an ideal attachment figure (Kirkpatrick, 2005).

ATG styles mirror human attachment patterns, including their ability to be categorized along the dimensions of anxiety and avoidance (Rowatt & Kirkpatrick, 2002). Avoidant ATG can be characterized as a relationship where, "God is generally impersonal, distant, and often seems to have little or no interest in [one's] personal affairs and problems," (Kirkpatrick & Shaver, 1992, p. 270). These individuals may feel that God doesn't like or care about them (Kirkpatrick & Shaver, 1992). On the other hand, anxious ATG relationships are those where, "God seems to be inconsistent in His reactions to [the person]; He sometimes seems very warm and responsive to [their] needs but sometimes not" (Kirkpatrick & Shaver, 1992, p. 270). Thus, they express confusion in their relationship with God and his feelings towards them. Individuals

with secure ATG are those who report low anxiety and low avoidance in this relationship (Beck & McDonald, 2004). Secure attachment relationships with God are those in which the individual perceives God to be, "generally warm and responsive," understanding, "when to be supportive and protective of [them] and when to let [them] make their own mistakes" (Kirkpatrick & Shaver, 1992, p. 270).

The attachment pattern individuals have with God has been shown to have implications for mental health and well-being. Leman et al. (2018) found that secure ATG was related to less depression, anxiety, and stress among a sample of 161 religious adults. Relatedly, they found that higher scores on anxiety and avoidance dimensions of ATG were associated with worse depression, anxiety, and stress. Rowatt and Kirkpatrick (2002) found that ATG anxiety was associated with higher levels of neuroticism and experiencing negative emotions. The body of evidence associating anxiety and avoidance dimensions of ATG with mental health and well-being continues to grow.

In addition to having more direct associations with mental health and well-being, ATG has been found to play a role in moderating the impacts of stressors on a range of physical and mental health indicators. For example, in an online study of 102 women, Strenger et al. (2015) observed that secure ATG buffered the impacts of sociocultural pressures that idealize thinness on eating disorder symptoms. In 2012, Ellison et al. observed the role of ATG in moderating the impacts of stressful life events. In their longitudinal study, they collected data from a nationwide sample of 906 elders and other active members of the Presbyterian Church in the United States. Their results indicated that secure ATG moderated the effects of stressful life circumstances on distress, such that distress related to stressful life circumstances was lower among those who

reported a more secure ATG (lower anxiety and avoidance). Higher ATG anxiety, on the other hand, was found to worsen the impacts of these stressful life circumstances on distress.

The Differential Role of Religion for Sexual Minorities

This brings us to an important point. While the benefits of religion for mental health and well-being have been well documented for the general population (Koenig, 2012; Levin, 2010), the impact of religion on these factors is more complicated for SMCs. For example, research has shown that religion may act as both a risk and a protective factor for suicide among sexual minorities (Aranmolate et al., 2017; Kralovec et al., 2012; Longo et al., 2013). Similarly, where religion has been found to be protective against depression more broadly (Balbuena et al., 2013; Ronneberg et al., 2014), this association is less straightforward for sexual minorities. Gattis et al. (2014) observed that while religion can act as a protective factor against depression for sexual minorities, it does so only for those who affiliate with denominations affirming of their sexual identities. For individuals who affiliate with a non-affirming denomination, religion acts a risk factor for depression. Furthermore, while the literature has largely supported a positive association between religious observance and well-being (Ellison et al., 2001), this association is yet again divided for sexual minorities, with religious observance being positively associated with well-being in affirming denominations, but negatively associated in non-affirming denominations (Boppana & Gross, 2019). Given this information, we cannot assume that religion has the same impact on mental health and well-being for sexual minorities as it does for heterosexual populations, including the construct of ATG.

Given ATG's potential for moderating the impacts of stressful life events, it is surprising that none of the existing ATG has included demographic information on the sexual orientation of research participants. As Kashubeck-West et al. (2017) discuss, the mental health profession has

often disregarded or discounted the importance of religion in the lives of sexual minorities, and the state of the current literature suggests that psychologists more broadly may also be subject to this bias. Although sexual minorities have been observed to be less religious than the general population in the United States (Barnes & Meyer, 2012), the role of religion still remains an important one in the lives of sexual minorities. A 2014 Gallup poll found that 49% of sexual minorities report religion as being an important aspect of their daily lives (Newport, 2014). As such, failing to examine the sexual orientation of research participants within the existing ATG research is misguided. Regardless of the exact reasons for their exclusion from the research, this represents a significant and concerning gap in our understanding of how ATG may act in the lives of SMCs who are at greater risk of experiencing minority stress.

The Current Study

Despite the differential role of religion in mitigating the impacts of minority stress among SMCs (Brewster et al., 2016), these populations have been largely excluded from the religious literature, broadly. This is especially true for the ATG literature, where reference to sexual minority identities is currently non-existent. As such, how ATG may function in the lives of SMCs is presently unknown. Because we know that religion has a more complex role in the lives of sexual minorities, and that minorities experience additional minority stressors above and beyond the general population, particularly in religious spheres, it is therefore important to examine how ATG may buffer the impacts of minority stress on mental health and well-being for this population. Therefore, the current study seeks to examine whether ATG buffers the impact of both proximal and distal minority stressors on the mental health and well-being of SMCs. Based on the research reviewed above, we hypothesized the following:

Hypothesis 1: ATG will moderate the relationship between daily experiences of heterosexism (a distal minority stressor) and mental health and well-being among SMCs, such that the relation between experiences of heterosexism and poorer mental health and well-being would be reduced for those with a more secure ATG (lower anxiety, lower avoidance).

Hypothesis 2: ATG will moderate the relation between internalized heterosexism (a proximal minority stressor) and mental health and well-being among SMCs, such that the relation between internalized heterosexism and poorer mental health and well-being would be reduced for those with a more secure ATG (lower anxiety, lower avoidance).

2. Method

Participants

Participants were recruited from across the United States. Participant demographics are displayed in Appendix 1 (all tables for this thesis are located in the appendices). Participants were recruited through snowball sampling via emails to sexual minority-serving organizations, through personal contacts of the authors, and through social media. Snowball sampling in this way has been identified as a means to identify hard-to-reach populations, particularly when there are multiple eligibility requirements for participation, such as our study's requirement for participants to identify as both a sexual minority and a Christian (Sadler et al., 2010). In an effort to obtain as diverse a sample as possible, attempts were made to contact relevant organizations in every state. Relevant organizations were defined as any organization serving lesbian, gay, bisexual, transgender, or queer (LGBTQ+) populations generally (e.g., PFLAG, LGBTQ+ community centers), LGBTQ+ organizations officially or unofficially associated with a Christian college or university, as well as other organizations that serve LGBTQ+ Christians

specifically (e.g., LOVEBoldly, Q Christian Fellowship). Where possible, organizations were invited to print off, distribute, or display a recruitment flyer which
was accompanied with a QR code linking possible participants to the study. The initial number of participants was 284.

Measures

Demographic Questionnaire

The demographic questionnaire included questions regarding participant's state of residence, age, gender, race, sexual orientation, social class, and ability status. Additionally, participants were asked if they identified as a Christian (regardless of participation in formal religious services or rituals). If so, participants were asked which religious denomination they identified with, with options to self-identify. Participants who were not over age 18, did not identify as a sexual minority, and/or did not identify as a Christian did not qualify for inclusion in the study, and were routed to a list of suicide resources. Since some individuals may not attend religious services corresponding to the religion they identified with (for example, a Catholic sexual minority who attends a non-denominational Christian church), participants were asked if they were affiliated with a local Christian religious institution, regardless of attendance, and which religious denomination this institution belonged to. Participants were then asked to rate how affirming they believed that their local religious institution and overall religious denomination were of sexual minorities. Finally, participants were asked if and how often they attended religious services.

Attachment to God

The Attachment to God Inventory (AGI; Beck & McDonald, 2004) is a 28-item scale that assesses two dimensions of attachment, Avoidance of Intimacy and Anxiety about

Abandonment, in regard to an individual's relationship with God. The scale is based off of Brennan, Clark, and Shaver's (1998) Experiences in Close Relationships Scale, which examines these two dimensions within the context of a person's romantic relationships in adulthood. The Avoidance of Intimacy subscale includes 14 items. Sample items include, "I just don't feel a deep need to be close to God," and, "I prefer not to depend too much on God." The Anxiety about Abandonment subscale also includes 14 items, including, "Sometimes I feel that God loves others more than me," and, "Almost daily, I feel that my relationship with God goes back and forth from 'hot' to 'cold.'" Participants responded to each item on a scale from 1-7, where 1 was labeled as "disagree strongly," 4 as "neutral/mixed," and 7 as "Agree Strongly." Beck and McDonald found good internal consistency for both the anxiety ($\alpha = .84$) and avoidance ($\alpha = .86$) dimensions of this scale (2004), having convergent validity with a measure of religious and existential well-being. Internal consistency for our sample was found to be good for both the anxiety ($\alpha = .91$) and avoidance ($\alpha = .85$) dimensions.

Daily Experiences of Heterosexism

The Daily Experiences of Heterosexism Questionnaire (DHEQ; Balsam et al., 2013), is a 50-item measure that assesses distal stress related to being a sexual minority and contains nine subscales. The subscales of the DHEQ include the Vigilance subscale (six items, e.g., "Watching what you say or do around heterosexual people."), Harassment and discrimination subscale (six items, e.g., "Being verbally harassed by strangers because you are LGBT."), Gender expression subscale (six items, e.g., "Being harassed in public because of your gender expression."), Parenting subscale (six items, e.g., "People assuming you are heterosexual because you have children."), Victimization subscale (four items, e.g., "Being punched, hit, kicked, or beaten because you are LGBT."), Family of origin subscale (six items, e.g., "Being

rejected by your mother for being LGBT."), Vicarious trauma subscale (six items, e.g., "Hearing about hate crimes (e.g., vandalism, physical or sexual assault) that happened to LGBT people you don't know."), Isolation subscale (four items, e.g., "Difficulty finding LGBT friends."), and the HIV/AIDS subscale (six items, e.g., "Other people assuming that you are HIV positive because you are LGBT."). Participants responded to each question using a 7-point Likert scale from 1 (*did not happen/not applicable to me*) to 7 (*it happened and it bothered me EXTREMELY),* with "*not at all,*" "*a little bit*," "*moderately*," and "*quite a bit*" falling in between. This response style enabled participants to simultaneously indicate whether an experience had happened at all to them, as well as how distressing the experience was for them if it occurred. Since there was no reason to believe ATG differentially impacts specific experiences of minority stress over another, we calculated a full-scale score for both the average total occurrences of heterosexist experiences endorsed by participants, as well as a mean score of how distressing these experiences were. Basalm et al.'s (2013) alphas for this measure ranged from .76 to .87. Internal consistency for our scale was low for both Victimization ($\alpha = .60$) and Isolation (.69) subscales. The low alpha for the Victimization subscale is possibly due to the small amount of these items which measure very different aspects of victimization (e.g., physical assault, sexual assault), thus making it difficult for one score to predict other scores within this subscale. The low alpha for the Isolation subscale may suggest that SMCs may experience belonging differently than the normative sample. For example, an individual may feel they have other SMCs they can talk to about being a sexual minority, but may not feel they fit in with the broader LGBTQ+ community because of their religious beliefs (Sumerau, 2016). The remaining subscale alphas were acceptable, ranging from .71 to .82, with the overall internal consistency for this scale being excellent ($\alpha = .90$).

Internalized Homophobia

The Internalized Homophobia scale (IHP) is a 9-item scale that was initially designed by Martin and Dean (1987) for use with gay men to assess negative feelings about their sexual identity. A sample item is, "Have you thought that being gay is a personal shortcoming?" In 1998, Herek, Cogan, Gillis and Glunt modified the scale for use with lesbian and bisexual individuals (e.g., "I feel that being lesbian/bisexual is a personal shortcoming for me."). The IHP has been found to have good internal consistency among lesbian and bisexual cisgender women (α=.71) as well as gay and bisexual cisgender men (α = .83; Herek et al., 1998; Syzmanski et al., 2008). It also has demonstrated good convergent validity with feelings towards the LGBTQ+ community, connection to this community, depression, openness around sexual identity, and others measures (Herek et al., 1998; Syzmanski et al., 2008). Given the diversity within the LGBTQ+ community, we decided to make similar adaptations to this scale to be inclusive of transgender and non-binary participants (e.g., "I feel that being a sexual minority is a personal shortcoming for me," and "I would like to get professional help in order to change my sexual orientation to exclusively heterosexual"). Participants responded to each question using a 5-point scale ranging from 1 (*disagree strongly*) to 5 (*agree strongly*). The coefficient alpha for this scale among our sample was .83.

Depression, Anxiety, and Stress

The Depression, Anxiety and Stress Scale-21 (DASS-21; Lovibond & Lovibond, 1995) is a 21-item scale measuring depression, anxiety, and stress. The DASS-21 has been observed to have good internal consistency, with coefficient alphas ranging from .81 to .88 (Osman et al., 2012). Similarly, our results showed good internal consistency for the Depression (α = .91), Anxiety (α = .86) and Stress (α = .87) subscales. It has also been found to have good convergent

validity with other measures of depression and anxiety and also demonstrates discriminant validity between the constructs it measures (Lovibond & Lovibond, 1995). The scale consists of three subscales with seven items each, assessing symptoms of depression (e.g., "I couldn't seem to experience any positive feeling at all."), anxiety (e.g., "I felt scared without any good reason.") and stress (e.g., "I found it difficult to relax."). Participants responded to each question using a 4-point Likert scale, ranging from 0 (*Did not apply to me at all*) to 3 (*Applied to me very much or most of the time*).

Psychological Well-being

The Psychological Well-being Scale (PWBS; Ryff & Keyes, 1995; Ryff et al., 2010) is an 18-item scale measuring aspects of psychological well-being, including autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and self-acceptance. The PWBS was designed as a briefer version of Ryff's (1989) initial study of these factors of psychological well-being. Three of the original twenty items for each of these aspects of psychological well-being were drawn from this initial study, which had demonstrated good internal consistency and convergent validity with measures of affect balance, life satisfaction, self-esteem, depression, morale, and locus of control. Ryff and Keyes (1995) observed low to moderate internal consistency in the PWBS subscales, ranging from .33 to .56, and suggested this was likely due to the small number of items per subscale and items being selected for construct validity, representing the breadth of each construct they examine. Despite this, Ryff and Keyes found that these subscales correlated highly with their original scales, with correlations ranging from .70 to .89. Similarly, we observed low to medium internal consistency in the subscales for this measure, ranging from $\alpha = .35$ (Purpose in Life subscale) to $\alpha = .71$ (Environmental Mastery subscale). The internal consistency for this scale as a whole for our

study was strong (α = .82), and correlated in expected directions with depression, anxiety, and suicidal ideation, such that lower sum psychological well-being scores were associated with greater depression, anxiety, and suicidal ideation (see Appendix 2). Sample items from this scale include, "When I look back at the story of my life, I am pleased with how things have turned out so far" (reverse scored), "The demands of everyday life get me down," and "In general, I feel I am in charge of the situation in which I live" (reverse scored). Participants responded to each question using a 7-point Likert scale that ranged from "Strongly Agree" to "Strongly Disagree."

Suicidal Ideation

The Suicidal Ideation Attributes Scale (SIDAS; van Spijker et al., 2014) is a five-item measure that examines the presence, frequency, and severity of suicidal ideation. This scale has been found to have good internal consistency (α = .91), and has convergent validity with other measures of suicide (e.g., C-SSRS, PHQ-9) as well as measures of anxiety and insomnia (e.g., GAD-7, ISI; van Spijker et al., 2014). Our results also showed good internal consistency for this scale (α = .82). Sample items include, "In the past month, how often have you had thoughts about suicide?" "In the past month, how close have you come to making a suicide attempt?" and "In the past month, how much have thoughts about suicide interfered with your ability to carry out daily activities, such as work, household tasks, or social activities?" Participants responded to each question using a Likert Scale that ranged from 0-10 with specific items using different corresponding scale markers (e.g., Never-Always, Not at all-Extremely).

Procedures

After following the link to the online survey, potential participants reviewed the informed consent screen. Those who did not consent were routed to a list of suicide hotlines and thanked for their time. Those who did consent to participate proceeded to the demographics portion of

the survey. Individuals qualified for the survey if they were over the age of 18, did not identify as exclusively heterosexual, and identified as a Christian (regardless of participation in formal religious services or rituals). Participants who qualified for inclusion in the study then filled out measures assessing their attachment to God (AGI; Beck & McDonald, 2004), daily experiences of heterosexism (DHEQ; Balsam et al., 2013), internalized homophobia (Martin & Dean, 1987; Herek et al., 1997), depression, anxiety, and stress (DASS-21; Lovibond & Lovibond, 1995), psychological well-being (PWBS; Ryff, 1989; Ryff & Keyes, 1995), and suicidal ideation (SIDAS; van Spijker et al., 2014). Upon completion of the survey, participants were taken to a list of suicide hotlines and had the opportunity to enter into a raffle to earn one of four $25 Amazon gift cards. Participants were also invited to share the survey with other Christian sexual minorities they knew.

3. Results

After running analyses to examine missing data, data from 74 individuals were removed due to more than 10% of their data being missing as a result of not filling out the survey completely. Four additional participants were eliminated due to failing two out of three validation checks embedded in the survey (e.g., "Please select 'a little disagree'). Of the remaining participants, only 12 individuals had less than 10% data missing, with a range of 1-9 items missing among these 12 individuals. Of these 12 individuals, 11 had 3 or less missed items, with only one person missing 9 items. This missing data was then accounted for using expectation maximization (Schlomer et al., 2010). The remaining participants completed 100% of the survey. The final sample size was 210.

Data collection began on February 26, 2020, before the March 13th declaration of a national emergency in the United States due to the worldwide COVID-19 pandemic. We

assumed that levels of stress, anxiety, and depression would likely be elevated due to the pandemic, so data collection was stopped on April 11, 2020. Because of the unique circumstances that arose due to the pandemic, *t*-tests were done to compare responses between pre- (n = 180) and post- (n = 30) national emergency declaration. Across all dependent variables, significant differences were only found for the Stress subscale of the DASS-21, with scores indicating significantly higher levels of stress pre-pandemic declaration (M = 32.17) than post-pandemic declaration (M = 30.27). One possible explanation for this surprising finding is the possibility that those who were experiencing higher levels of stress post-pandemic were less likely to add to that stress by participating in research. Because of these significant differences, the DASS-21 Stress subscale was not included in our analyses.

Anxiety and avoidance dimensions have been shown to be significantly correlated for adult attachment styles (Cameron et al., 2012). This has not been found for the anxiety and avoidance dimensions of ATG (Beck & McDonald, 2004). Correlations were calculated in order to confirm that ATG dimensions were not significantly correlated for this study, as well as to examine relations between variables (see Appendix 2). Aligning with previous research, anxious and avoidant dimensions of ATG were not found to significantly correlate.

Correlations among ATG dimensions and our other study variables were particularly of note. ATG anxiety was positively correlated with internalized heterosexism, depression, anxiety, distress related to DEH, occurrences of DEH, and suicidal ideation. Specifically, this means that among our sample, less ATG anxiety (greater security) was related to lower levels of internalized heterosexism, less depression, less anxiety, less distress from DEH, fewer occurrences of DEH, and less suicidal ideation. Both ATG anxiety and avoidance were negatively correlated with psychological well-being, such that greater anxiety or avoidance in one's ATG was related to

lower psychological well-being. With the exception of psychological well-being, ATG Avoidance was not found to significantly correlate with any other variable in our study (see Appendix 2).

Moderation analyses: Hypothesis 1

All moderation analyses were completed utilizing Hayes (2013) PROCESS macro for SPSS. In regard to hypothesis 1, sixteen moderation analyses were utilized to examine how the relation between daily experiences of heterosexism (DEH), a distal minority stressor, and our dependent measures of mental health and well-being differed based upon the ATG dimension scores of SMCs. Because Balsam et al.'s (2013) questionnaire examines both the total occurrence of DEH as well as mean distress related to DEH, we completed separate analyses to examine ATG's role in buffering the impacts of both the occurrence and distress aspects of DEH.

First, we examined whether ATG anxiety moderated the relation between the total number (occurrence) of reported DEH and suicidal ideation, depression, anxiety, and psychological well-being, respectively. ATG anxiety did not significantly moderate any of these relations (see Appendix 3). Next, moderation analyses were run to see if ATG anxiety moderated the relation between average distress related to DEH and these same outcome measures of suicidal ideation, depression, anxiety and psychological well-being. Similarly, no significant results were found for these moderation analyses (see Appendix 3).

We then conducted analogous sets of analyses examining the role of ATG avoidance in moderating the relation between both aspects of DEH and suicidal ideation, depression, anxiety, and psychological well-being, respectively. ATG avoidance did not moderate the association for either occurrence or distress related to DEH and our outcome variables (see Appendix 3).

Hypothesis 1 was therefore not supported, such that neither ATG anxiety or avoidance dimensions moderated the relation between aspects of DEH and our dependent variables.

Moderation analyses: Hypothesis 2

Moderation analyses were then run to examine whether ATG anxiety or avoidance moderated the relation between internalized heterosexism (IH) and our measures of mental health and well-being. ATG anxiety did not significantly moderate the relation between IH and suicidal ideation, depression, anxiety, or psychological well-being (see Appendix 3). ATG avoidance similarly did not significantly moderate the relation between IH and suicidal ideation, depression, anxiety, or psychological well-being (see Appendix 3). Thus, Hypothesis 2 was also not supported, such that ATG avoidance and anxiety dimensions did not buffer the impacts of IH on the mental health and well-being of SMCs.

4. Discussion

To our knowledge this was the first study examining the role of ATG in buffering the impacts of minority stress in the lives of SMCs. While our results indicated that ATG dimensions did not moderate the impacts of either proximal (internalized heterosexism) or distal (daily experiences of harassment and discrimination) minority stressors on mental health and well-being of SMCs, we did observe important associations among our variables with potential implications for the mental health and well-being of this population.

The results of our study suggest that sexual minorities who experience higher levels of anxiety in their relationship with God also experience more suicidal ideation, meaning they have more thoughts related to wanting to die by suicide. Individuals with greater anxiety in their ATG were also found to experience greater internalized heterosexism, report more depression, greater anxiety, more experiences of harassment and discrimination, and greater distress related to those

experiences. More secure ATG was therefore associated with better mental health and well-being for SMCs.

Individuals whose ATG Anxiety is high deal with the uncertainty created by an inconsistent God (Kirkpatrick & Shaver, 1992). While they sometimes feel cared for and protected by God, other times He is noticeably absent in times of need. SMCs with high ATG anxiety may sometimes feel as though God loves them, but at other times feel rejected by God. This back and forth, unpredictable relationship with God is familiar for SMCs who belong to denominations that are less affirming of their sexual identity. In a qualitative study of the experiences of 36 religious sexual minorities, Kubicek et al. (2009) observed that these individuals reported mixed messages about God's love towards them. "The most frequently cited contradiction was between the idea that gay people will be punished by God, and the concept that God is a loving, omniscient, perfect creator" (Kubicek et al., 2009, p. 618). On one hand, Christianity's message is that, "...neither death, nor angels, nor principalities, nor powers, nor things present, nor things to come, nor height, nor depth, nor any other creature, shall be able to separate us from the love of God, which is in Christ Jesus our Lord" (Romans 8:38-39, Kings James Version). This suggests to the SMC that God's love for them will always be consistent. On the other hand, many non-affirming religious denominations rely upon Biblical teachings which (depending on the translation) suggests that homosexuality is a sin worthy of death and eternal damnation (e.g., Leviticus 18:22, 20:13, King James Version). This back and forth acceptance and rejection of SMCs by God echoes Kirkpatrick and Shaver's (1992) conceptualization of Anxious ATG.

SMCs who score higher on the Avoidance dimension of ATG are more likely to experience God as cold and rejecting. These individuals may find little to no benefit in this

relationship and may believe that God dislikes them (Kirkpatrick & Shaver, 1992). As such, they do not seek close proximity to God. Pulling away from God is also an experience that is common for SMCs. A study by Rosser (1990) found that while 86% of LGB individuals are raised religious, only 16% identify as religious after self-identifying as LGB. Most notably, a study by Gibbs and Goldbach (2015) found that 74% of LGB individuals who choose to leave their religion of origin were raised Christian. Interestingly, scoring higher on avoidance in this relationship was unrelated to many of the variables for which ATG anxiety was associated in our study. ATG avoidance was only found to have a significant negative relationship with psychological well-being, such that greater avoidance in one's relationship with God was associated with worse psychological well-being.

Previous research has suggested that religious socialization in both the home and in church settings plays an important role in how individuals understand and conceptualize who God is and God's relationship to them (Deguara, 2018; Roberts, 1989). As such, the messages that SMCs hear from both parents and religious leaders, particularly in relation to how God views sexual minorities, are likely to have an impact upon their ATG. As expressed earlier, affiliation with a Christian denomination that is affirming of sexual minorities has been found to be a protective factor for depression and is associated with better well-being for SMCs (Boppana & Gross, 2019; Gattis et al., 2014). As such, messages that affirm and support sexual minority identities as opposed to condemning them may be central to better mental health and well-being as well as greater security in SMC relationships with God.

Limitations and Future Directions

The correlational nature of our findings represents difficulties in determining directionality and causality. It is possible, for example, that SMCs who are more anxious may be

more likely to experience anxiety in their relationship with God, as opposed to experiences of God as unpredictable in His love and care resulting in greater anxiety for these SMCs. Longitudinal studies in the examination of ATG in moderating the impacts of stressful life events among the broader population provides support for ATG moderating the impacts of stressors on mental health, as opposed to mental health and stressors impacting ATG (Ellison et al., 2012). However, consistent with our observations that religious variables may not function the same for SMCs as the general Christian population, this is an area for future research.

Despite efforts to recruit a nation-wide representative sample utilizing snowball sampling via PFLAG and other LGBTQ+ specific organizations that serve a diverse population, our final sample was predominately made up of white, middle-class, cisgender gay men. While it is possible that recruitment being cut off due to the pandemic may have impacted the diversity of our sample, additional efforts should have been made to specifically reach out to LGBTQ+ organizations that serve Black, Indigenous, and other communities of color, to ensure that their voices and experiences were better represented in this research. Additionally, while our sample included more transgender and non-binary voices than the population average, this study examined solely their experiences of being a sexual minority. The experiences of trans and non-binary individuals in specific relation to stigma, prejudice and discrimination related to their gender identity within religious spheres is an additional important area for future research.

Previous research has indicated that the impact of religion on the mental health and wellbeing of SMCs varies based upon whether or not they attend a denomination that is affirming of sexual minority identities (Aranmolate et al., 2017; Boppana & Gross, 2019; Gattis et al., 2014; Kralovec et al., 2012). While participants in our study provided information about how affirming they viewed their local religious institution as well as denomination overall,

examining these differences was beyond the scope of the current study. Thus, future research may consider examining whether ATG moderates the impacts of minority stress on SMCs dependent on whether or not they perceive their denomination to be affirming. Furthermore, it is important to note that Christianity is not a monolith in its approach towards sexual minorities. The experiences of sexual minorities across and within Christian denominations are not uniform, with some openly accepting sexual minorities, some demonizing such identities, and others taking a "love the sinner, hate the sin" approach. As such, individual experiences between denominations and even within denominations may differ in regard to how affirming the denomination is perceived to be. Future research may consider examining differences between and/or within certain religious denominations. Given that sexual minorities have been found to report that they are more spiritual than religious (Halkitis et al., 2009), it may also be useful to examine how those who identify as spiritual but who do not formally attend religious services differ from those who do.

Finally, we also note the impact of Covid-19 on the results of our study, particularly in terms of how data collection was cut short. This cut-off resulted in a lower than expected number of participants. A G*power analysis indicated that we would need a sample size ranging from 115 for a medium effect to 882 for a small effect. As such, our sample size of 210 participants may not have had enough power to detect whether or not a moderation effect of Attachment to God exists among this population. Future research should consider replication with a larger sample to determine if such an effect exists.

5. Conclusion

Our research suggests that while ATG may not buffer the adverse impacts of minority stress on the mental health and wellbeing of SMCs, the type of attachment relationship these

individuals have with God may have implications for their mental health and well-being. SMCs who report less anxiety in their relationship with God were found to experience less suicidality and depression, less anxiety, and better psychological well-being. Greater avoidance in a relationship with God among SMCs however, was only associated with worse psychological well-being and was not related to depression, anxiety, or suicidality. How an individual views God and their relationship to Him may stem from both the church and the home (Roberts, 1989; Deguara, 2018). In traditionally conservative Christian religious environments and homes, SMCs continue to receive the message that who they are is unacceptable to God, and that God will ultimately reject them and send them to Hell. These messages are harmful both in terms of the additional minority stress (and accompanying mental health difficulties) they introduce in the lives of SMCs as well as the potential impacts these messages may have on the attachment relationships that SMCs have with God. As future research continues to examine the unique experiences of SMCs and other religious sexual minorities, we hope that this research will lead towards institutional change that effectively combats minority stress, positively impacting the mental health and well-being of these individuals.

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Appendices

Appendix 1. Demographics

Characteristic		*n*	%	*M (SD)*
Age		210		32.49 (12.43)
Gender				
	Woman	86	41.0	
	Man	107	51.0	
	Transgender	11	5.2	
	Cisgender	51	24.3	
	Non-Binary	12	5.7	
	Other	10	4.8	
Sexual Orientation				
	Straight/Heterosexual	1	.5	
	Gay	105	50.0	
	Lesbian	40	19.0	
	Bisexual	58	27.6	
	Pansexual	23	11.0	
	Queer	47	22.4	
	Asexual	15	7.1	
	Same-Sex Attracted	22	10.5	
	Other	8	3.8	
Race and/or ethnicity				
	Black/African American	5	2.4	
	Asian/Asian American	6	2.9	
	Middle Eastern	1	.5	
	American Indian/Native American	1	.5	
	White/European American	201	95.7	
	Latinx	4	1.9	
	Multiracial/Biracial	3	1.4	
	Other	1	.5	
Subjective Social Status (lowest to highest)				5.35 (1.58)
	1	1	0.5	
	2	4	1.9	
	3	23	11.0	
	4	41	19.5	
	5	37	17.6	
	6	48	22.9	
	7	44	21.0	

Appendix 1. Demographics (continued)

Characteristic		*n*	%	*M (SD)*
Subjective Social Status (continued))				
	8	9	4.3	
	9	2	1.0	
	10	1	0.5	
Ability Status				
	Disabled	50	23.8	
	Non-Disabled	160	76.2	
Religious Identity				
	Anglican	9	4.3	
	Baptist	12	5.7	
	Catholic	13	6.2	
	Church of Jesus Christ of Latter-Day Saints	45	21.4	
	Disciples of Christ	4	1.9	
	Eastern Orthodox	3	1.5	
	Episcopalian	4	2.0	
	Lutheran	8	3.8	
	Methodist	19	9.0	
	Non-denominational Christian/Evangelical	44	21.0	
	Non-denominational/Non-Evangelical	4	1.5	
	Other	16	7.6	
	Pentecostal	3	1.4	
	Presbyterian	12	5.7	
	Salvation Army	4	2.0	
	Seventh-Day Adventist	3	1.4	
	United Church of Christ	7	3.3	
Local Religious Institution Affiliation				
	Anglican	7	3.3	
	Baptist	12	5.7	
	Catholic	7	3.3	
	Church of Jesus Christ of Latter-Day Saints	36	17.1	
	Disciples of Christ	3	1.4	
	Eastern Orthodox	3	1.4	
	Episcopalian	4	2.0	
	Lutheran	8	3.8	
	Methodist	18	8.6	

Appendix 1. Demographics (continued)

Characteristic	*n*	%	*M (SD)*
Local Religious Institution Affiliation (continued)			
Non-denominational Christian/Evangelical	22	10.5	
Other	14	6.7	
Pentecostal	3	1.4	
Presbyterian	11	5.2	
Salvation Army	4	2.0	
Seventh-Day Adventist	2	1.0	
Unaffiliated	44	21.0	
United Church of Christ	12	5.8	
Local Religious Institution Affirming?			3.11 (1.48)
Strongly Disagree	29	17.5	
Disagree	39	23.5	
Neither Disagree or Agree	27	16.3	
Agree	26	15.7	
Strongly Agree	45	27.1	
Overall Religious Denomination Affirming?			2.51 (1.39)
Strongly Disagree	62	29.5	
Disagree	61	29.0	
Neither Disagree or Agree	28	13.5	
Agree	28	13.5	
Strongly Agree	28	13.5	
Religious Attendance?			
Never	27	12.9	
More than once a week	32	15.2	
Once a week	78	37.1	
2-3 times a month	24	11.4	
Monthly or less	49	23.3	

Note. Participants were provided the option to select all gender, sexual orientation, and race and/or ethnicity options that applied so results are not orthogonal. Individuals who chose a heterosexual sexual orientation also had to select a sexual minority identity such as same-sex attracted to be included in the study.

Appendix 2. Descriptive statistics and correlations (n = 210)

Variable	*M*	*SD*	1	2	3	4	5	6	7	8	9
1. ATG Anxiety	47.853	18.72	1.00	.108	.231**	.288**	.491**	.230**	.395**	.384**	-.400**
2. ATG Avoidance	51.111	14.537		1.00	.071	-.004	-.013	.104	.116	.093	-.236**
3. Total DEH	19.481	7.543			1.00	.861**	.309**	.191**	.285**	.367**	-.278**
4. Mean Distress of DEH	1.947	.484				1.00	.341**	.262**	.314**	.449**	-.220**
5. Internal. Heterosexism	19.743	7.616					1.00	.153*	.332**	.368**	-.309**
6. Suicidal Ideation	7.191	9.373						1.00	.617**	.485**	-.451**
7. Depression	29.309	11.601							1.00	.681**	-.619**
8. Anxiety	25.267	10.379								1.00	-.433**
9. Psych. Well-being	90.614	15.027									1.00

**p<.01 *p<.05; ATG= Attachment to God, DEH=Daily Experiences of Heterosexism

Appendix 3. Moderation analyses

	Attach. to God Anxiety as Moderator				Attach. to God Avoidance As Moderator			
Predictor/Outcome Variable	**coeff**	**SE**	**t**	**Sig.**	**coeff**	**SE**	**t**	**Sig.**
Internal. Heterosexism								
Suicidal Ideation	-.001	.005	-.236	.814	.010	.006	1.841	.067
Depression	-.040	.073	-.550	.583	.007	.007	1.081	.281
Anxiety	.000	.005	-.003	.998	.005	.005	.912	.363
Psych. Well-being	-.004	.007	-.533	.595	.004	.009	.424	.672
Mean Distress of DEH								
Suicidal Ideation	.030	.063	.473	.634	.121	.085	1.425	.156
Depression	-.031	.057	-.538	.591	.085	.103	.821	.413
Anxiety	.052	.062	.834	.404	.118	.087	1.356	.177
Psych. Well-being	-.011	.096	-.118	.906	.039	.135	.289	.773
Total DEH								
Suicidal Ideation	.001	.004	.159	.874	.008	.005	1.592	.113
Depression	-.002	.005	-.385	.701	.002	.006	.342	.732
Anxiety	.003	.004	.730	.466	.004	.005	.651	.516
Psych. Well-being	-.001	.006	-.185	.853	.002	.008	.278	.782

DEH= Daily Experiences of Heterosexism

Vita

Adam D.A. Maughan grew up in Avon, Utah, a small rural community in northern Utah. He graduated from Utah State University with a Bachelors of Science in English as well as a Bachelors of Science in Psychology in 2018. Prior to entering his PhD program at the University of Tennessee, Knoxville, Adam engaged in advocacy work to build bridges between members of the LGBTQ+ community and the Church of Jesus Christ of Latter-Day Saints. As a part of Dr. Joe Miles lab, Adam's research interests include the mental health and wellbeing of religious sexual minorities, the process and outcomes of intergroup dialogue, suicide prevention, as well as access to and quality of mental health services for sexual minorities. He is extremely grateful for his family, friends, advisor, and lab mates for all of their support.