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# Religious Conflict, Sexual Identity, and Suicidal Behaviors among LGBT Young Adults

**Jeremy J. Gibbs**

PhD Student, 410-207-7263, 213-821-2088

Jeremy J. Gibbs: jeremyjg@usc.edu

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## INTRODUCTION

Lesbian, gay, bisexual and transgender (LGBT) young adults are at disproportionate risk for experiencing distress and abuse. A recent meta-analysis by Friedman et al. (2011) found that lesbian, gay, and bisexual (LGB) adolescents report higher rates of abuse, victimization, and bullying than their heterosexual peers. LGBT young adults also report higher rates of mental illness (King et al., 2008; Lewis 2009; Mustanski, Garofalo, & Emerson, 2010), suicidal ideation (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009; King et al., 2008; Lewis, 2009) and self-harm when compared to their non-LGBT peers (Almeida et al., 2009; King et al., 2008). LGBT young adults are over five times more likely than their non-LGBT peers to report suicidal ideation (Almeida et al., 2009). In fact, recent findings suggest that LGB young adults are five times more likely to report previous suicide attempt compared to their non-LGBT peers (Hatzenbuehler, 2011) and that 25% to 32% of transgender late adolescents and young adults have had a previous suicide attempt (Clements-Nolle, Marx, & Katz, 2006, Grossman & D'Augelli, 2007).

In understanding mechanisms that contribute to mental health outcomes including suicide, researchers often employ a risk and protective factor model, where risk factors are understood to contribute to negative behavioral health outcomes and protective factors buffer against them (Hawkins, Catalano & Miller, 2002; Institute of Medicine [IOM], 2009). Minority stress theory posits that in addition to common strains, LGBT individuals also experience unique stressors (risk factors) related to their sexual and gender identity, and that these chronic stressors are associated with negative mental health outcomes (Hatzenbuehler, Hilt, & Nolen-Hoeksema, 2010; Mays, Cochran & Barnes, 2007; Meyer, 2003). These minority-related risk factors for LGBT people include negative events (e.g., discrimination, victimization), negative attitudes towards homosexuality, internalized discomfort with sexual and/or gender identity, and emotional distress related to acceptance (Kelleher, 2009; Rosario, Rotheram-Borus & Reid, 1996; Rosario, Schrimshaw, Hunter & Gwadz, 2002). Numerous studies have connected minority stressors to suicidal behaviors among LGBT young adults (Mays & Cochran, 2001; Russell, 2003; Ryan, Huebner, Diaz, & Sanchez, 2009; Savin-Williams & Ream, 2003).

Generally, religiosity (i.e., level of religious dedication, belief, and religious activity) is considered a protective factor against negative mental health outcomes. A recent systematic review by Wong, Rew, and Slaikeu (2006) found that religiosity and religious affiliation among the general population are associated with positive mental health outcomes for young adults and adolescents. Other research has found that religious affiliation and religiosity are associated with lower levels of depression in adolescents (Cotton, Larkin, Hoopes, Cromer, & Rosenthal, 2005) and in young adults (Taliaferro, Rienzo, Pigg, Miller, & Dodd, 2009), and lower rates of suicidality in adolescents (Rew, Thomas, Horner, Resnick, & Beuhring, 2001) and in young adults (Taliaferro et al., 2009). A strong correlation, however, also exists between level of religiosity and negative attitudes toward homosexuality (Rowatt, LaBouff, Johnson, Froese, & Tsang, 2009). Additionally, the majority of Americans (57%) identify religious belief (belief in God) as a requisite for moral judgment (Kohut, Wike, & Horowitz, 2007). Due to these factors, LGBT persons who mature in a religious community context report experiencing increased discrimination and internalized homophobia (i.e., negative attitudes, beliefs, feelings, and stereotypes about LGBT people that is directed inward by someone with same-sex attraction or feelings of discontent with one's biological gender; Barnes & Meyer, 2012; Harris, Cook, & Kashubeck-West, 2008; Kralovec, Fartacek, Fartacek, & Plöderl, 2012; Shilo & Savaya, 2012).

In light of this, recent studies have investigated the relative impact of religious affiliation and religiosity on mental health outcomes in LGBT adults (e.g., Barnes & Meyer, 2012; Harris et al., 2008; Kralovec et al., 2012; Shilo & Savaya, 2012). Findings from these studies have been generally inconclusive in determining the aspects of religiosity that are associated with mental health outcomes. One study found that, for LGB adults, suicidal thoughts had no association with a religious affiliation (Kralovec et al., 2012). In fact, a number of studies have found that measures of religiosity, across religious affiliations (e.g. Protestant, Catholic, Jewish, Buddhist), were not associated with any mental health outcomes for LGB adults (Barnes & Meyer, 2012; Harris et al., 2008; Shilo & Savaya, 2012) and very little is known about this association among individuals who are transgender. For researchers who explore minority stress, these findings may seem counter-intuitive, as religiosity has been associated with higher rates of internalized homophobia among LGBT adults (Barnes & Meyer, 2012, Kralovec et al., 2012; Shilo & Savaya, 2012) and internalized homophobia has been associated with negative mental health outcomes (Kralovec et al., 2012; Shilo & Savaya, 2012).

To better understand this complicated relationship between religiosity and LGBT identification, emerging qualitative literature has explored the relationship between religious identity conflict (i.e., religious beliefs that are against ones sexual identity, gender identity, or sexual attraction) and mental health outcomes of LGBT adults. Qualitative studies with adults have indicated a relationship between religious and LGBT identity conflict and depression (Ganzevoort, Van der Laan & Olsman, 2011; Levy & Reeves, 2011; Wolkomir, 2001) and suicide (Coyle & Rafalin, 2000; Wolkomir, 2001; Walton, 2006). Further, of the limited studies that have investigated religious identity conflict quantitatively among young adults have done so with either a full youth sample with a large age range (13–25 years old; Ream & Savin-Williams, 2005) or with a full adult sample with an even broader age range (16–83 years old; Sherry, Adelman, Whilde & Quick, 2010). These age ranges encompass

individuals at different developmental milestones, which may obscure the findings relevant to LGBT young adults. To date, no quantitative study is known to have explored the relationship between religious identity conflict, negative mental health outcomes and internalized homophobia as mediator, nor done so using a large national sample of only LGBT young adults (18–24 year olds). Therefore the current study aimed to investigate the relationships between religious and sexual identity conflict, internalized homophobia, and suicidality amongst LGBT young adults (18–24 year olds) in an effort to better inform research and clinical practice with LGBT young adults.

## METHODS

In order to explore the relationship between religious and LGBT identity conflict and suicidality (suicidal thoughts, chronic suicidal thoughts, and suicide attempts) a secondary data analysis was conducted using data from a large Internet based survey of LGBT young adults collected by OutProud: The National Coalition for Gay, Lesbian, Bisexual and Transgender Youth (Kryzan & Walsh, 2000). Data were collected by OutProud between September and October, 2000, through an online survey. Using the Internet, researchers have often obtained samples that are hidden or difficult to recruit through traditional methods (Bowen, 2005; Meyer & Wilson, 2009; Rosser, Oakes, Bockting, & Miner, 2007)

The cross-sectional survey was developed collaboratively with experts in LGBT mental health, and substance abuse research (Kryzan & Walsh, 2000). Links to the survey were made available through online and in-print outlets (e.g. Oasis Magazine, Out in America, OutProud), and websites that cater to young LGBT persons. Once the website for the survey was accessed by participants, an introductory letter explained the study goals and the OutProud privacy policy; no identifying information was collected from participants. With the inclusion of more than 260 variables collected from 5,281 U.S. resident respondents, the OutProud survey represents the only known national sample with a large enough pool to analyze religious and sexual orientation identity conflict. The only requirements for participation were identifying as 25 years of age or younger and willingness to answer questions about sexual minority experiences. For the purpose of this secondary analysis, the sample was restricted to emerging adults, age 18 to 24 years (a subsample of 2,949 respondents). Institution Review Board (IRB) approval was not necessary for this study due to utilization of secondary data which retained no identifiable information.

Study participants ranged from age 18 to 24 (m=20.07; SD=1.978). The majority of participants identified as male (75.6%) and female (21.8) with approximately 2% identifying as transgender. The racial/ethnic makeup of the sample was largely White identifying (82.1%). Sixty-one percent of participants identified as gay or lesbian, 27% as bisexual, 10% as questioning, 2% as other, and less than 1% identified as heterosexual. Regarding current religious affiliation, about 45% of the sample identified as some form of Christian denomination, 25% non-religious, 14% reporting not knowing their current religious affiliation, and the remaining reporting a diversity of religious affiliations. Table 1 provides the full description of the study sample.

## Measurement

**Demographics—**Respondents were asked to report several demographic details including: age, gender, race, sexual orientation, and religious affiliation. Participants indicated their *age* by inputting a two-digit number. *Gender* had five options to choose from: Male, Female, Transgender Male (Female to Male), Transgender Female (Male to Female), and other. *Sexual orientation* was assessed with the question: "how would you describe your sexual orientation?" Response options were limited to bisexual, gay, heterosexual, lesbian, questioning/unsure, and other. Current religious affiliation was indicated through the item "what do you consider your current religious affiliation," and had 20 response options. This variable was then collapsed to form 10 different groups: 1) Christian Protestant (Baptist, Episcopal, Lutheran, MCC, Methodist, Presbyterian, Quaker, Unitarian), 2) Christian Catholic (Roman Catholic), 3) Jewish, 4) Buddhist/Hindu, 5) Mormon, 6) Pagan/Wiccan, 7) No religious affiliation, 8) Other Christian, 9) Other non-Christian (Other non-Christian, Muslim), 10) Don't Know. Participants were also prompted to report their "original religious affiliation" if they responded "yes" to an item asking if the participant at any time has left of changed his or her religious affiliation. The same response options were available for the original religious affiliation as were for the current religious affiliation item.

**Indicators of Religious and Sexual Orientation Identity Conflict—**Participants responded to several items that assessed religious conflict characteristics. From these items three indicators of identity conflict were created: 1) left religion due to conflict, 2) anti-homosexual parental religious beliefs, 3) conflict self-report groups.

The *leaving religion due to conflict* variable was created using the item: "have you at any time in your life left or changed your religious affiliation because of its views toward sexuality?" Answering "yes" to this item indicated that at some point in time the individual experienced conflict between their religious affiliation and sexuality.

Reports of parental religious beliefs being anti-homosexual indicate the potential for religious identity conflict. *Anti-homosexual parental religious beliefs* were assessed with the item: "have your parents' religious beliefs made it more difficult for you to tell them about your sexuality?" A response of "yes" indicated the experience of conflict through the form of normative parental religious beliefs.

Four mutually exclusive *conflict self-report groups* were created: Non-religious upbringing, religious upbringing with no conflict, religious upbringing with resolved conflict, and religious upbringing with unresolved conflict. Three items were used to create these groups. Conflict was self-reported with the item: "have your religious beliefs affected your acceptance of your sexual orientation?" Response options for this item considered *unresolved conflict* included: "yes, my religious beliefs have made it impossible for me to accept being queer," and "yes, but I will continue to ignore it." The term "queer" was used for several items within the survey as an umbrella term, like LGBT, to refer to all sexual and gender minorities. *Resolved conflict* was indicated through the responses "yes, but I have since reconciled my beliefs with my sexual orientation" and "yes, and I have changed my religious affiliation or beliefs as a result." No conflict was indicated with a "no" response to this item. Non-religious upbringing was indicated if the individual answered "Non-

Religious" to the question "What was your original religious affiliation?" or if the individual indicated "Non-Religious" to the current religious affiliation item and reported "no" to the item asking if the participant has ever left or changed their religious affiliation. If participants indicated that they had a religious upbringing (i.e., they indicated a current religion and answered "no" to ever having left or changed their religion, or they answered "yes" to having left or changed their religion and indicated their original religious affiliation) they were determined to be "religious upbringing with no conflict," "religious upbringing with unresolved conflict," or "religious upbringing with resolved conflict" depending on each individual's response to the conflict item. All other participants were placed in the non-religious upbringing category.

**Internalized homophobia—**A total internalized homophobia score (ranging from 0 to 3) was created by adding up the total of three dichotomous items assessing comfort with being LGBT, desire to not be LGBT, and desire to change from being LGBT. Non-comfort with being LGBT was assessed using the item: "how comfortable do you feel being queer?" This item was recoded to be binary non-comfort with being LGBT. Answers "neither comfortable nor uncomfortable", "uncomfortable" and "very uncomfortable" were recoded to 1, while "very comfortable" and "comfortable" were made 0. The non-comfort item was dichotomized in this way because we were most interested in the converse of being comfortable. Ideally individuals would be comfortable with their sexual or gender identity so a response of "neither comfortable nor uncomfortable" indicates that this person is not comfortable. Desire to not be LGBT was assessed with the question "Which of these statements most closely says how you feel about being queer?" A desire to not be LGBT was indicated as 1 on the binary item if the response was: "I would prefer being heterosexual," "I really do not want to be queer," and "I hate being queer and would do anything to change to heterosexual." Responses "I feel very good about my sexual orientation," "I feel good about being queer but wish it just wasn't a big deal," and "it doesn't make a difference one way or another to me" were recoded as 0. For the desire to not be LGBT item, the response option "it doesn't make a difference one way or the other to me" was treated as an indication of indifference, which does not indicate a desire to not be LGBT. The last item, desire to change one's sexual orientation was assessed with the item: "if you could change your sexual orientation would you?" Responses coded as 1 included: "yes, I want to change it," "yes, but I have tried and failed," "yes, and I believe that I have successfully done so," and "maybe." A code of 0 was assigned to "no, I am happy with who I am." These three dichotomous items were then totaled to equal the total of internalized homophobia, with higher values indicating more internalized homophobia.

**Suicidality—**Three different outcome measures were used for measuring suicide risk: suicidal thoughts in the last month, chronic suicidal thoughts in the last month, and suicide attempt in the last year. *Suicidal thoughts* were measured using the likert-like item: "have you thought about hurting yourself or killing yourself in the past 30 days?" This included responses: "no, not at all," "I have thought about it once or twice," "I have thought about it two or three times," "I think about it every day," and "I think about it so much I can't think about anything else." This item was recoded dichotomously so that all affirmative answers yielded a 1 and the "no" response yielded a 0. A dichotomous, instead of a continuous,

variable was utilized for analysis because presence of suicidal thoughts rather than frequency was the focus of this study. However, in order to account for *chronic suicidal thoughts* this same original item was recoded so that responses indicating fleeting suicidal ideation were recoded as 0 (i.e., I have thought about it once or twice, and I have thought about it two or three times) while items indicating chronic suicidal ideation were recoded as 1 (i.e., I think about it every day, and I think about it so much I can't think about anything else). The measure for *suicide attempt in the last year* required using the respondent's current age and subtracting the age reported to the item; "how old were you at your last [suicide] attempt." If the result of the subtraction was 0 then a 1 was indicated for the binary variable *suicide attempt in the last year*. All other values were made 0 on this variable. For example: if the respondent indicated his age as 19 and last suicide attempt was at age 17 then the result would be 2 indicating no suicide attempt in the last year (with a response of 0). Suicide attempt in the last year, as opposed to a different time frame, was used for two reasons: out of concern for recall bias, and because this study focuses on current mental health instead of lifetime mental health. It is conceivable that participants are able to recall the last year more accurately than several years prior. Further, a measure of suicide attempt in the last year assesses the most current state of mental health rather than a lifetime summation.

## Analysis

Analysis was conducted in three stages: descriptive statistics, investigation of the identity conflict indicators as covariates of suicide, and mediation analyses to determine the mediating power of internalized homophobia on the relationships between identity conflict indicators and suicidality. First, descriptive analyses were run to investigate the demographic characteristics, religious affiliation of origin, identity conflict indicators, level of internalized homophobia, and suicidal features of the sample.

The second stage of analysis involved running bivariate regressions to determine the relationships between study variables. Fifteen regression analyses were run: 3 linear regressions with identity conflict indicators and internalized homophobia as the outcome, 4 bivariate logistic regressions with suicidal thoughts in the last month as the outcome, 4 bivariate logistic regressions with chronic suicidal thoughts in the last month as the outcome (with analysis restricted to participants reporting suicidal thoughts in the last month), and 4 bivariate logistic regressions with suicide in the last year as the outcome. The three linear regressions tested for a relationship between each identity conflict indicator and internalized homophobia. The logistic regressions were used to determine the relationship between indicators with suicide outcomes and internalized homophobia (potential mediator) with suicide outcomes.

Mediation analysis was conducted using the procedures outlined in by Baron and Kenny (1986). Because this analysis utilized binary logistic regressions with a continuous mediator (internalized homophobia) the procedures were slightly altered as prescribed by MacKinnon and Dwyer (1993). When testing mediation in logistic regression it is important to note that a variable's scale changes from when it is a predictor variable to an outcome variable. For this reason it becomes necessary to standardize regression coefficients by multiplying the

coefficient by the standard deviation of the predictor variable and dividing by the standard deviation of the outcome variable (MacKinnon & Dwyer, 1993). Using these procedures, internalized homophobia was then tested as a mediator for the relationship between identity conflict indicators and suicide outcomes.

## RESULTS

Seventeen percent of the sample matured in a non-religious environment, while 40% reported a religious upbringing without experiencing religious and sexual orientation identity conflict (see Table 2 for these results). The remainder of the sample (43%) reported maturation in a religious community and experiencing conflict between their religious beliefs and sexuality. Of the entire sample, 31% reported resolving this conflict, and 12% reported an unresolved conflict. A t-test for comparison of means indicates that of those who report experiencing conflict, individuals who have resolved the conflict (M=20.19, SD=2.016) are significantly older on average (t(889)=2.891, p=.004) than those reporting unresolved conflict (M=19.99, SD=2.023). Further, of those reporting conflict between their religious beliefs and sexuality 42% left their religious affiliation due to the conflict. Of the participants who left their religion the most common original religion was some form of Christian denomination, which accounted for 74% of the subsample (see table 3). The current religious affiliation of this group however was mostly non-religious (24%), reporting “don’t know” (21%), and a smaller proportion reporting some form of Christian denomination (32%). Approximately 48% the sample that matured in a religious environment reported having difficulty discussing their sexuality with their parents due to their parent’s anti-homosexual religious beliefs.

On average, the sample reported experiencing a minimal level of internalized homophobia (M=.971, SD=1.115). Thirty-three percent of the sample reported having suicidal thoughts in the last month. Of those reporting suicidal thoughts in the last month 15% report these as chronically occurring. Further, 81 participants reported attempting suicide in the last year (3% of the sample).

Linear regressions assessing indicators of identity conflict associations with internalized homophobia yielded three significant findings (see Table 4 for results). Controlling for those who matured in a religious environment but do not report current conflict, those who report unresolved conflict between their sexuality and religious beliefs report significantly higher rates of internalized homophobia, when compared to those who did not mature in a religious environment (B=.964, SE=.076, t=12.718, p<.001). Similarly, having parents with anti-homosexual religious beliefs is significantly associated with a .289 (SE=.046) increase in internalized homophobia (t=6.298, p<001). Leaving one’s religion of origin due to reported conflict is associated with a decrease in internalized homophobia by .775 (SE=.065, t= −11.923, p<.001)

Internalized homophobia was found to be associated with two of the suicide outcome variables. A higher rate of internalized homophobia was associated with a higher odds of reporting suicidal thoughts in the last month (OR=1.193, 95%CI=1.114–1.278) and reporting chronic suicidal thoughts over fleeting thoughts (OR=1.271, 95%CI=1.093–

1.479). Internalized homophobia was not found to be significantly associated with suicide attempt in the last year.

Logistic regressions between identity conflict indicators and suicide outcomes indicate six significant relationships. All three indicators (i.e., religious upbringing with unresolved conflict, parental anti-homosexual religious beliefs, and leaving one's religion of origin due to conflict) were found to be associated with suicidal thoughts in the last month, parental anti-homosexual religious beliefs were found to be associated with chronic suicidal thoughts, and two (i.e., parental anti-homosexual religious beliefs, and leaving one's religion of origin due to conflict) were found to be associated with suicide attempt in the last year. Those in the self reported unresolved identity conflict group had 1.415 the odds of reporting suicidal thoughts in the last month compared to those who did not mature in religious environment (95% CI=1.059–1.890). Having, compared to not having parents with anti-homosexual religious beliefs, was associated with 1.565 the odds of having suicidal thoughts in the last month (95% CI= 1.318–1.859), a higher odds of reporting chronic suicidal thoughts in the last month (OR=1.572, 95% CI=1.039–2.379), and over two times the odds of a suicide attempt in the last year (95%CI= 1.217–3.436). Further, leaving one's religion of origin due to conflict was associated with a higher odds of suicidal thoughts (OR=1.335, 95%CI=1.052–1.695) and over two times the odds of a suicide attempt in the last year (95%CI=1.236–4.541).

Because internalized homophobia was not associated with suicide attempt in the last year, mediation was only tested for suicidal thoughts and chronic suicidal thoughts in the last month. Mediation analyses indicated that for suicidal thoughts internalized homophobia fully mediated the relationship between one indicator of conflict (i.e., maturation in a religious environment with unresolved conflict) and suicidal thoughts and partially mediates the relationships between two indicators (i.e., parental anti-homosexual religious beliefs, and leaving one's religion of origin due to conflict) and suicidal thoughts. Results also indicate that internalized homophobia fully mediates the relationship between parental anti-homosexual religious beliefs and chronic suicidal thoughts. Table 5 provides the logistic regression results for these mediation analyses.

A logistic regression investigating the relationships between internalized homophobia and identity conflict self report with suicidal thoughts indicates that internalized homophobia fully mediates the relationship between identity conflict self report and suicidal thoughts. As internalized homophobia increases the odds of reporting suicidal thoughts increases (OR=1.178, 95%CI=1.096–1.265). Identity conflict self-report group was not significantly related to suicidal thoughts when considering internalized homophobia.

Internalized homophobia also fully mediates the relationship between parental anti-homosexual religious beliefs and chronic suicidal thoughts for participants indicating suicidal thoughts in the last month. As internalized homophobia increases the odds of reporting chronic suicidal thoughts compared to fleeting suicidal thoughts increases (OR=1.283, 95%CI=1.079–1.525), and the relationship between parental anti-homosexual religious beliefs is no longer significant.

Internalized homophobia (OR=1.142, 95%CI=1.058–1.233) and parental anti-homosexual religious beliefs (OR=1.510, 95%CI=1.286–17.797) were both found to be significantly associated with suicidal thoughts within the last month. A Sobel test value of 2.997 ($p<.01$) indicates that internalized homophobia significantly partially mediates the impact of parental anti-homosexual religious beliefs on suicidal thoughts.

Similarly, leaving one's religion due to conflict (OR=1.658, 95%CI=1.279–2.149) and internalized homophobia (OR=1.308, 95%CI=1.174–1.457) were both found to be significantly associated with suicidal thoughts. A significant indirect effect was found (Sobel=−4.525, $p<.001$) indicating that internalized homophobia acts as a partial mediator in this relationship. Further investigation indicates that the direct effect of leaving one's religion due to conflict on suicidal thoughts is stronger (B=.136) than the indirect effect through the reduction in internalized homophobia (B=−.035).

## DISCUSSSION

The purpose of this study was three fold: 1) to determine if religious and LGBT identity conflict indicators are associated with suicidality, 2) to investigate if internalized homophobia mediates this relationship, and 3) to determine if a religious upbringing is associated with suicidality. In our study, data indicated that identity conflict that comes from dissonance felt between religious beliefs and LGBT identity was associated with higher risk of suicide.

All three indicators were associated with suicidal thoughts in the last month, parental anti-homosexual religious beliefs was associated with chronic suicidal thoughts in the last month and two indicators (i.e., leaving ones religion and parents religious beliefs about homosexuality) were associated with suicide attempt in the last year. In the case of suicide attempts, the two indicators were associated with a more than two times odds of having attempted suicide in the past year. It is important to note that the young adults included in the sample were not adolescents living at home, but college-aged young adults primarily living out of their parents' home. These two findings are especially unsettling, and add evidence not only to the literature on general family support and LGBT young adult outcomes, which find that family support is negatively associated with negative behavioral health outcomes (e.g., Goldbach, Tanner-Smith, Bagwell & Dunlap, 2013), but to the more specific relationship that their religious beliefs may have on this critical behavioral health concern. While changing parental beliefs on homosexuality (particularly as the beliefs in this study were founded in religious doctrine) may not always be feasible, these findings indicate that there is a critical need to intervene with, not only, LGBT young adults but potentially their parents, families, and their belief systems. Further, while leaving one's religion could be considered a functional way of dealing with the conflict (Schuck & Liddle, 2001), leaving one's religion due to the conflict was not associated with better mental health outcomes but instead a higher odds of both suicide attempt and suicidal thoughts.

Given the established relationship between internalized homophobia and suicide, it was included as a mediator to determine if religious conflict independently explained variance in suicidality beyond that of internalized homophobia. As expected, the conflict self-report

variable's impact on suicidal thoughts in the last month was completely diminished when internalized homophobia was considered. However, our study found that internalized homophobia only partially mediated the relationship between religious conflict and suicide, suggesting that other factors are influencing an individual's risk. We hypothesize that along with religious conflict, regardless of the source, other protective factors may be lost including social support networks. In the cases of parental beliefs and leaving one's religion, internalized homophobia had a minimal effect, suggesting that these indicators of conflict are independently associated with suicidal thoughts. Further it appears that religious conflict, as indicated through parental beliefs, has a limited direct impact on chronic suicidal thoughts, as internalized homophobia fully mediated this relationship. This finding suggests that although parental religious beliefs are independently associated with suicidal thoughts when taking into account internalized homophobia, the relationship between parental beliefs and chronic suicidal thoughts are best accounted for by the level of internalized homophobia.

After consideration of internalized homophobia, the relationship between leaving one's religion and suicidal thoughts was significant. In our analysis, leaving one's religion is associated with a decrease in internalized homophobia. However, while this expected relationship emerged, we also found that leaving one's religion was associated with a higher risk of suicidal thoughts. Thus, a dual relationship was found where leaving the religion was related to lower internalized homophobia, leading to a lower odds of suicidal thoughts, but also an increase in the odds of suicidal thoughts directly. Further, the strength of the direct effect and indirect effect suggests that leaving one's religion of origin has a sum impact of increasing the odds of suicidal thoughts, a potentially important clinical implication for those working with LGBT persons who are struggling to come to terms with both religious and LGBT identities. As our measure was an indicator of conflict, it is possible it was also measuring an addition construct (e.g. those who leave their religion may experience a disruption in their support system). This indicator, as well as parental anti-homosexual religious beliefs, may be measuring both conflict and problems in primary support. Concerns with our current measurement of minority stress constructs have been noted in other literature (Goldbach et al., 2013).

Internalized homophobia was not associated with suicide attempt in the last year. Conversely, parental beliefs and leaving the religion of origin were associated with a suicide attempt in the last year. This has important implications on clinical practice, as direct interventions that are focused on reducing suicide by diminishing feelings of internalized homophobia alone may be ineffective with this population. Further, this finding suggests that relationships (parental, and religious community) may be more impacting on deterring a suicide attempt than one's own gay self-concept, and adds evidence for family-centered approaches such as those being explored by other researchers in the area (e.g., Family Acceptance Project; Ryan, Russell, Huebner, Diaz, Sanchez, 2010).

The last aim of this study was to investigate how religious upbringing impacts suicide and internalized homophobia. In our study, those who experienced a religious upbringing and are currently experiencing religious conflict were most at risk of considering suicide. Further, a religious upbringing in itself does not provide protection from suicidal ideation

when compared to a non-religious upbringing. Thus, it appears that a religious upbringing that includes unresolved religious and LGBT identity conflict puts an individual more at risk of suicidal thoughts.

There were two important clinical implications found in the current study. First, it may seem counterintuitive that when individuals choose to leave their religion in order to experience more self-acceptance that they inadvertently experience more risk for suicide. Clinicians should be aware that leaving one's religion of origin may add additional stressors that ultimately place a client at additional risk for suicide. Further, the negative impact felt from leaving one's religion due to conflict has a stronger impact than the positive indirect impact through a reduction in internalized homophobia. As many LGBT young adults often experience multiple levels of loss, clinical interventions should ideally entail a plan for enhancing supportive resources without risk of further isolation from communities of historical significance to the client (i.e., loss of community, potential loss of protective belief structure). This may involve encouraging clients to be involved in communities that incorporate their religious tradition and their LGBT identity, which has been found qualitatively to be supportive (Jaspal & Cinnirella, 2010; Thumma, 1991). Second, it is apparent that LGBT young adults who experience religious identity conflict are at significant risk for suicide. When individuals experience conflict with an accepted belief structure this can cause a great deal of distress, which may lead to a desire to escape. For this reason, suicide risk assessments could be enhanced by further understanding the loss of spiritual resources and subsequent challenges adjusting to this loss.

The future of this research area will require further operationalization of religious identity conflict. The dearth of validated minority stress construct measures have been noted in other research as well (e.g., Goldbach, et al., 2013). In our current study, indicators were utilized to measure conflict. The development of better measurement instruments, that measure this religious LGBT identity conflict, will help to parse out the relationships discussed in this study. These relationships also require further study through replication with an internalized homophobia variable that is scalar.

The current study had several limitations. First, the data was collected in 2000 by internet-based purposive sampling, and some of these constructs may have changed in the last decade. To date, however, this dataset remains the largest known to collect on variables of minority stress. As with all cross-sectional data, causation cannot be determined and the exact temporal relationship between variables remains unclear. This includes the time ordering of when a participant left their religion, and whether it occurred prior to or after the individual experienced their most recent suicide attempt, which using this data could not be determined because no item was included in the survey to ask about the age the individual left their religion. Further, the study was largely male (75%), largely Caucasian (82%), and had very few transgender participants (2%). Thus, the study is limited in its ability to generalize to both women and the experiences of gender identity differences. Additionally, racial/ethnic minority individuals who identify as LGBT may experience very unique identity conflict issues as an intersectional approach would suggest (Murphy, Hunt, Zajicek, Norris, & Hamilton, 2009), as well as prior research with non-Caucasian samples of sexual and gender minority people (Figueroa & Tasker, 2013; Jaspal & Cinnirella, 2010; Pitt,

2010,). These limitations in generalizability further highlight the need for study samples that are racially diverse and represent a diversity of genders and gender expression. Finally, the study was limited by using an internalized homophobia variable that was not based on a scale but rather three binary questions. Although this created variable simulated that of a larger more extensive internalized homophobia scale, it could not account for significant variations in the construct. Despite these concerns, the study offers novel evidence to clarify the complicated relationship between LGBT identity, internalized homophobia, religiosity, and suicidal risk.

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**Table 1**

Sample description

| Sample Characteristics (total N) | N | % | Range | Mean | SD |
|---|---|---|---|---|---|
| Age | 2,949 | | 18–24 | 20.070 | 1.979 |
| **Gender (2,949)** | | | | | |
| Male | 2,230 | 75.6 | | | |
| Female | 644 | 21.8 | | | |
| Transgender Male | 21 | 0.7 | | | |
| Transgender Female | 27 | 0.9 | | | |
| Other | 27 | 0.9 | | | |
| **Race/Ethnicity (2,949)** | | | | | |
| Black/African American | 84 | 2.8 | | | |
| White | 2,420 | 82.1 | | | |
| Latino | 130 | 4.4 | | | |
| Asian | 126 | 4.3 | | | |
| Other | 189 | 6.4 | | | |
| **Sexual Orientation (2,949)** | | | | | |
| Gay/Lesbian | 1,814 | 61.5 | | | |
| Bisexual | 788 | 26.7 | | | |
| Heterosexual | 5 | 0.2 | | | |
| Questioning | 285 | 9.7 | | | |
| Other | 57 | 1.9 | | | |
| **Current Religious Affiliation (2,929)** | | | | | |
| Christian (Protestant) | 549 | 18.7 | | | |
| Christian (Catholic) | 422 | 14.4 | | | |
| Jewish | 98 | 3.3 | | | |
| Buddhist/Hindu | 55 | 1.9 | | | |
| Mormon | 28 | 1.0 | | | |
| Pagan/Wiccan | 173 | 5.9 | | | |
| Non-Religious | 733 | 25.0 | | | |
| Other Christian | 347 | 11.8 | | | |

| Sample Characteristics (total N) | N | % | Range | Mean | SD |
|---|---|---|---|---|---|
| Other Non-Christian | 126 | 4.3 | | | |
| Don't Know | 398 | 13.6 | | | |

**Table 2**

Study variable characteristics

| **Indicators of Identity Conflict (total N)** | **N** | **%** | | | |
|---|---|---|---|---|---|
| **Religious and Sexual Orientation Conflict Self Report (2,888)** | | | | | |
| Non-Religious upbringing | 486 | 16.8 | | | |
| Religious upbringing, no conflict | 1,171 | 40.5 | | | |
| Religious upbringing, resolved conflict | 890 | 30.8 | | | |
| Religious upbringing, unresolved conflict | 341 | 11.8 | | | |
| **Anti-homosexual Parental Religious Beliefs (2,399)**[1] | | | | | |
| Yes | 1,146 | 47.8 | | | |
| No | 1,253 | 52.2 | | | |
| **Left Religion of Origin due to Conflict (1,214)**[2] | | | | | |
| Yes | 509 | 41.9 | | | |
| No | 705 | 58.1 | | | |
| Mental Health Outcomes (total N) | N | % | Range | Mean | SD |
| Internalized Homophobia | 2,906 | | 0–3 | 0.971 | 1.115 |
| **Suicidal Thoughts in the Last Month (2,922)** | 955 | 32.7 | | | |
| I have thought about it once or twice[3] | 578 | 60.5 | | | |
| I have thought about it two or three times[3] | 234 | 24.5 | | | |
| I think about it every day[3] | 129 | 13.5 | | | |
| I think about it so much I can't think of anything else[3] | 14 | 1.5 | | | |
| Suicide Attempt in Last Year (2,945) | 81 | 2.8 | | | |

[1]Restricted to those with Religious up-bringing,

[2]Restricted to those with Religious up-bringing and experienced conflict,

[3]Restricted to those indicating suicidal thoughts in the last month

## Table 3

Past and current religious affiliation of those who report leaving their religion due to conflict (N=509)

| | N | % |
|---|---|---|
| **Previous Religious Affiliation** | | |
| Christian (Protestant) | 195 | 38.7 |
| Christian (Catholic) | 174 | 34.5 |
| Jewish | 5 | 1.0 |
| Buddhist/Hindu | 1 | 0.2 |
| Mormon | 16 | 3.2 |
| Pagan/Wiccan | 0 | 0.0 |
| Non-Religious | 0 | 0.0 |
| Other Christian | 106 | 21.0 |
| Other Non-Christian | 1 | 0.2 |
| Don’t Know | 7 | 1.4 |
| **Current Religious Affiliation** | | |
| Christian (Protestant) | 67 | 13.2 |
| Christian (Catholic) | 23 | 4.5 |
| Jewish | 7 | 1.4 |
| Buddhist/Hindu | 16 | 3.1 |
| Mormon | 4 | 0.8 |
| Pagan/Wiccan | 55 | 10.8 |
| Non-Religious | 121 | 23.8 |
| Other Christian | 76 | 14.9 |
| Other Non-Christian | 32 | 6.3 |
| Don’t Know | 108 | 21.2 |

**Table 4**

Bivariate Regressions for Suicidality and Internalized Homophobia

| | Internalized Homophobia | | | Suicidal Thoughts in Last Month | | | Chronic Suicidal Thoughts in Last Month[1] | | | Suicide Attempt in Last Year | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Indicators of Conflict** | **B** | **SE** | **t** | **OR** | **95% CI** | | **OR** | **95% CI** | | **OR** | **95% CI** | |
| Internalized Homophobia (as mediator) | | | | 1.193 | 1.114 | 1.278 *** | 1.271 | 1.093 | 1.479 ** | 1.067 | 0.877 | 1.298 |
| Report of Conflict (reference group= nonreligious upbringing) | | | | | | | | | | | | |
| Religious Upbringing with no Conflict | 0.021 | 0.058 | 0.368 | 0.994 | 0.792 | 1.247 | 0.644 | 0.377 | 1.098 | 0.760 | 0.391 | 1.474 |
| Religious Upbringing with Resolved Conflict | 0.088 | 0.060 | 1.457 | 1.146 | 0.906 | 1.451 | 0.739 | 0.430 | 1.269 | 1.215 | 0.638 | 2.313 |
| Religious Upbringing with Unresolved Conflict | 0.964 | 0.076 | 12.718 *** | 1.415 | 1.059 | 1.890 * | 1.468 | 0.817 | 2.640 | 1.054 | 0.463 | 2.402 |
| Anti-homosexual Parental Religious Beliefs | 0.289 | 0.046 | 6.298 *** | 1.565 | 1.318 | 1.859 *** | 1.572 | 1.039 | 2.379 * | 2.045 | 1.217 | 3.436 ** |
| Left Religion of Origin due to Conflict | −0.775 | 0.065 | −11.923 *** | 1.335 | 1.052 | 1.695 * | 0.861 | 0.512 | 1.447 | 2.369 | 1.236 | 4.541 ** |

* p < .05,

** p < .01,

*** p<.001,

[1] Restricted analysis to participants indicating suicidal thoughts in the last month (N=955)

**Table 5**

Logistic Regressions testing for Mediation of Internalized Homophobia

| | Suicidal Thoughts in Last Month | | | | | |
|---|---|---|---|---|---|---|
| **Indicators of Conflict** | **OR** | **95% CI** | | **OR** | **95% CI** | |
| Report of Conflict (reference group= nonreligious upbringing)[1] | | | | | | |
| Religious Upbringing with no Conflict | 0.994 | 0.792 | 1.247 | 1.006 | 0.800 | 1.265 |
| Religious Upbringing with Resolved Conflict | 1.146 | 0.906 | 1.451 | 1.137 | 0.896 | 1.442 |
| Religious Upbringing with Unresolved Conflict | 1.415 | 1.059 | 1.890 * | 1.213 | 0.899 | 1.637 |
| Internalized Homophobia | | | | 1.178 | 1.096 | 1.265 *** |
| Anti-homosexual Parental Religious Beliefs | 1.565 | 1.318 | 1.859 *** | 1.510 | 1.286 | 1.797 *** |
| Internalized Homophobia[2] | | | | 1.142 | 1.058 | 1.233 ** |
| Left Religion of Origin due to conflict | 1.335 | 1.052 | 1.695 * | 1.658 | 1.279 | 2.149 *** |
| Internalized Homophobia[3] | | | | 1.308 | 1.174 | 1.457 *** |
| | Chronic Suicidal Thoughts in Last Month | | | | | |
| | OR | 95% CI | | OR | 95% CI | |
| Anti-homosexual Parental Religious Beliefs | 1.572 | 1.039 | 2.379 * | 1.423 | 0.932 | 2.172 |
| Internalized Homophobia[4] | | | | 1.283 | 1.079 | 1.525 ** |

* p < .05,

** p < .01,

*** p<.001,

[1] N= 2,853;

[2] Analysis restricted to those with religious up-bringing (N= 2,354);

[3] Analysis restricted to those with religious up-bringing and reporting conflict (N= 1197),

[4] Analysis restricted to those with religious up-bringing and reporting suicial thoughts in the last month (N=785)