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Religious Affiliation, Internalized Homophobia, and Mental Health in Lesbians, Gay Men, and Bisexuals

David M. Barnes
Columbia University

Ilan H. Meyer
University of California, Los Angeles

Most religious environments in the United States do not affirm homosexuality. The authors investigated the relationship between exposure to nonaffirming religious environments and internalized homophobia and mental health in a sample of lesbians, gay men, and bisexuals (LGBs) in New York City. Guided by minority stress theory, the authors hypothesized that exposure to nonaffirming religious settings would lead to higher internalized homophobia, more depressive symptoms, and less psychological well-being. The authors hypothesized that Black and Latino LGBs would be more likely than White LGBs to participate in nonaffirming religious settings and would therefore have higher internalized homophobia than White LGBs. Participants were 355 LGBs recruited through community-based venue sampling and evenly divided among Black, Latino, and White race or ethnic groups and among age groups within each race or ethnic group, as well as between women and men. Results supported the general hypothesis that nonaffirming religion was associated with higher internalized homophobia. There was no main effect of nonaffirming religion on mental health, an unexpected finding discussed in this article. Latinos, but not Blacks, had higher internalized homophobia than Whites, and as predicted, this was mediated by their greater exposure to nonaffirming religion.

In the United States, religiosity is associated with better mental health outcomes. Although such findings are not invariable across all dimensions of religiosity and mental health outcomes (Ano & Vasconcelles, 2005; Ellison, Boardman, Williams, & Jackson, 2001; Smith, McCullough, & Poll, 2003), the preponderance of the evidence shows that multiple manifestations of religiosity have salutary effects on mental health, including less depression and psychological distress (Chatters et al., 2008; Ellison, 1995; Ellison & Flannelly, 2009; Ellison et al., 2001; Hettler & Cohen, 1998; Van Olphen et al., 2003), greater life satisfaction, personal happiness, and psychological well-being (Ellison, 1991; Ellison et al., 2001; Krause, 2004; Witter, Stock, Okun, & Haring, 1985).

But is religiosity associated with better mental health outcomes among lesbians, gay men, and bisexuals (LGBs)? Little research is available to answer this question. Given the censorious view of LGBs in many religious contexts, the answer is far from certain. Two colliding factors may be at work: On the one hand, religiosity appears to have a generalized salutogenic effect; on the other hand, a social environment characterized by rejection and stigma has a pathogenic effect (Meyer, 2003). In this article, we examine the impact of religious affiliation on mental health in LGB individuals.

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Correspondence concerning this article should be addressed to David Barnes, Department of Epidemiology, Room 720D, 722 W. 168th St., Mailman School of Public Health, Columbia University, New York, NY 10032. Electronic mail may be sent to dmb23@columbia.edu.

Religious Affiliation and Attitudes Toward LGB People

Most American religious denominations have taken proscriptive action against sexual minorities, condemning same-sex behavior as sinful, barring LGBs from spiritual leadership positions (or requiring their celibacy in such positions), and refusing to sanction same-sex union ceremonies (Clark, Brown, & Hochstein, 1990; Morrow, 2003; Sherkat, 2002). The three largest American religious denominations, the Roman Catholic Church, the Southern Baptist Convention, and the United Methodist Church, which represent approximately 35% of Americans' religious affiliations (Pew Forum on Religion and Public Life [Pew], 2008), currently endorse these positions. Some denominations, such as the Unitarian-Universalist, Unity, United Church of Christ, Episcopalian, and Metropolitan Community churches (Schuck & Liddle, 2001) and Reformed Judaism (Morrow, 2003), have assumed a more tolerant or even affirming stance toward LGBs, but they represent a minority of Americans' religious affiliations (Sherkat, 2002). In this article, we refer to the former religious settings as *nonaffirming* and the latter as *affirming*; we operationalize this based on participants' perceptions of their worship environment rather than based on denomination.

Nonaffirming Religious Affiliation as a Stressor

Minority stress theory suggests that disparities in mental health between LGB and heterosexual populations are explained by differential exposure to stigma and prejudice. It suggests that because LGB people are exposed to more stigma and prejudice than heterosexuals in our society, they will experience greater stress and resultant negative health effects (Meyer, 2003). Minority stress theory identifies the quality of the social environment as the source of stress. On the basis of this theory, we assess whether exposure to nonaffirming religious settings is related to internalized homophobia—one of the stress processes described by minority stress theory—and mental health outcomes in LGBs.

Internalized homophobia refers to the LGB person's internalization of society's negative attitudes and beliefs about homosexuality and directing these attitudes toward one's self. Because most antigay attitudes are learned through normal socialization in our society, internalized homophobia can be a particularly insidious stressor. It originates in the socialization process, but once it is internalized, it can be enacted even in contexts where immediate social opprobrium is not explicit (Meyer & Dean, 1998). When enacted, internalized homophobia's targets of devaluation are homosexuality in general, other LGBs, and one's own LGB identity (Shidlo, 1994). Indeed, overcoming internalized homophobia is an important developmental task in the coming out process that LGB individuals undergo and is seen by clinicians as a necessary step toward achieving good mental health and well-being (Eliason & Schope, 2007). Internalized homophobia has been linked to a host of negative outcomes, including anxiety, depression, suicidal ideation, sexual risk-taking, problems in intimacy, and lower well-being and overall self-esteem (Frost & Meyer, 2009; Herek, Gillis, & Cogan, 2009; Herek & Glunt, 1995; Meyer, 1995; Meyer & Dean, 1998; Rowen & Malcolm, 2002; Williamson, 2000).

For LGB people growing up in nonaffirming religious settings, religious teachings can be an important part of their socialization into antigay attitudes and stigma. As the LGB person continues to attend in nonaffirming religious settings, these settings may continue to foster and sustain internalized homophobia.

LGBs and Religious Affiliation

Given the rejection of LGBs in many religious organizations, it is not surprising that studies find that LGBs are less likely than heterosexuals to engage in institutional religion, more likely to abandon the religious affiliation they grew up with, and, among those with a religious affiliation, LGBs have lower levels of attendance at religious services than heterosexuals (Herek, Norton, Allen, & Sims, 2010; Sherkat, 2002).

Most studies do not make clear distinctions between attendance in affirming and nonaffirming religious environments. However, data suggest that LGBs who affiliate with religious organizations participate mostly in nonaffirming denominations despite their relatively inhospitable social climate (Dahl & Galliher, 2009; Schuck & Liddle, 2001). For example, in a national probability sample of LGBs, Schuck and Liddle (2001) showed that LGB Protestants were about 2.5 times more likely to be affiliated with a mainstream, that is, nonaffirming, Protestant denomination than with a gay-affirming denomination (data on non-Protestant groups were not presented). In a different national probability sample, LGBs were 2.5 times more likely to attend services in settings where heterosexuals, rather than LGBs, were the majority (Herek et al., 2010). Although a heterosexual majority does not necessarily mean the setting is nonaffirming, in fact, most such settings are nonaffirming (Morrow, 2003; Sherkat, 2002).

Religiosity and Internalized Homophobia

With one exception, studies that examined LGBs' religiosity and internalized homophobia did not distinguish between affirming and nonaffirming worship settings. In the exception, Lease, Horne, and Noffsinger-Frazier (2005) showed in a sample of White LGBs currently involved in organized faith groups that exposure to more affirming settings predicted lower internalized homophobia; in turn, lower internalized homophobia predicted better mental health outcomes. In other studies, the level of gay-affirming or nonaffirming attitude at worship places must be inferred from proxy variables such as measures of LGBs' conservative versus liberal religious beliefs. Weis and Dain (1979) showed in an LGB sample that more conservative religious views predicted more negative attitudes toward homosexuality. Notwithstanding this limitation, the evidence is consistent with Lease et al.'s (2005) finding, suggesting that nonaffirming settings may have a significant effect in promoting internalized homophobia among LGBs (Harris, Cook, & Kashubeck-West, 2008; Herek et al., 2009; Wagner, Serafini, Rabkin, Remien, & Williams, 1994).

There is reason to believe that the relationship between religious affiliation and internalized homophobia among LGBs may vary by race and ethnicity, because religiosity itself varies across race and ethnic groups in the U.S. general population. For example, in the general population, Latinos and Blacks are more likely than Whites to say religion is very important, to attend church at least weekly, and to say the Bible is the literal word of God (Ellison, 1995; Jacobson, Heaton, & Dennis, 1990; Pew, 2007). Despite these differences, there is no good evidence that Latino and Black LGBs attend in more nonaffirming settings than Whites do. In fact, although evidence clearly points to greater religiosity among Latinos and Blacks compared with Whites, evidence also suggests White evangelical churches provide the most homophobic worship settings (Kubicek et al., 2009; Pew, 2008, 2010; Pew Forum on Religion, 2007; Reimer & Park, 2001). To the extent that the race or ethnic patterns of religious attendance seen in the general population also occur among LGBs, then Black and Latino LGBs would be more frequently exposed to homophobic messages in religious settings than Whites because of their greater level of affiliation with religious organizations. Therefore, they would be subject to greater levels of internalized homophobia than White LGBs.

Hypotheses

We examined whether affiliation with nonaffirming religious settings is related to higher levels of internalized homophobia in

LGBs. We hypothesized that LGBs who attend services in nonaffirming settings will have higher levels of internalized homophobia than LGBs who attend services in affirming settings and those who never attend. We likewise hypothesized that, among those who attend in nonaffirming settings, more frequent attendance will predict higher internalized homophobia.

Internalized homophobia refers to a *specific* self-esteem (Herek et al., 2009), namely, the positive or negative valence of how the individual regards the LGB aspect of his or her identity. This stands in contrast to *global* self-esteem that reflects an individual's positive or negative attitude toward the self as a whole (Rosenberg, Schooler, Schoenbach, & Rosenberg, 1995). Although specific self-esteem and global self-esteem are conceptually overlapping constructs, they are clearly not exchangeable and not highly correlated (Marsh, 1986). We proposed that the impact of nonaffirming religious settings is specific to one's gay identity. As a test of this specificity of the effect, we hypothesized that attendance in nonaffirming religious settings will be related to internalized homophobia but not to global self-esteem.

We also hypothesized that Black and Latino LGBs will have greater attendance in nonaffirming religious settings compared to Whites, and as a result, Black and Latino LGBs will have higher levels of internalized homophobia than White LGBs.

Finally, we hypothesized that because of its purported effect on internalized homophobia, exposure to nonaffirming religious settings will be associated with more depressive symptoms and less psychological well-being. This hypothesis contradicts the consistent finding in the general population, noted at the outset, that religiosity is associated with less depression and greater well-being. We based our hypothesis on minority stress theory, which suggests that a harmful social environment (nonaffirming settings) will be related to greater stress exposure (internalized homophobia), which, in turn, will be related to adverse mental health outcomes.

Despite consistent evidence that in the general population women have greater religiosity than men (Sherkat & Ellison, 1999; Stark, 2002), the same pattern does not arise in LGB samples (Herek et al., 2010; Sherkat, 2002). Accordingly, we made no hypotheses about gender differences in religiosity nor, therefore, gender differences in religious exposures explaining gender differences in internalized homophobia.

Method

Sampling and Procedure

Data come from Project Stride, a study designed to explore relationships between stress, identity, and health outcomes in a diverse sample of LGBs in New York City. The study was conducted in New York City over an 11-month period in 2004 and 2005. To ensure ethnic, gender, cultural, political, and economic diversity in the sample, the investigators used a community-based venue sampling approach. Twenty-five outreach workers recruited potential participants in 274 venues representing a wide array of communities across 32 New York City zip codes. Sampling venues included those that cater especially to LGB populations and general population venues, including business establishments, such as bookstores and cafes. Also included were events, such as the Lesbian Film Festival and Black Pride Picnic, and outdoor areas, such as parks. Snowball referral was used to identify participants who are less likely to be found in public venues. Each respondent was asked to nominate up to four potential participants; nominees were sent an invitation to participate in the study. Prospective participants completed brief screening forms at the venues and were eligible if they were between 18 and 59 years old, had lived in New York City for at least 2 years, self-identified as lesbian, gay, or bisexual; Black, Latino, or White; and as male or female (which matched their gender at birth). For ease of reporting, we refer to the social identities listed here, but participants did not have to identify using these identity labels: They may have used any label that suggests these social identities, such as African American for Black, queer or same-gender loving for gay. Eligible individuals constituted the sampling frame. From this sampling frame, we sampled equal numbers of Blacks, Latinos, and Whites; an even number of men and women in each race or ethnic group; and even distributions of race and ethnicities and genders in the age groups. To reduce sampling bias, no more than four participants were recruited from any one source at any one recruitment time.

The response rate was 79%, calculated based on the formula developed by the American Association for Public Opinion Research (AAPOR) as the proportion of interviewed respondents out of all the individuals who were interviewed and those who refused. The cooperation rate was 60%, calculated as the proportion of interviewed respondents out of all the eligible individual who were interviewed, those who refused, and the eligible individuals whom interviewers were unable to contact (AAPOR, 2005; formulas RR2, and COOP2, respectively). Response and cooperation rates did not vary significantly by sexual orientation, race or ethnic group, or gender. Data were gathered through in-person interviews using computer-assisted personal interviewing.

The final sample included 396 participants who resided in 128 New York City zip codes, and no more than 3.5% lived in any one zip code. (Further information about Project Stride can be obtained at http://www.columbia.edu/~im15/.) For administrative reasons, the religion questionnaire, from which the present data are drawn, was added after interviewing had begun, resulting in a sample size of 355 reported here. The only significant difference between those answering and those not answering the religion questions was that 50% of the 355 participants who were asked the religion questions had a bachelor's degree or higher compared with 32% of the 41 participants who were not asked the question ($\chi^2 = 4.852$, $p = .028$).

By design, Whites, Blacks, and Latinos and women and men within each race or ethnic group were equally represented in the full sample ($N = 396$). This race or ethnicity balance was only slightly altered in the subsample answering the religion questions: Whites ($n = 121$, women = 62, men = 59), Blacks ($n = 120$, women = 59, men = 61), and Latinos ($n = 114$, women = 57, men = 57). Ages ranged from 18 to 58, with a mean of 32.6 (*SD* 9.3). Mean ages by race or ethnic group were as follows: Whites (33.6; *SD,* 10.14), Blacks (31.7; *SD,* 8.3), and Latinos (32.4; *SD,* 9.2). Of the 355 participants, 21% had a high school diploma or less, 29% had some college or an associate's degree, and 50% had a bachelor's degree or higher; 16% were

unemployed; and 56% had a negative net worth, meaning their debt exceeded their assets. Whites were significantly more likely than Blacks and Latinos to have a bachelor's degree or higher, to be employed, and not to have negative net worth.

Measures

Predictor variables. ***Religiosity.*** All religion variables were assessed using standard questions frequently used in this domain and recommended by the Fetzer Institute's national working group on religion and health research (Fetzer Institute 1999), with the exception of a question on nonaffirming religious settings for which we devised a new item. To ascertain religious preference, participants were asked: "What is your religious preference? Is it Protestant, Catholic, Jewish, some other religion, or no religion?" Those answering *no religion* were classified for the present study as nonaffiliated. All participants, including those who answered *no religion*, were subsequently asked: "How often do you attend religious services?" Eleven response options ranged from *Never* to *Several times a day*. Those who answered anything other than *Never* to this question were then asked: "Are the religious services you attend directed specifically toward gay and lesbian communities?" Response options were *No*, *Yes*, and *No, but gay-friendly*. We classified the first response option as nonaffirming affiliation and collapsed the other two response options into one affirming affiliation category. Note that we do not know that all settings classified as nonaffirming are necessarily rejecting or hostile toward LGBs; however, it is likely that they were not experienced by participants as affirming or gay-friendly. All participants were also asked: "How often do you pray privately in places other than a church or synagogue?" Eight response options ranged from *Never* to *More than once a day*. Finally, all participants were asked to what extent they considered themselves a religious person and a spiritual person with four response options ranging from *Not at all* to *Very*.

Exposure was assessed in two ways: *affiliation* with a nonaffirming religious setting and *frequency* of service attendance in this setting. The distinction between affiliation and frequency allows us to differentiate between binary and dose–response relationships between nonaffirming affiliation and internalized homophobia. Affiliation exposure was dichotomized as affirming versus nonaffirming, and attendance frequency was dichotomized at *more than once a month* versus *once a month or less* for descriptive statistics and at the median for regression analyses.

Control variables. To assess employment status (unemployed = 1, employed = 0), participants were asked their current employment situation. They were given 10 response options and asked to endorse all that applied. Anyone endorsing looking for work, unemployed, temporarily laid off, or disabled was categorized as unemployed; anyone not endorsing one of these options was categorized as employed. To assess education, participants were asked their highest year of school or degree completed. We collapsed across these and compared those with a college degree or higher (1) to all others (0). Net worth was assessed by asking participants to calculate how much they would owe, or have left over, after converting all of their assets to cash and paying off all debts (Conger et al., 2002). Responses were coded to create a dichotomous net worth variable indicating negative net worth (1) versus positive net worth (0).

Outcome variables. ***Internalized homophobia.*** We assessed internalized homophobia by a 10-item internalized homophobia scale (Meyer, Rossano, Ellis, & Bradford, 2002). Items include "You have felt alienated from yourself because of being [lesbian/gay/bisexual]," "You have felt that being [lesbian/gay/bisexual] has allowed you to express a natural part of your sexual identity," and "You have wished that you could develop more feelings toward [the opposite sex]." The items were worded so that the sexual orientation in each question matched the participant's self-identified orientation. Participants were asked the frequency in the past year that they experienced the feelings or thoughts described in each item. The four-point response options range from 1 (*Often*) to 4 (*Never*). Negatively framed items were reverse coded so that higher scores indicated higher levels of internalized homophobia. Item scores were summed and divided by 10 to produce an average item score for each individual. The measure had good reliability in the present study with Cronbach's $\alpha = .84$.

Self-esteem. Rosenberg's (1965) 10-item measure of self-esteem was used in this study. Items are framed both positively and negatively and include "I feel that I am a person of worth, at least on an equal basis with others"; "I wish I could have more respect for myself"; and "On the whole, I am satisfied with myself." The four-point response options ranged from 1 (*Strongly agree*) to 4 (*Disagree strongly*). Positively worded items were reverse scored so that higher scores signify higher levels of self-esteem. The data reported next used the total self-esteem scores, which could range from 10 to 40. The measure is commonly used and has strong reliability and validity (Blascovich & Tomaka, 1991). The measure had good reliability in the present study with Cronbach's $\alpha = .86$.

Psychological well-being. This study used an index of psychological well-being developed by Ryff (1989) and Ryff and Keyes (1995) that measures psychological well-being with reference to one's development over the life span, rather than to a more recent, abbreviated time period. It is an 18-item measure that taps into the following six dimensions: self-acceptance, positive relationships with others, autonomy, environmental mastery, purpose in life, and personal growth. The following six items are each, respectively, examples from these domains: "When I look at the story of my life, I am pleased with how things have turned out"; "I have not experienced many warm and trusting relationships with others"; "I judge myself by what I think is important, not by the values of what others think are important"; "In general, I feel I am in charge of the situation in which I live"; "Some people wander aimlessly in life, but I am not one of them"; and "I gave up trying to make big improvements or changes in my life a long time ago." Seven response options range from 1 (*Strongly agree*) to 7 (*Strongly disagree*). Items were coded so that higher scores represented higher well-being. The internal consistency reliability for the total scale in our sample was .75, and subscale alphas ranged from .25 to .55. Because of the relatively low subscale alphas, we created a score for the overall scale by dividing each individual's total score by

18. This is in accord with recent findings indicating that the scale is unidimensional rather than multifactorial (Springer & Hauser, 2006).

Depressive symptoms. This study used the Center for Epidemiologic Studies–Depression (CES-D) scale. This is a 20-item measure that asks respondents to assess how often in the past week they experienced the phenomena described in the items, which included, ''You felt that everything was an effort''; ''You felt hopeful about the future''; ''You were happy''; and ''You did not feel like eating, your appetite was poor.'' Participants responded on a four-point scale ranging from 1 (*Rarely or none of the time, < 1 day)* to 4 (*Most or all of the time, 5–7 days)*. Responses were coded so that higher scores demonstrated greater depressive symptomatology. Item scores were summed and divided by 20 to produce an item average score for each individual. The CES-D is a commonly used scale and in studies of diverse populations has demonstrated good internal consistency reliabilities ranging from .83 to .90 (Conerly, Baker, Dye, Douglas, & Zabora, 2002; Foley, Reed, Mutran, & DeVellis, 2002; Jones-Webb & Snowden, 1993; Kim, Han, Hill, Rose, & Roary, 2003; Makambi, Williams, Taylor, Rosenberg, & Adams-Campbell, 2009; Radloff, 1977; Roberts, 1980). Among LGB populations, internal consistency reliability has ranged from .87 to .92 (Frost, Parsons, & Nanin, 2007; Lewis, Derlega, Griffin, & Krowinski, 2003). In clinical and nonclinical populations, the CES-D has shown strong convergent validity, indicated by high correlations with reports of clinical depression, DSM depression diagnoses, and other self-report measures of depression (evidence reviewed in McDowell & Newell, 1996; Roberts & Vernon, 1983). In the present study, the measure had good reliability, with Cronbach's $\alpha = .92$.

Results

Descriptive Statistics

To derive our descriptive statistics for the religiosity variables, we stratified each religion variable by race or ethnic group and by sex and tested for significant differences using the chi-square statistic. Table 1 displays these results. We provide U.S. population statistics for comparison. As can be seen in comparison with the general U.S. population, this sample of LGB individuals is less religious as measured in religious affiliation, frequency of religious service attendance and prayer, and level of self-reported religiosity. By contrast, LGBs reported higher levels of spirituality than participants in the general population samples.

Also seen in Table 1, religiosity differed significantly for race and ethnic groups. Compared with Whites, Blacks and Latinos reported higher levels of religiosity on every measure, and both racial and ethnic minority groups were more likely than Whites to affiliate with nonaffirming religious settings and to attend services more frequently in these settings.

In Table 2, we show the mean values of race or ethnic groups, genders, and religious exposure groups on internalized homophobia. Blacks and Latinos had higher internalized homophobia than Whites (but this was statistically significant for Latinos only), men had nearly identical levels with women, and those affiliated with nonaffirming religious settings had higher levels of internalized homophobia than those affiliated with affirming settings and those who never attended at all. Among LGBs attending in nonaffirming settings, those whose attendance frequency was above the median had higher levels of internalized homophobia than those below the median (but this difference was not statistically significant). In results not shown, the differences between Blacks and Latinos, $t(232) = -1.15$, $p = .25$, between men and women, $t(353) = 0.64$, $p = .52$, and between those attending in affirming settings ($M = 1.25$, $SD = 0.35$) and those never attending ($M = 1.31$, $SD = 0.40$), $t(170) = -0.88$, $p = .39$, were found not to be statistically significant.

Religiosity and Internalized Homophobia

To test our hypotheses, we used ordinary least squares multiple linear regression analyses in all cases except one; when testing the second step of our mediational hypothesis, we used logistic regression because these outcomes (the hypothesized mediators) were dichotomous. All regression analyses controlled for employment, net worth, and education.

Consistent with our hypothesis, participants who attended in nonaffirming religious settings had significantly higher internalized homophobia than those who attended in affirming settings and those who never attended, but we found no support for our hypothesis regarding frequency of attendance—individuals who attended in nonaffirming religious settings more frequently did not differ in levels of internalized homophobia from those who attended less frequently (Table 2). In results not shown, both nonaffirming affiliation, $B = 0.01$, $t(349) = 0.15$, $p = .89$, and frequency of attendance in nonaffirming settings, $B = 0.03$, $t(177) = 0.43$, $p = .67$, were unrelated to self-esteem, demonstrating that the patterns regarding nonaffirming religious exposures and internalized homophobia are specific to one's sense of him- or herself as a gay, lesbian, or bisexual person and not to global self-esteem.

We hypothesized that Blacks and Latinos would have higher internalized homophobia than Whites because of greater exposure to nonaffirming religion (Table 3; exposure is defined both as affiliation and frequency). We used Kenny, Kashy, and Bolger's (1998) four-step procedure to test for evidence of mediation. Step one of this mediation test is to see whether the exposure of interest has a significant association with the outcome of interest, not controlling for the mediator. Analysis reported in Table 2 shows that both Blacks and Latinos had higher internalized homophobia than Whites, but the difference was statistically significant for Latinos only, so the test of mediation would apply to Latinos only. We, nevertheless, included analysis for Blacks in subsequent models to see whether the directions of association were consistent with our hypothesis. In the second step, we showed that, compared with Whites, Blacks and Latinos have greater exposure to nonaffirming religion (both affiliation and frequency of attendance; Table 3, models 1 and 3). In the third step, we showed that both potential mediators predict internalized homophobia, controlling for race or ethnic group (Table 3, models 2 and 4). In the final step, we determined the extent to which affiliation and frequency exposures mediated the relationship between race or ethnic group and internalized homophobia by examining the change in the race or ethnic group coefficients when each hypothesized mediator is added to

Table 1. *Religious Measures by Race/Ethnicity*

	Stride								GSS[a]	PEW[b]	KN[c]
	n (%)				*n* (%)						
Variable	White	Black	Latino	χ^2	Female	Male	χ^2	Total	(%)		
Religion											
No religion	70 (58)	43 (36)	40 (35)	100.70 ***	85 (48)	68 (39)	7.33	153 (43)		(16.1)	
Catholic	13 (11)	13 (11)	45 (40)		30 (17)	41 (23)		71 (20)			
Other religion	14 (12)	29 (24)	23 (20)		29 (16)	37 (21)		66 (19)			
Protestant	7 (6)	32 (27)	6 (5)		21 (12)	24 (14)		45 (13)			
Jewish	17 (14)	2 (2)	0 (0)		13 (7)	6 (3)		19 (5)			
Do not know	0 (0)	1 (0)	0 (0)		0 (0)	1 (0)		1 (0)			
Total	121 (100)	120 (100)	114 (100)		178 (100)	177 (100)		355 (100)			
Religious service frequency											
Never	58 (48)	36 (30)	42 (37)	19.96 **	70 (39)	66 (37)	3.23	136 (38)	(15.4)	(11)	(37)
≤ Once/month	60 (50)	64 (53)	52 (46)		92 (52)	84 (48)		176 (50)			
> Once/month	3 (3)	20 (17)	20 (18)		16 (9)	27 (15)		43 (12)			
Total	121 (100)	120 (100)	114 (100)		178 (100)	177 (100)		355 (100)			
Attend nonaffirming services[d]											
Yes	44 (71)	71 (87)	62 (90)	9.45**	89 (84)	88 (82)	.112	177 (83)			
Total	62 (100)	82 (100)	69 (100)		106 (100)	107 (100)		213 (100)			
Religious service frequency in nonaffirming attenders											
> once/month	2 (5)	15 (21)	17 (27)	8.96 *		12 (14)	22 (25)	3.78	34 (19)		
Total	44 (100)	71 (100)	62 (100)			89 (50)	88 (100)		177 (100)		
Consider self a religious person											
Not at all	59 (49)	35 (29)	26 (23)	28.52 ***		65 (37)	55 (31)	2.30	120 (34)	(14)	
Slightly	38 (31)	31 (26)	39 (34)			49 (28)	59 (33)		108 (30)	(23)	
Moderately	17 (14)	40 (33)	32 (28)			43 (24)	46 (26)		89 (25)	(44)	
Very	7 (6)	14 (12)	17 (15)			21 (12)	17 (10)		38 (11)	(19)	
Total	121 (100)	120 (100)	114 (100)			178 (100)	177 (100)		355 (100)	(100)	
Consider self a spiritual person											
Not at all	10 (8)	1 (1)	7 (6)	15.72 *		9 (5)	9 (5)	5.11	18 (5)	(9)	
Slightly	22 (18)	16 (13)	19 (17)			35 (20)	22 (12)		57 (16)	(21)	
Moderately	40 (33)	28 (23)	30 (26)			52 (29)	46 (26)		98 (28)	(41)	
Very	49 (41)	75 (63)	58 (51)			82 (46)	100 (57)		182 (51)	(28)	
Total	121 (100)	120 (100)	114 (100)			178 (100)	177 (100)		355 (100)	(100)	
Private prayer frequency[e]											
Never	54 (45)	7 (6)	20 (18)	66.93 ***		40 (23)	41 (23)	.106	81 (23)		(13)
< Once/day	44 (37)	43 (36)	43 (38)			64 (36)	66 (37)		130 (37)		(36)
≥ Once/day	22 (18)	70 (58)	51 (45)			73 (41)	70 (40)		143 (40)		(51)
Total	120 (100)	120 (100)	114 (100)			177 (100)	177 (100)		354 (100)		

Note. [a]GSS (General Social Survey) data (Davis, Smith, & Marsden, 2009) are from the 2004 survey, $n = 2800$, except for questions on religiosity ($n = 4412$) and spirituality ($n = 4395$), which are a composite of data from the 1998 and 2006 surveys. Different categorizations between studies preclude comparisons with Stride participants across all response levels.
[b]Pew data are from a 2008 survey, the *U.S. Religious Landscape Survey*, $n = 35{,}556$. Different categorizations between studies preclude comparisons with Stride participants across all response levels.
[c]KN data are from a 2005 lesbians, gay men, and bisexual (LGB) sample of 662 from the Knowledge Networks Panel. Different categorizations between studies preclude comparisons with Stride participants across all response levels.
[d]Six participants who reported attending religious services answered *Not applicable* when answering the subsequent question about whether those services were directed toward the gay and lesbian communities. They are not included in any of the analyses pertaining to this latter variable.
[e]One participant endorsed *Not applicable* when responding to the frequency of private prayer question and is not included here.
*$p < .05$. **$p < .01$. ***$p < .001$.

the regression model. The results indicate mediation by both religious exposures of the association between Latinos and internalized homophobia (Table 3, models 2 and 4). The regression coefficients for the Latino variable decreased from those reported in Table 2 by 20% and 13%, respectively, when we added the affiliation and frequency exposures to the equation. Additionally, inclusion of the mediators in the model rendered the difference between Latinos and Whites on internalized homophobia nonsignificant. Of note, the changes in coefficients were greater for Blacks than Latinos, changing by 50% and 25%, respectively (Table 3, models 2 and 4). Thus, although the difference in internalized homophobia between Blacks and Whites was not statistically significant, Blacks did have higher levels of internalized homophobia than Whites, and this difference was diminished when the hypothesized mediators were included in the models.

Table 2. *Internalized Homophobia and Religious Exposure Among Lesbians, Gay Men, and Bisexuals (*N = *355)*

Variable	*M*	*SD*	*B*	*SE*	*p*	95% CI	Adjusted R^2
White	1.32	0.43	Ref				
Black	1.43	0.49	0.08	0.07	.25	−0.06, 0.21	
Latino	1.51	0.58	0.15	0.07	.03	0.01, 0.28	.03
Men	1.44	0.53					
Women	1.40	0.48					
Affirming affiliation and nonattenders	1.30	0.39	Ref				
Nonaffirming affiliation	1.54	0.58	0.22	0.05	.00	0.12, 0.32	.07
Nonaffirming low attendance	1.51	0.56	Ref				
Nonaffirming high attendance	1.57	0.60	0.05	0.09	.58	−0.12, 0.22	.02

Note. All regression equations control for employment status, education, and net worth.

Table 3. *The Association of Race/Ethnicity, Internalized Homophobia, and Attendance in Nonaffirming Religious Settings (*N = *355)*

	Nonaffirming affiliation					Internalized homophobia			
	Model 1					Model 2			
	B	*SE*	*p*	OR	95% CI	*B*	*SE*	*p*	95% CI
Black	0.93	0.29	.00	2.53	1.46, 4.40	0.04	0.07	.54	−0.09, 0.18
Latino	0.74	0.29	.01	2.10	1.20, 3.66	0.12	0.07	.08	−0.01, 0.26
Nonaffirming affiliation						0.21	0.05	.00	0.10, 0.32
N	355					349			
Adjusted R^2						.07			
	Model 3					Model 4			
Black	1.21	0.37	.00	3.35	1.62, 6.92	0.06	0.07	.38	−0.08, 0.20
Latino	1.37	0.37	.00	3.93	1.90, 8.14	0.13	0.07	.08	−0.01, 0.27
Nonaffirming high attendance						0.16	0.06	.01	0.03, 0.28
N	355					349			
Adjusted R^2						.05			

Note. All models control for employment status, education, and net worth. The referent group for Black and Latino is White. The referent group for nonaffirming affiliation is those attending in affirming settings and those never attending. The referent group for nonaffirming high attendance is those with low attendance in nonaffirming settings, those attending in affirming settings, and those never attending.

Table 4. *The Association Between Affiliation With Nonaffirming Religious Organizations and Mental Health Outcomes (*N = *313)*

	Depressive symptoms							
	Model 1				Model 2			
	B	*SE*	*p*	95% CI	*B*	*SE*	*p*	95% CI
Nonaffirming affiliation	−0.04	0.06	.48	−0.17, 0.08	−0.10	0.06	.10	−0.22, 0.02
Internalized homophobia					0.27	0.06	.00	0.16, 0.39
N	312				312			
Adjusted R^2	.04				.09			
	Psychological well-being							
	Model 3				Model 4			
Nonaffirming affiliation	0.05	0.08	.58	−0.12, 0.21	0.14	0.08	.10	−0.03, 0.30
Internalized homophobia					−0.42	0.08	.00	−0.58, −0.27
N	313				313			
Adjusted R^2	.04				.12			

Note. All models control for employment status, education, and net worth. The referent for nonaffirming affiliation is those never attending.

Religiosity, Internalized Homophobia, and Mental Health

We did not find support for our hypothesis that exposure to nonaffirming religious settings—operationalized as individuals with affiliation with nonaffirming religious settings versus those who never attend religious services—predicts more depressive symptoms and worse psychological well-being (Table 4, models 1 and 3). We based our hypothesis on the premise that increased internalized homophobia among those attending nonaffirming religious settings would lead to worse mental health.

However, given that religiosity may have both positive and negative impacts on mental health among LGBs, we investigated these relationships further. Specifically, we assessed the extent to which the effect of nonaffirming religion on mental health outcomes changed when internalized homophobia was controlled for (Table 4, models 2 and 4). We found that nonaffirming religion became a stronger predictor in the expected direction of both mental health variables when internalized homophobia was included in the models, suggesting that internalized homophobia may have suppressed the otherwise positive effect that exposure to religion can have on mental health.

Discussion

Lesbians, gay men, and bisexuals in our sample were less religious than the general U.S. population, a finding consistent with other studies. Black and Latino LGBs evidenced greater levels of religiosity than Whites on all religion measures, a pattern also observed in national general population samples. No difference was found between women and men on the religion measures, a finding that reinforces previous findings that gender differences observed in the general population—that women evidence greater religiosity than men—do not persist in LGB samples.

We conclude that nonaffirming religious settings present a hostile social environment to LGB individuals. Using minority stress theory as a framework, we tested the general hypothesis that nonaffirming religion is associated with internalized homophobia and mental health problems. We showed that affiliation with nonaffirming religious settings, but not frequency of attendance in such settings, was significantly associated with greater internalized homophobia. We also showed that this association was specific to internalized homophobia and did not generalize to self-esteem.

We found that Latino, but not Black, LGBs have significantly higher internalized homophobia than White LGBs after adjusting for socioeconomic covariates, and Latinos' greater affiliation with nonaffirming religious settings and more frequent attendance in these settings explained this. Thus, participation in nonaffirming religion is associated with significantly higher levels of internalized homophobia in the overall sample and in Latinos, compared with Whites. With respect to Blacks, we note that the pattern of findings was consistent with our hypotheses, despite not achieving statistical significance. Our finding of differences between Latinos and Blacks is too provisional for us to suggest an explanation. Additional future studies can help to explore these patterns.

Consistent with minority stress theory, we predicted that the social environments in nonaffirming religious settings, which promote homophobia, induce internalized homophobia. Our findings are, in general, consistent with this causal proposition, although, given the cross-sectional nature of our data, they provide no evidence of causality.

It is important to remember that internalized homophobia is not an individual trait as much as it is a reflection of an interaction between the person and her or his environment (Frost & Meyer, 2009; Russell & Bohan, 2006). In all likelihood, the causal relationship between religious affiliation and internalized homophobia begins early in life and is reiterated through continued participation in nonaffirming religious settings throughout life. Children and youth are partly inducted into homophobic beliefs through places of worship at a time when they are most susceptible to internalizing such beliefs. The authority of the religious environment and the apparent concurrence of an entire community gives such early socialization a special force. LGB persons raised in nonaffirming religious environments may become inured to their homophobic messages. Such acquired homophobic beliefs are internalized and are difficult to shake off when individuals begin to see themselves as LGB persons.

It would appear that LGB people can simply dissociate themselves from nonaffirming religious settings. After all, as adults, LGB individuals have options to worship in more affirming settings or to avoid religious worship settings altogether. Given that those with no religion formed the largest block of participants in our sample, it is probably safe to assume that at least some have, in fact, abandoned religion at some point in their lives. Indeed, those who opt for affirming settings or who have no religious affiliation at all have significantly lower levels of internalized homophobia than those who opt for nonaffirming settings. One may therefore ask why some LGB individuals choose not to move to worship in affirming settings or even renounce their religion altogether. Why do they continue to participate in religious institutions that condemn and sometimes villainize them?

The answer is complex. As we said above, some LGBs may become inured to the homophobic environment in nonaffirming settings. But even when they perceive homophobia in their religious institutions, LGBs may retain affiliations with nonaffirming settings because they derive great personal meaning from the religious setting they have been accustomed to (often since childhood). As well, religious settings provide an affiliation and connection with a community that is difficult to discard. Leaving one's religious institution is socially, culturally, and spiritually discomforting (Haldeman, 2004; Pitt, 2010a).

This is the case particularly for racial or ethnic minorities. Writers have described the special meanings that the church has for African Americans as a bulwark against societal racism and as a promoter of racial and ethnic identity and pride (Krause, 2004; Meyer & Ouellette, 2009; Taylor, Thornton, & Chatters, 1987). In a historic climate of prejudice and discrimination, Black churches in America have played multiple roles in the community, including providing a social center, a locus for the distribution of social services and tangible goods (e.g., counseling), and transmitter of American slave history (Ellison, 1995; Ellison & Flannelly, 2009; Krause, 2004; Taylor et al., 1987;

Ward, 2005). Thus, and particularly for racial or ethnic minorities, the special functions and meanings of religious institutions can be lost when moving to gay-affirming religious settings, which are often predominantly White (Pitt, 2010b). Despite the stress of remaining in a nonaffirming setting, the costs of leaving may be even greater.

To continue worshipping in nonaffirming settings, LGBs employ various strategies for resolving or tolerating the tensions inherent in the juxtaposition of being an LGB person but affiliating with a nonaffirming religious institution (Dahl & Galliher, 2009; Kubicek et al., 2009; Meyer & Ouellette, 2009; Pitt, 2010a, 2010b; Rodriguez & Ouellette, 2000; Schuck & Liddle, 2001). One strategy derives from a belief that the Bible is an historic document that is the inspired, not actual, word of God; as such, it occasionally reflects antiquated mores, including its views of homosexuality (Kubicek et al., 2009; Pitt, 2010a). Another strategy is to compartmentalize LGB and religious identities, so that in religious settings, where one's religious identity is salient, one's LGB identity is suppressed (Rodriguez & Ouellette, 2000). Finally, a set of strategies attempts to neutralize the authority of antihomosexual messages in religious settings by challenging the credibility of the messenger, typically a pastor or priest. LGBs may do this by questioning religious leaders' Biblical knowledge, morality, misguided emphasis on Old Testament legalism versus New Testament themes of compassion and unconditional love, or their insincere and cynical playing to certain constituencies in the pews (Pitt, 2010a).

With this in mind, we interpret our findings that, although participation in nonaffirming religious settings was related to internalized homophobia and internalized homophobia predicted depressive symptoms and psychological well-being, participation in nonaffirming religious settings was not related to adverse mental health outcomes. We suspect that our result is explained, in part, by the countervailing effects of religion among LGB people. One pathway that we had hypothesized has negative impact through internalized homophobia, but another pathway leads to a salutary effect through improved social support and what Ellison et al. (2001) referred to as the "broad sense of the world's coherence, predictability, and meaningfulness" (p. 220) that religion confers.

The net effect of these countervailing influences may explain our findings. Supporting this proposition is the finding that when we controlled for internalized homophobia in regression equations predicting depressive symptoms and psychological well-being, the coefficient for exposure to nonaffirming religion became larger in the predicted direction. This suggests that internalized homophobia may dampen the otherwise salutary effects that affiliation with religion otherwise can have on LGBs' mental health.

Limitations

Our study has several limitations. Clearly, we cannot determine the causal order of internalized homophobia and affiliation in nonaffirming religious settings. It is possible that rather than religious affiliation affecting internalized homophobia, the reverse is true—internalized homophobia predetermines the kinds of religious settings LGB people affiliate with. In view of the fact that most individuals are initiated into a church well before they come out as gay or lesbian and in view of the important role religion plays in the socialization processes, and especially, religion's authority in conveying social mores, we find this alternative explanation less plausible than our original construction—that church attendance affects internalized homophobia. It is likely, however, that there is a reiterative process whereby religious socialization produces internalized homophobia that, in turn, reinforces participation in nonaffirming settings.

Also, our study used a nonprobability sample in one U.S. city. Of course, this does not allow generalizability of population estimates. But our main aim was to test theoretical associations, which calls for increasing internal, rather than external, validity (Shadish, Cook, & Campbell, 2002). The theory-based associations we describe are unlikely to be unique to the New York setting or to any sampling particularities and therefore present little threat to external validity. Further support to the validity of our results is provided by the similarity between our sample's patterns for participation in religious activities and those obtained by Herek et al. (2010) in a national probability sample of LGBs.

Conclusions

Our finding that exposure to nonaffirming religion is associated with higher levels of internalized homophobia had not been tested empirically in a sample of LGBs that is diverse with respect to race or ethnicity and engagement in religion. Although the evidence from our study and others suggests that LGBs are less religious than the general population, religious exposure is an important component of the social climate for a significant proportion of LGBs, particularly Blacks and Latinos. A large majority of LGBs attend religious settings that are not affirming of their sexuality and a core social identity. LGB people most likely attend services in such settings because of ties formed in childhood and adolescence. Their commitment to such settings as adults betrays a bind where they have to weigh the spiritual, social, psychological, and material costs of abandoning versus maintaining these religious affiliations.

Our results contribute to the increasing evidence that clinicians working with LGBs need to be attuned to their clients' religious backgrounds and current religious commitments (Bartoli & Gillem, 2008; Haldeman, 2004; Morrow, 2003). Clients' exposures to homophobic religious environments should be plumbed, as well as how clients have responded to the strain that engagement in these environments may have caused them. To the extent that clients were slow to extract themselves from nonaffirming environments or continue to expose themselves to such environments, clinicians need to be sensitive to competing forces that keep LGBs there (Bartoli and Gillem, 2008; Haldeman, 2004). Additionally, affirming environments perhaps need to pay attention to the extent to which they are potentially a refuge for a large number of LGB individuals coming from diverse religious, cultural, and social backgrounds. Increased sensitivity to this diversity could help meet some currently unmet demand for affirming settings. A profitable avenue of future research would be to compare mental health outcomes longitudinally of those who stay in nonaffirming settings with those who traverse to affirming settings. Presumably, given a

fitting affirming environment, those who make this change continue to reap the mental health benefits often afforded by religious communities while avoiding the competing costs imposed by nonaffirming environments.

Keywords: lesbians; gay men; bisexuals; minority stress theory; homosexuality; homophobia; internalized homophobia; self-esteem; nonaffirming religious settings; affirming religious settings

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