Minority Stress and the Moderating Role of Religious Coping Among Religious and Spiritual Sexual Minority Individuals
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CITATION
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In prior research with primarily heterosexual religious and spiritual individuals, positive and negative forms of religious coping have been posited to moderate the links between minority stressors and psychological outcomes (Kim, Kendall, & Webb, 2015; Szymanski & Obiri, 2011). With a sample of 143 sexual minority people, the present study extended these hypotheses by examining the moderating roles of positive and negative religious coping in the link of 2 sexual minority-specific minority stress variables (heterosexist discrimination, internalized heterosexism) with psychological distress and well-being. In partial support of our hypotheses, we found that positive religious coping moderated the relation of internalized heterosexism and psychological well-being such that greater positive religious coping weakened the deleterious impact of internalized heterosexism on psychological well-being. Negative religious coping did not moderate any links. As the first test of the moderating roles of religious coping styles in the sexual minority stress-psychological distress link, the present study yields important findings for research and practice with religious and spiritual sexual minority individuals.

Keywords: LGB, religiosity, spirituality, religious coping, minority stress

A substantial body of research with sexual minority people (i.e., individuals who identify as lesbian, gay, bisexual, queer, questioning, or some other nonheterosexual identity) supports the links of minority stressors—such as discrimination and internalized prejudice—with negative outcomes such as psychological distress, depression, and anxiety (e.g., Brewster & Moradi, 2010; Lehavot & Simoni, 2011; Meyer, 2003; Newcomb & Mustanski, 2010). Indeed, the Institute of Medicine of the National Academies (2011) stated that minority stress theory was a major conceptual framework with which to examine the health of sexual minority people. However, there are several areas in which minority stress theory may still be refined.

First, it is important to identify processes that influence the links of minority stressors with mental health concerns among sexual minority people (e.g., Meyer, 2003). In addition, because sexual minority people are themselves a diverse group, it is important to attend to identity intersections and the potential roles of other facets of identity, such as religiosity, in shaping the mental health of sexual minority people. Importantly, prior research suggests that some individuals with stigmatized identities may cope with adversity and oppression by using helpful strategies drawn from their religious or spiritual identities (e.g., Clark, Anderson, Clark, & Williams, 1999; Lehavot & Simoni, 2011; Szymanski & Obiri, 2011). However, other research suggests that using maladaptive religious coping strategies may exacerbate minority stress for some sexual minority people (Murr, 2013; Severson, Muñoz-Laboy, Kaufman, 2014). Thus, the goal of the present study was to test positive and negative religious coping styles as moderators of the links of minority stressors with mental health among sexual minority people.

Minority Stressors and Mental Health

Aligned with Meyer’s (2003) framework, the present investigation focuses on multiple manifestations of heterosexist minority stress. The first stressor is heterosexist discrimination, which includes experiences in which sexual minority people are rejected, harassed, mistreated, or harmed because of their sexual orientation. A second source of stress for sexual minority people is internalized heterosexism, or sexual minority individuals’ own endorsement of prejudice against sexual minority orientations, people, or communities. Prior research has consistently supported the associations of both heterosexist discrimination and internalized heterosexism with greater psychological distress and lower well-being (e.g., Brewster & Moradi, 2010; Lehavot & Simoni, 2011; Newcomb & Mustanski, 2010; Szymanski, Kashubeck-West, & Meyer, 2008).
Religious Coping

Based on self-reported ratings of the personal importance of religion, a Gallup poll found that 69% of American adults are “very” or “moderately” religious (Newport, 2012). Given the prominence of religion in the lives of many individuals, it is unsurprising that scholars have explored the relations of dimensions of religiosity with mental health (Brewster, Robinson, Sandil, Esposito, & Geiger, 2014). One aspect of religiosity that has received scholarly empirical attention is religious coping style, which is posited to be conceptually and empirically distinct from nonreligious forms of coping (Pargament, 1997; Pargament, Feuille, & Burdzy, 2011). For many religious individuals, religion provides a system of meaning that helps them cope with hardships and life circumstances outside their power (Park & Folkman, 1997). Moreover, religious coping styles are believed to be more robust predictors of mental health outcomes than other indicators of religiosity, such as frequency of prayer or salience of religious identity (Pargament, 1997). However, there are important distinctions in how coping strategies are used. Specifically, positive and negative styles of religious coping may manifest and impact mental health differently (Pargament et al., 2011; Szymanski & Obiri, 2011). Positive religious coping refers to turning to God for spiritual support, forgiveness, and guidance in letting go of stressful emotions and life circumstances (Pargament et al., 2011; Pargament, Koenig, & Perez, 2000; Pargament, Smith, Koenig, & Perez, 1998). These coping methods may be captured through phrases such as “let go and let God” or “I can do all things through Him who strengthens me.” In contrast, negative religious coping is marked by redefining stressful life events through religion as punishment, acts of Satan or malevolent forces, or a lapse in God’s power.

In empirical research, positive religious coping tends to be associated with greater posttraumatic growth and indicators of psychological well-being (e.g., self-esteem, life satisfaction) whereas negative religious coping is associated with greater emotional distress, depression, and posttraumatic stress and poorer life satisfaction and physical health (Bjorck & Thurman, 2007; Koenig, Pargament, & Nielsen, 1998; Lee, Nezu, & Nezu, 2014; Pargament et al., 1998; Szymanski & Obiri, 2011). In addition, although most research in this area is conducted with Christian samples, studies with samples of Buddhist, Hindu, Jewish, and Muslim individuals have yielded parallel results (for a review, see Abu-Raiya & Pargament, 2014). However, similar to most psychological research (for a review, see Huang et al., 2010) many of the above studies do not report the sexual orientation of their samples, which makes it difficult to determine to what degree their results generalize to sexual minority people.

Sexual Minority People and Religion

In comparison to the broader psychological literature on religion, spirituality, and mental health, relatively few studies focus on the intersections of these beliefs and sexual orientation. This may be due, in part, to sexual orientation differences in religiosity: Data from a national probability sample of 662 self-identified lesbian, gay, and bisexual adults in the United States indicated lower levels of religiosity among the sample than the general U.S. adult population (Herek, Norton, Allen, & Sims, 2010). It may also reflect the assumption in the literature that “religions in general, and Christianity in particular, are often perceived as anathema” to sexual minority people (O’Brien, 2004, p. 180). Numerous studies have documented the persistence of heterosexist attitudes and policies within diverse religious groups (e.g., Buchanan et al., 2001). In such religious contexts, sexual minority people may be taught that their identities are unacceptable, immoral, or incompatible with their religious identities (Barton, 2010; Severson et al., 2014). Greater participation in these communities has been linked to a higher incidence of anxiety, internalized heterosexism, loneliness, and other adverse emotional outcomes for sexual minority people (Hamblin & Gross, 2013; Henrichson, 2007; Rowen & Malcolm, 2002; Severson et al., 2014; Sowe, Brown, & Taylor, 2014).

However, several studies indicate that aspects of religiosity and spirituality may also promote well-being among sexual minority people (e.g., Brennan-Ing, Seidel, Larson, & Karpiak, 2013; Le-havot & Simoni, 2011). For example, affirmation and acceptance of sexual minority people from one’s religious community was associated with better mental health in a sample of religious sexual minority people (Lease, Horne, & Noffsinger-Frazier, 2005). Thus, religion does not universally play a negative role in the lives of sexual minority individuals; in fact, similar to their heterosexual peers, religious sexual minority individuals may draw from their religious backgrounds to cope with stressful situations (Kubiczek et al., 2009). This raises the possibility that some religious coping strategies may even attenuate the deleterious effects of minority stressors.

Religious Coping Styles as Moderators of the Minority Stress-Mental Health Link

Conceptual support for the moderating roles of religious coping styles in the links of minority stressors with mental health comes from the biopsychosocial model of stress; this framework posits that environmental stressors require individuals to use coping responses that, in turn, shape mental health (Clark et al., 1999). Notably, such coping strategies may be adaptive and thus improve mental health, or they may be maladaptive and contribute to poorer mental health (Diaz, 1998). Although religious and spiritual beliefs have received notable support as moderators of the link between general stressors and mental health in heterosexual samples (for a review, see Pargament, 1997 or Smith, McCullough, & Poll, 2003), studies attending specifically to religious coping styles as moderators have yielded mixed support. Some studies have found that positive religious coping buffers links between stressors and poor mental or physical health outcomes (e.g., Bjorck & Thurman, 2007), some have found only that types of negative religious coping strengthen this link (Fabricatore, Handal, Rubio, & Gilner, 2004), and other studies have reported support for the moderating roles of both positive and negative religious coping (Carpenter, Laney, & Mezulis, 2012; Horton & Loukas, 2013). More germane to minority stress and the current study, Szymanski and Obiri (2011) found that neither positive nor negative religious coping moderated the relations of racist discrimination and internalized racism with psychological distress in a sample of predominantly heterosexual African Americans. Most recently, a study with Asian American undergraduates reported that, contrary to their expectations, negative (but not positive) religious coping actually
dampened the deleterious impact of racist discrimination on mental health (Kim, Kendall, & Webb, 2015).

To our knowledge, no study has tested religious coping as a moderator of the links of heterosexist minority stressors with mental health outcomes. However, qualitative research findings suggest that some sexual minority people use positive religious coping strategies to reframe experiences of minority stress and promote psychological health (Brennan-Ing et al., 2013; Jeffries, Dodge, & Sandfort, 2008; Kubicek et al., 2009). For example, one young gay man in Kubicek and colleague’s (2009) study noted that “If He created me, He created me being gay. He created everything . . . So you have to say, ‘Okay, God created everything so this was created by Him, so it may have a purpose’” (p. 619). Qualitative research also supports that some sexual minority people draw on negative religious coping strategies to deal with their experiences of rejection, which in turn, negatively impacts psychological well-being (Murr, 2013; Severson et al., 2014). Illustratively, one lesbian participant in Murr’s (2013) study revealed “[w]hen I found out that I was not accepted in the Lutheran Church . . . I was just like ‘Okay, if I’m going to Hell I’m going to be, like, the best at being bad’” (p. 357). Taken together, understanding how religious and spiritual sexual minority people use positive and negative coping strategies to moderate minority stress may have important implications for the mental health outcomes of this group.

The Present Study

For our first set of hypotheses—consistent with prior research regarding minority stressors and mental health—we predicted that heterosexist discrimination and internalized heterosexism would be related to greater psychological distress and lower psychological well-being. We also hypothesized that heterosexist discrimination and internalized heterosexism would be related to lower levels of positive religious coping and higher levels negative religious coping. In turn, we predicted that positive religious coping would be related to better mental health (i.e., lower psychological distress, higher psychological well-being) whereas negative religious coping would be related to poorer mental health (i.e., higher psychological distress, lower psychological well-being).

Our second set of hypotheses involved moderation patterns. We predicted that positive religious coping would attenuate the relations of heterosexist discrimination and internalized heterosexism with the mental health indicators, whereas negative religious coping would strengthen these relations.

Method

Participants

The final sample included 143 sexual minority individuals. Participants ranged in age from 18 to 77 (M = 38.8, SD = 14.50, Mdn = 36). Because of small levels of missing demographic data, subsequent percentages may not sum to 100%. With regard to sexual orientation, approximately 46% identified as exclusively gay/lesbian, 20% as mostly lesbian/gay, 31% identified as bisexual, and 4% as mostly heterosexual. In terms of religion, 39% of participants identified as Christian, 21% as spiritual but not religious, 11% as Jewish, 8% as Buddhist, 7% as spiritual, 1% each as Hindu and Muslim, and 13% as Other (e.g., Pagan). With regard to gender, approximately 50% of participants identified as men, 36% as women, 4% as transgender men, 1% as transgender women, and 10% as “other gender identities” (e.g., androgynous). Approximately 71% of participants identified their race/ethnicity as European American/White, 10% as African American/Black, as 6% multiracial, as 5% Latino/a American/Hispanic, 3% as Asian American/Pacific Islander, 1% as American Indian/Native American, and 4% as “Other” (e.g., East Indian, Arabic). In terms of highest level of education, 40% of participants attained a graduate or professional degree, 32% bachelor’s degree, 24% attended some college, 3% graduated high school, 2% possessed less than a high school education. With regard to self-identified social class, 41% identified as middle class, 31% identified as working class, 15% as upper-middle class, 13% identified as lower class, and 1% as upper class. In terms of geographical region, 53% lived in urban areas, 32% in suburban areas, and 14% in rural areas.

Procedures

Participants completed an online survey on Qualtrics and were recruited via email, social networking sites, and online resources such as electronic mailing lists, discussion boards, and virtual communities for sexual minority individuals. Participants were directed to an online survey that began with an informed consent that stated that the researchers were conducting a study exploring the roles of religiosity and spirituality for individuals who identify as sexual minorities. To participate in the study, respondents had to first affirm that they (a) were 18 years of age or older and (b) currently reside in the United States, and (3) identify as lesbian, gay, bisexual, or queer. A total of 320 entries were submitted, however data cleaning yielded1 a final sample of 143 participants.

Measures

Experiences of heterosexist discrimination were measured with the Heterosexist Harassment, Rejection, and Discrimination Scale (HHRDS; Szymanski, 2006). The HHRDS is a 14 item Likert-type with response ranging from 1 (the event has never happened to you) to 6 (even happened most of all the time). The HHRDS measures the frequency participants report having experienced heterosexist harassment, rejection, and discrimination within the past year with responses (e.g., “How many times have you heard anti-LGB remarks from family members?”). Internal consistency for the HHRDS was .90 and it was correlated as expected with measures of internalized heterosexism and psychological distress in a sample of lesbian women (Szymanski, 2006). In the present sample, Cronbach’s alpha for HHRDS items was .90.

1 One hundred three cases were removed from the dataset because they were missing more than 20% of the items in the survey (excluding demographic items); this 20% missing data criterion falls within the tolerance range studied or recommended by prior researchers (Parent, 2013). An additional participant was removed because the participant identified as exclusively heterosexual. Because the study focused on religious and spiritual beliefs, 73 participants who identified as atheist or agnostic were also removed. Little’s missing completely at random (MCAR) test indicated that the remaining missing data were MCAR, χ²(1,691) = 1.683.97, p = .544. Thus, we imputed data for the few missing items using expectation maximization procedures in SPSS (Parent, 2013).
Internalized heterosexism was measured with a bisexual- and queer-inclusive version of the Internalized Homophobia Scale (IHP; Herek et al., 1997; Martin & Dean, 1988). The IHP is a 9-item Likert-type scale with responses ranging from 1 (strongly disagree) to 5 (strongly agree). The IHP assesses the internalization of homophobic beliefs (e.g., “I feel like being LGBTQ lesbain, gay, bisexual, transsexual, queer is a personal shortcoming for me”). Past research with a community sample of sexual minority individuals reported internal consistency reliabilities of .71 for lesbian women and .83 for gay men; in terms of validity, IHS scores correlate positively with other measures of psychological distress and perceived stigma (Herek et al., 1997). In the present sample, Cronbach’s alpha for IHS items was .92.

Positive and negative religious coping was assessed using the Brief Measure of Religious Coping Styles (B-RCOPE, Pargament et al., 1998, 2011). The B-RCOPE is a 14-item Likert-type scale with responses ranging from 1 (not at all) to 4 (a great deal), which assesses positive (e.g., “Looked for spiritual support from my church in this crisis”) and negative (e.g., “Worried whether God had abandoned us”) patterns of religious coping. With a sample of African Americans, the B-RCOPE items yielded Cronbach’s alphas of .95 (positive coping) and .87 (negative coping), respectively (Szymanski & Obiri, 2011). The validity of the RCOPE has been supported in clinical and college samples through theoretically consistent relations with indices of religiosity (Freiheit, Sonstegard, Schmitt & Vye, 2006). In the present sample, Cronbach’s alpha for B-RCOPE items were .93 (positive) and .85 (negative).

Psychological distress was assessed using the Hopkins Symptom Checklist-21 (HSCL-21; Green et al., 1988). This HSCL-21 is a 21-item Likert-type scale with responses ranging from 1 (not at all) to 4 (extremely). The HSCL-21 assesses how often participants have experienced each symptom in the past week (e.g., “Feeling lonely”). Past research with sexual minority people reported an internal consistency reliability of .96 (Brewster & Moradi, 2010). In terms of validity, the HSCL-21 scores relate positively with other measures of psychological distress (Kawamura & Frost, 2004). In the present sample, Cronbach’s alpha for HSCL-21 items was .92.

Psychological well-being was assessed using the 18-item Psychological Well-being Scale (PWB; Ryff, 1989; Ryff & Keyes, 1995). The PWB is an 18-item Likert-type scale with responses ranging from 1 (strong disagreement) to 6 (strong agreement), which examines psychological well-being (e.g., “In general, I feel I am in charge of the situation in which I live”). Past research with sexual minority individuals demonstrated an internal consistency reliability of .75 (Kertzner et al., 2009). In terms of validity, PWB scores relate positively with other measures of psychological well-being (Frost & Meyer, 2012). In the present sample, Cronbach’s alpha for PWB items was .85.

Results

Bivariate correlations and descriptive statistics for the variables of interest are presented in Table 1. Cohen’s (1992) benchmarks are used to describe small ($r = .10$), medium ($r = .30$), and large ($r = .50$) effects. Correlations were largely consistent with hypotheses. Specifically, heterosexist discrimination and internalized heterosexism were significantly related to greater psychological distress and lower psychological well-being. Both of the minority stressors were also significantly related to greater negative religious coping, but only internalized heterosexism was significantly related to greater positive religious coping. Lastly, negative religious coping was significantly related to greater distress and lower well-being, but positive religious coping was not significantly related to mental health. Significant correlations ranged from small to large.

Moderating Roles of Religious Coping

Four regression models were tested to determine if positive or religious coping moderated the relations of the minority stress variables (heterosexist discrimination and internalized heterosexism) with the two mental health variables (psychological distress and psychological well-being). We tested one model for each pairing of one of the two moderators with one of the two criterion variables. In these analyses, the predictors and moderators were centered to reduce multicollinearity (Aiken & West, 1991). Results are presented in Table 2. With psychological distress as the criterion variable, none of the interactions of positive or negative religious coping with the minority stress variables were significant. With psychological well-being as the criterion variable, none of the interactions involving negative religious coping were significant and the Heterosexist Discrimination × Positive Religious Coping interaction was also nonsignificant. However, in partial support of the moderation hypotheses, the Internalized Heterosexism × Positive Religious Coping interaction was significant and associated with an incremental increase in variance explained in psychological well-being, $F(1,137) = 4.10, p = .045, R^2 = .02$.

A simple slope analysis was performed to determine the nature of the significant Internalized Heterosexism × Positive Religious Coping interaction. We examined the relation of internalized heterosexism with psychological well-being at low (1 SD below the mean), mean, and high (1 SD above the mean) levels of positive religious coping. Internalized heterosexism was negatively related to psychological well-being when positive religious coping was low, ($\beta = -0.65, t(137) = -5.30, p < .001$), average ($\beta = -0.52, t(137) = -6.77, p < .001$), and high, ($\beta = -0.39, t(137) = -5.41, p < .001$). In addition, the significant regression coefficient for the Internalized heterosexism × Positive religious coping interaction (see Table 2) indicates that the magnitude of the association of internalized-heterosexism with psychological well-being differs (i.e., decreases) significantly as positive religious coping increases. Thus, in partial support of hypotheses, greater positive religious coping weakened the relation of internalized heterosexism with psychological well-being. The nature of this interaction is depicted in Figure 1.

Discussion

The present study expanded research with sexual minority populations by exploring the links of minority stressors (i.e., hetero-
sexist discrimination, internalized heterosexism) and religious coping strategies (i.e., positive and negative religious coping) with psychological distress and well-being. Furthermore, the study responded to calls to explore variables that may moderate the deleterious links of minority stressors with psychological health (Meyer, 2003). Although prior studies with marginalized populations have begun to examine the moderating roles of religious coping styles in the link between minority stressors and psychological outcomes (e.g., Kim et al., 2015; Szymanski & Obiri, 2011), the present study is the first of its kind to quantitatively explore this model with sexual minority people. Data from the study offer a nuanced look at the relations between identification as a sexual minority person and religious coping practices that yield important implications for future research and clinical practice.

Results of the present study largely supported our first set of hypotheses about direct associations among the variables of interest. Consistent with prior research with sexual minority populations (e.g., Newcomb & Mustanski, 2010), both heterosexist discrimination and internalized heterosexism were correlated positively with psychological distress and negatively with well-being. Consistent with findings from prior studies on religious coping strategies, negative religious coping was strongly and positively related to psychological distress and negatively with well-being, but positive religious coping was unrelated to these indicators of mental health (e.g., Bjorck & Thurman, 2007; Pargament et al., 1998, 2000; Szymanski & Obiri, 2011). Such findings suggest that although negative religious coping is clearly deleterious to mental health, positive religious coping may not offer a direct benefit to mental health for some sexual minority people. These results contrast findings from prior qualitative studies with sexual minority people on the perceived helpfulness of positive religious coping in heightening dimensions of mental health and well-being (Brennan-Ing et al., 2013; Jeffries, Dodge, & Sandfort, 2008; Kubicke et al., 2009).

Previously unexplored in any quantitative study with sexual minority people, internalized heterosexism was related to greater use of positive religious coping strategies. Moreover, heterosexist discrimination and internalized heterosexism were both associated with more use of negative religious coping. Such findings likely indicate that for some individuals, both positive and negative religious coping strategies are used simultaneously in reaction to minority stressors. Indeed, positive and religious coping strategies were positively and moderately correlated with one another—an association demonstrated previously, though with less strength, in

Table 1
Bivariate Correlations, Descriptive Statistics, and Cronbach’s Alphas for Variables of Interest

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Possible range</th>
<th>M</th>
<th>SD</th>
<th>α</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Heterosexist discrimination</td>
<td>—</td>
<td>—</td>
<td></td>
<td></td>
<td></td>
<td>1–6</td>
<td>1.79</td>
<td>.72</td>
<td>.90</td>
</tr>
<tr>
<td>2. Internalized heterosexism</td>
<td>.17</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>1–5</td>
<td>1.54</td>
<td>.77</td>
<td>.91</td>
</tr>
<tr>
<td>3. Positive religious coping</td>
<td>.16</td>
<td>.19</td>
<td></td>
<td>—</td>
<td>—</td>
<td>0–3</td>
<td>1.26</td>
<td>.95</td>
<td>.92</td>
</tr>
<tr>
<td>4. Negative religious coping</td>
<td>.39</td>
<td>.58</td>
<td>.43</td>
<td>—</td>
<td>—</td>
<td>0–3</td>
<td>.51</td>
<td>.65</td>
<td>.85</td>
</tr>
<tr>
<td>5. Psychological distress</td>
<td>.45</td>
<td>.70</td>
<td>.50</td>
<td>—</td>
<td>—</td>
<td>1–4</td>
<td>1.92</td>
<td>.59</td>
<td>.92</td>
</tr>
<tr>
<td>6. Psychological Well-being</td>
<td>−.26</td>
<td>−.48</td>
<td>−.57</td>
<td>—</td>
<td>—</td>
<td>1–7</td>
<td>5.38</td>
<td>.83</td>
<td>.85</td>
</tr>
</tbody>
</table>

*p < .05. **p < .01. ***p < .001.

Table 2
Tests of Religious Coping as Moderators of Relations of Minority Stressors With Mental Health

<table>
<thead>
<tr>
<th>Step</th>
<th>Predictors</th>
<th>B</th>
<th>β</th>
<th>Part</th>
<th>t</th>
<th>R²</th>
<th>ΔR²</th>
<th>ΔF</th>
<th>df</th>
<th>B</th>
<th>β</th>
<th>Part</th>
<th>t</th>
<th>R²</th>
<th>ΔR²</th>
<th>ΔF</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Discrimination</td>
<td>.32</td>
<td>.38</td>
<td>.36</td>
<td>1.33</td>
<td>.36</td>
<td>.36</td>
<td>.36</td>
<td>26.54***</td>
<td>(3, 139)</td>
<td>.28</td>
<td>.33</td>
<td>.28</td>
<td>4.31***</td>
<td>.41</td>
<td>.41</td>
<td>32.53***</td>
</tr>
<tr>
<td></td>
<td>IH</td>
<td>.32</td>
<td>.42</td>
<td>.35</td>
<td>1.73</td>
<td>.36</td>
<td>.36</td>
<td>.01</td>
<td>(1, 138)</td>
<td>.20</td>
<td>.27</td>
<td>.19</td>
<td>2.88**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Coping</td>
<td>−.03</td>
<td>−.05</td>
<td>−.04</td>
<td>−.63</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.29</td>
<td>.32</td>
<td>.23</td>
<td>3.55***</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Discrim. × Coping</td>
<td>.01</td>
<td>.01</td>
<td>.01</td>
<td></td>
<td>.09</td>
<td>.36</td>
<td>.00</td>
<td>.01</td>
<td>(1, 138)</td>
<td>−.08</td>
<td>−.10</td>
<td>−.08</td>
<td>1.27</td>
<td>.42</td>
<td>.01</td>
<td>1.84</td>
</tr>
<tr>
<td>3</td>
<td>IH × Coping</td>
<td>−.01</td>
<td>−.01</td>
<td>−.01</td>
<td>−.11</td>
<td>.36</td>
<td>.00</td>
<td>.01</td>
<td>(1, 137)</td>
<td>−.01</td>
<td>−.02</td>
<td>−.01</td>
<td>−.20</td>
<td>.42</td>
<td>.00</td>
<td>.04</td>
<td>(1, 137)</td>
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</table>

Criterion: Psychological well-being

<table>
<thead>
<tr>
<th>Step</th>
<th>Predictors</th>
<th>B</th>
<th>β</th>
<th>Part</th>
<th>t</th>
<th>R²</th>
<th>ΔR²</th>
<th>ΔF</th>
<th>df</th>
<th>B</th>
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<th>ΔF</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Discrimination</td>
<td>−.20</td>
<td>−.18</td>
<td>−.17</td>
<td>−2.35</td>
<td>.30</td>
<td>.30</td>
<td>19.66***</td>
<td>(3, 139)</td>
<td>−.13</td>
<td>−.11</td>
<td>−.10</td>
<td>−1.32</td>
<td>.28</td>
<td>.28</td>
<td>17.80***</td>
<td>(3, 139)</td>
</tr>
<tr>
<td></td>
<td>IH</td>
<td>−.61</td>
<td>−.57</td>
<td>−.48</td>
<td>−6.77***</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>−.39</td>
<td>−.37</td>
<td>−.26</td>
<td>−3.55**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Coping</td>
<td>.17</td>
<td>.20</td>
<td>.19</td>
<td>2.63*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>−.22</td>
<td>−.17</td>
<td>−.12</td>
<td>−1.68</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Discrim. × Coping</td>
<td>−.05</td>
<td>−.04</td>
<td>−.04</td>
<td>−.50</td>
<td>.30</td>
<td>.00</td>
<td>.28</td>
<td>(1, 138)</td>
<td>−.04</td>
<td>−.04</td>
<td>−.03</td>
<td>−.47</td>
<td>.28</td>
<td>.00</td>
<td>.19</td>
<td>(1, 138)</td>
</tr>
<tr>
<td>3</td>
<td>IH × Coping</td>
<td>−.16</td>
<td>.17</td>
<td>.14</td>
<td>2.02*</td>
<td>.32</td>
<td>.02</td>
<td>4.10*</td>
<td>(1, 137)</td>
<td>−.02</td>
<td>−.02</td>
<td>.02</td>
<td>2.11</td>
<td>.28</td>
<td>.00</td>
<td>.05</td>
<td>(1, 137)</td>
</tr>
</tbody>
</table>

Note. Discim. = Heterosexist discrimination; IH = Internalized heterosexism. The Bs, bs, and t values are derived from the final regression equations including all predictors and interactions.

*p < .05. **p < .01. ***p < .001.
a study with predominately heterosexual African American participants (Szymanski & Obiri, 2011).

The potential for positive and negative religious coping strategies to moderate relations between the minority stressors (i.e., heterosexist discrimination, internalized heterosexism) and mental health outcomes (i.e., distress, well-being) was assessed by our second set of hypotheses. In partial support of our hypotheses, we found that positive religious coping moderated the relation of internalized heterosexism on psychological well-being, such that, greater positive religious coping weakened the deleterious impact of internalized heterosexism on psychological well-being. Although prior studies regarding general stressors and well-being have demonstrated support for the buffering role of positive religious coping (e.g., Bjorck & Thurman, 2007), no prior study on minority stress with marginalized groups has supported this link (e.g., Kim et al., 2015; Szymanski & Obiri, 2011). Our results support the growing theory that positive religious coping contributes to enhancing positive psychological outcomes, yet does not alleviate negative psychological symptoms (Lee et al., 2014; Tix & Frazier, 1998).

Implications for Practice

Data from the present study add to the growing body of research that supports positive associations between minority stressors and poor psychological outcomes for sexual minority populations. As such, validating the experiences of sexual minority clients by openly discussing the potential links between heterosexist environments and mental health may be beneficial in clinical work; moreover, practitioners may consider exploring the ways in which internalized heterosexism manifests itself in their clients’ personal narratives (Eubanks-Carter, Burkell, & Goldfried, 2005). Though prompting clients to connect to some sort of religious faith or spiritual resource is often presented as a helpful clinical strategy in counseling training programs (for a review, see Brewster et al., 2014; D’Andrea & Sprenger, 2007), practitioners should also be aware of the complicated and painful history of some religious and spiritual institutions with the LGBTQ community. Thus, when working with sexual minority clients, practitioners may want to consider approaching discussions of faith tentatively—attending to both the positive and negative dimensions of belief for their religious and spiritual clients. For some religious or spiritual clients, bolstering the use of positive religious coping strategies may be an effective means of reducing the impact of internalized heterosexism on well-being. However, practitioners may also benefit from exploring how negative religious coping strategies can relate to symptoms of distress, and, if clients are using negative religious coping strategies, practitioners may consider working to counter these maladaptive schemas and foster more adaptive beliefs.

Limitations and Future Directions

Findings from the present study should be interpreted in light of a few limitations. Online recruitment—which confines participation to individuals with Internet access—may have contributed to the relatively homogenous demographic composition of our sample; indeed, roughly 60% of participants had either a bachelor’s degree or more years of education, and about 70% identified their race as White. Thus, future research should explore the use and implications of religious coping strategies for sexual minority people of color and individuals with fewer years of formal education.

Although the present study was designed to examine the experiences of religious and spiritual sexual minority people, it is important to acknowledge that some atheist and agnostic sexual minority individuals (see Footnotes 1 and 2) completed the study but were excluded from the final sample. Our decision to exclude these nonbelieving participants was informed by the constructs we assessed and the measures we used in the study. A significant concern with most instruments on religiosity/spirituality or religious coping is that they have not been normed or used with nonbelievers (Hwang, Hammer, & Cragun, 2011). Further, most of the items on religiosity measures are not applicable to the experiences of nonbelievers, and perhaps even display cultural insensitivity, as they assume that participants believe in God (e.g., “Looked for a stronger connection with God”); by definition, nonbelievers do not believe in a God/gods or any supernatural higher power (Bullivant & Ruse, 2013). As an example specific to religious coping and our study, if a religious participant answered “never” to “felt punished by god for my lack of devotion” this is a meaningful response (they have a healthy relationship with God), however, if an atheist participant responded with “never” to the same question this response lacks meaning, because they do not believe in God; thus, the item is not an indicator of how healthy or unhealthy this religious coping strategy is for nonbelievers. Taken together, data garnered from nonbelieving individuals on their use of religious coping strategies may not be valid or interpretable. Future research that centers explicitly on the ways in which nonbelieving sexual minority individuals cope with minority stress is critical—particularly considering that, compared to heterosexuals,
sexual minority people are three times more likely to identify as atheist or agnostic (Linneman & Clendenen, 2009).

Another potential limitation of our study is the wide array of religious and spiritual identities included in the participant composition. In light of prior research (e.g., Tix & Frazier, 1998) that found that distinctions in religious affiliation may moderate the effectiveness of religious coping on adjustment after stressful life events, future studies may find it fruitful to systematically explore how methods of religious coping used vary across faiths. Another significant limitation of our study was that we assessed the experiences of many different sexual orientation groups concomitantly. Such a practice may obfuscate more nuanced group-specific findings, particularly considering that there is mounting evidence that gay and lesbian individuals, compared to bisexual people, may experience different manifestations of minority stress (e.g., Brewster & Moradi, 2010) and that minority stress may also vary across genders (Lehavot & Simoni, 2011). Further, rigid gender role expectations within some religious and spiritual sectors (e.g., pressure for women to display marianismo, the inability of women to take on church leadership roles) may contribute to how sexual minority women understand and internalize their minority stress experiences. Thus, future studies should stretch beyond exploring religious coping of sexual minority individuals as a monolithic group, and instead attend to potential within-group differences in these links.

References


