Religion and Religiosity: Protective or Harmful Factors for Sexual Minority Youth?

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Abstract

Sexual minority youth are disproportionately impacted by a number of psychosocial risks including a greater likelihood of non-suicidal self-injury (NSSI) when compared to heterosexual counterparts. Emerging research seeks to identify the risk and resilience factors that contribute to the mental health of this stigmatized population. Considering that most Americans grow up with at least some religious teachings and that most major world religions have historically condemned same sex sexuality, the current study examines the association between religious tradition, religiosity and NSSI behavior. Results indicate that religion plays both a protective and harmful role for sexual minority youth. Those identifying as Christians with high religious guidance had the greatest risk, seculars had a comparatively moderate risk, and Christians with low religious guidance had the least risk. Implications for clinical practice and future areas of research are discussed.

Key words: religion, religiosity, sexual minority youth, non-suicidal self-injury, cutting

Religion and Religiosity: Protective or Harmful Factors for Sexual Minority Youth?

Sexual minority youth[1] are disproportionately impacted by a number of psychosocial risks. Among those risks are mental health issues such as increased likelihood of suicidal thoughts or attempts (Bagley & Tremblay, 2000), non-suicidal self-injury (Blake et al., 2001; Whitlock et al., 2011), depression and other mental health symptoms (Hart & Heimberg, 2001), as well as decreased academic achievement (Pearson, Muller, & Wilkinson, 2007; Remafedi, 1987). Sexual minority youth are more likely to become homeless (Cochran, Stewart, Ginzler, & Cauce, 2002; Milburn, Ayala, Batterham, & Rotheram-Borus, 2006), experience victimization (Toomey, Ryan, Diaz, Card, & Russell, 2010), and become involved in alcohol and drugs (Blake et al., 2001) when compared to their heterosexual counterparts. Given that these youth experience environments at home, school, and with peers that frequently invalidate and stigmatize their sexual orientation (Sue & Sue, 2008), this higher prevalence of risks is not surprising.

While more research has been conducted on the risks associated with lived experiences of sexual minority youth, there is a body of emerging work that is beginning to look at internal and external factors that support the resilience of these young people. Among those identified to date are supportive family members and strong, healthy friendship networks (Doty, Willoughby, Lindahl, & Malik, 2010), the presence of gay-straight alliances in schools, and the presence of safe, non-judgmental adults with whom the youth can talk about their sexual orientation or gender identity (Walls, Kane, & Wisneski, 2010). These factors appear to help support the youth in countering the social stigmatization and, by doing so, develop a healthy sexual and gender identity (Rose, Boyce Rodgers, & Small, 2006).

[1] We use the term sexual minority youth to indicate individuals aged 13 to 25 who identify as gay, lesbian, bisexual, queer, pansexual, questioning or who use some other term to indicate a sexual orientation other than heterosexual, and those whose gender identity does not match the gender identity they were assigned at birth (transgender).

Even less, however, is known about factors such as religion that – theoretically – may be seen as either a risk or resilience factor. In this study, we examine the role of religious tradition and religiosity on one specific psychosocial risk, that of engaging in non-suicidal self-injurious behavior such as cutting or burning oneself. NSSI has started to receive growing attention from scholars and practitioners because of its increasing prevalence among young people (Blake et al., 2001; Brener, Krug, & Simon, 2000; Briere & Gil, 1998). Recent work further suggests that NSSI is another disproportionate risk among sexual minority youth and young adults (Author, 2007, 2010b; Whitlock et al., 2011; for bisexual young adults see Whitlock and Knox, 2007).

In this study, we examine the relationship between religion – both religious tradition and religiosity – and NSSI, controlling for numerous variables that have been demonstrated to have a relationship with NSSI. In doing so, we hope to shed light on what role religion might play in coping with or exacerbating the psychosocial risks in the lives of sexual minority youth.

Literature Review

Religious Tradition and Religiosity

Before examining the literature on the impact of religion, it is important to briefly outline the difference between religious tradition and religiosity as theoretical constructs, as each have been found to play different roles in the scholarship on religion. Religiosity is the devoutness or importance of religion in one's life (see, for example, Craven, 2004; Regnerus, Smith, & Sikkink, 1997), whereas religious tradition represents the categorization of religious beliefs into major families that share a core belief system and history (e.g., Christian, Buddhist, etc.). Differentiating religious tradition and religiosity is important as they can have different impacts on attitudes, beliefs, and behaviors (Stefurak, Taylor, & Mehta, 2010). For example evangelical

Protestants tend to have the most conservative attitudes on issues of 'morality,'[2] followed by Catholics, mainline and liberal Protestants, with Jews and seculars having the most progressive attitudes (Burdette, Hill, & Moulton, 2005; Steensland et al., 2000). This pattern has been found on issues such as abortion and sexuality among others (Bolzendahl & Brooks, 2005; Evans, 2002).

Religiosity can have explanatory value above and beyond religious tradition in predicting attitudes, beliefs, and behaviors. For example, in their examination of abortion attitudes, Gay and Lynxwiler (1999) found that liberal Protestants, moderate Protestants, non-denominational Protestants, and African American Protestants were all significantly less likely to support women's rights to legal abortions than seculars when religious tradition variables were included in a model *without* a measure of religiosity. With the addition of the religiosity variable to the model, however, all of these differences became non-significant, suggesting that devoutness had more explanatory value than did religious tradition. The importance of religiosity has been found regarding attitudes toward abortion (Blasi, 2006), lesbian and gay rights (Hicks & Lee, 2006), and euthanasia (Soen, 2005). Overall, findings suggest that increased levels of religiosity are associated with more politically conservative attitudes.

Religion as a Protective and Risk Factor

With fair consistency in the social science literature, religiosity has been associated with weak to moderate positive mental health outcomes (Fabricatore, Handal, Rubio, & Gilner, 2004; Plante & Sharma, 2001). This has included decreases in suicidality (Dervic et al., 2004; Gearing & Lizardiz, 2009; Martin, 1984), decreased substance abuse (Brenda & Corwyn, 2000; Shields,

[2] The term 'morality' is typically used in the literature and U.S. political vernacular to indicate issues regarding sexuality and reproduction. This is clearly problematic in that its narrow focus implies that issues like poverty, access to medical care, and other such issues have no moral dimension, and is also a product of the religious cultural hegemony whereby Christian privilege has dictated the landscape of the political discussion deciding which issues are considered morality issues and which are not (see Wallis, 2006).

Broome, Delany, Fletcher, & Flynn, 2007), and lower rates of depression (Koenig, McCullough, & Larson; Smith, McCullough, & Poll, 2003). Similarly, religion is often a source of coping with physical illness (Nelson, Rosenfeld, Breitbart, & Galietta, 2002; Pargament, 1997; Råholm, 2002), and other adverse life events (Schuster et al., 2001; Walker, Reid, O'Neill, & Brown, 2009).

Differences have also been documented based on religious tradition. For example, Protestants have a higher suicide rate than do Roman Catholics, with Jewish individuals having the lowest rates (Maris et al., 2000). Muslims, however, have lower recorded rates of suicidal behaviors than those from other religious traditions, including Christianity and Buddhism (Abdel-Khalek, 2004; Ineichen, 1998).

Higher levels of religiosity have also been associated with a few negative psychosocial outcomes such as increased levels of guilt (Chau, Johnson, Bowers, Darvill, & Danko, 1990; Jones & Francis, 2000), higher levels of authoritarianism (Gartner et al., 1991; Stefurak, Taylor, & Mehta, 2010), higher levels of fear and alienation (Exline & Yali, 2000), higher levels of scrupulosity (Gonsalvez, Hains, & Stoyles, 2010), and increased levels of depression among certain groups (for example, adolescents of Asian descent [Petts & Jolliff, 2008]).

Religious Traditions' Teachings and Evolving Attitudes regarding Same Sex Sexuality

Though most world religions condemn same sex sexuality, it is important to note the variety and complexity of religious teachings, the extent to which the congregations endorse such doctrine, and the recent changes in attitudes that have emerged. Catholicism, for example, bases much of its sexual ethos on what is referred to as the "laws of nature," suggesting that sexual contact is intended exclusively for procreation. However, birth control is widely practiced among Catholics, though officially condemned by the church (Helminiak, 2006). Evolving sexual ethics within this religious tradition are beginning to acknowledge the interpersonal

dimension of sex beyond procreation which is reflected in church documents including those originating in the Second Vatican Council (Helminiak, 2006).

Contemporary Protestant religions demonstrate even greater variety in teachings from complete support for sexual minorities to absolute disapproval (Helminiak, 2008). The emergence of "open and affirming" churches, stemming mostly from Protestant traditions, is illustrative of evolving religious attitudes and changing communities (Scheitle, Merino, & Moore, 2010). For example, the United Church of Christ adopted the "Covenant of Openness and Affirmation" in 1985 and a similar statement was made by some congregations of the Presbyterian tradition called "More Light Churches" (Scheitle, Merino, & Moore, 2010). The adoption of an affirming stance is oftentimes at the discretion of the local congregation but is becoming more prevalent; in order to obtain such a status, a specific statement of support for gay, lesbian, and bisexual people must be made (Scheitle, Merino, & Moore, 2010). In a qualitative study of 30 mainline Protestant pastors in the Northeast, Cadge and Wildeman (2008) found that overall, pastors viewed themselves as facilitators and educators, oftentimes clarifying scriptural passages or leading congregational discussions about sexuality. Other pastors described themselves as "quiet advocates" with interventions that personalized the issue of sexual minorities, serving to make it less an abstract issue and more about humanity. Though major religions seem to take firm stances regarding sexuality, it is evident that within-church dialogues are illuminating the nuances and complexity of the issue, questioning the pervasive right/wrong dichotomy.

Additionally, in line with Yamane's (2007) observation that American's individual level beliefs are often at odds with the official dogma of the denomination to which they belong, Woodford, Levy, and Silverschanz (2011) found that slightly more than 60% of their sample of

over 2,500 Christian-identified undergraduate and graduate students disagreed with their church's official stance on same-sex sexuality. Moon (2004) demonstrates the way in which attitudes about same sex sexuality are complicated by what she terms *everyday theologies* – that is the way in which lived experiences further shape religious beliefs and social attitudes. Relationships between religious tradition, religiosity, and religious beliefs and sexuality are anything but straightforward.

Religion and Same-sex Sexual Orientation

In their examination of various faith tradition's teachings regarding same-sex sexuality through a survey with a national representative sample, Rowatt, LaBouff, Johnson, Froese, and Tsang (2009) found, as predicted, that religiosity was associated with decreased acceptance of gay, lesbian, and bisexual (GLB) people, but was not correlated with racial prejudice. They termed this pattern "selective intolerance" whereby religions *in general* support some types of prejudices while discouraging others. Given that most world religious traditions have endorsed condemnation of same-sex sexuality (Wilcox, 2002; Siker, 2007) as one group for which intolerance is supported, and that most Americans grow up with at least some religious teachings (Emerson, Sikkink, & James, 2010), it is important to consider the messages that sexual minority youth receive as they develop their sexual identity within this context.

The conflict between one's sexual orientation and one's religious belief system results in "competing selves" with emotional and cognitive conflicts between the two (Sherry, Adelman, Whilde, & Quick, 2010). Among those in their sample of GLB adults, for example, Schuck & Liddle (2001) found that two-thirds indicated experiencing these conflicts stemming from religious messages that asserted the sinfulness of same-sex sexual attraction, the need for

forgiveness, and eternal celibacy. Unresolved, these competing selves can lead to depression and suicidality arising from feelings of guilt, shame, and self-loathing (Schuck & Liddle, 2001).

Of course the impact of religion depends partly on the religious tradition and the degree of importance of religion in one's life. Research suggests that GLB persons who perceive their church to be liberal with religious doubts being part of a healthy developmental process, experience less shame and lower levels of internalized homophobia than those from more conservative religious backgrounds (Sherry et al., 2010). Individuals with greater post-conventional religious reasoning where they critically evaluate the religious beliefs of their faith tradition have been shown to have lower levels of internalized homophobia and a better integrated sexual identity (Harris, Cook, & Kashubeck-West, 2008).

In terms of religious tradition, Rowen and Malcolm (2002) found GLB persons who belonged to any religious institution had higher levels of internalized homophobia than GLB persons who were unaffiliated. Catholics and Protestants have, likewise, been shown to have a higher likelihood of perceiving a conflict between religion and their sexual orientation than Jews and seculars (Schuck & Liddle, 2000), and gay men from fundamentalist Christian backgrounds in one qualitative study indicated that they all believed that their Christianity had a negative impact on their feelings about their sexual orientation (van Loon, 2004). For those from more conservative religious backgrounds, the trauma of isolation, ostracism from their church community, being disowned by family, guilt, and being asked to change through conversion therapy were common themes (van Loon, 2004; Sherry et al., 2010).

Integrating sexuality and religion in gay-affirming churches as previously described is one strategy that some GLB persons have found to be successful in resolving the conflict between their sexuality and their religion (Rodriguez & Ouellette, 2000; McQueeney, 2009). For

some, however, the questioning of religious beliefs led them to leave their faith tradition altogether or significantly alter their relationship to their faith, including transitioning to spirituality rather than associating with organized religion (Sherry et al., 2010).

Hypothesis

Considering literature indicating that religious beliefs and a GLBT identity can create internal conflict, higher levels of guilt and shame, and increased depression (Schuck & Liddle, 2001; van Loon, 2004), and that the mental health benefits of religion may not be able to buffer these risk factors, we hypothesize that both religious tradition and religiosity will be significant predictors of non-suicidal self-harming behaviors beyond demographic variables and psychosocial risk factors. Specifically, we anticipate that those with a Christian religious belief system will have a greater likelihood of engaging in NSSI than those who embrace a secular worldview, and we anticipate that greater levels of religiosity will, likewise, be associated with greater likelihood of self-harming behavior.

Method

Participants

Of the initial survey entries, all respondents who were heterosexual or who failed to answer the sexual orientation question, or who were older than 25 years of age were dropped from the sample to insure that the sample only included sexual minority youth and young adults. In addition, a number of respondents entered the survey (completed the consent form), but failed to answer any questions or answered only 2 or 3 questions before exiting from the survey. Those were likewise dropped from the data. The final usable sample consists of 250 youth who identify as gay, lesbian, bisexual, transgender, questioning, or queer, between the ages of 13 and 25 who self-selected to participate in the Center's online survey. A missing data analysis was conducted

to investigate the pattern of missingness in order to inform the method of addressing missing data. None of the variables of interest had more than 4% missing. Significance tests comparing those with missing data to those with present data as related to NSSI were performed. Religion by NSSI was the only relationship of interest that demonstrated a significant difference between those who failed to report religion and those who did, indicating that it was not missing completely at random. Multiple imputation was used for all variables and to address the concerns surrounding the pattern of missing data for religion, two models were run. The first, used the imputed data; the second, used only the cases for which data were present. No significant differences emerged in the results, supporting the appropriateness of using the imputed dataset.

The sample used for analyses was comprised of 46.4% (*n*=116) females, 46.0% (*n*=115) males, and 7.6% (*n*=19) transgender respondents. The majority at 60.0% (*n*=150) were White, 15.2% (*n*=38) were Latino/a, 12.0% (*n*=30) were bi- or multi-racial, 6.0% (*n*=15) were American Indian, Pacific Islander, or other race, 5.2% (*n*=13) were Asian American, and 1.6% (*n*=4) were African American. The average age was 18.05 years (*SD*=2.83), with a range from 13 to 25.

Measures

Demographics. Respondents were asked to identify their gender with five potential responses: “female”, “male”, “trans/male”, “trans/female”, “self identify/other”. Responses were recoded into three categories: male, female, and transgender. Respondents were asked to indicate their age, and for race and ethnicity, respondents were given the options of describing themselves as “American Indian or Alaska Native”, “Asian”, “Black or African American”, “Hispanic or Latino/Latina”, “Native Hawaiian or other Pacific Islander”, “White”, or “Biracial/Multiracial.”

Because of low numbers of participants, “American Indian or Alaska Native” and “Native Hawaiian or other Pacific Islander” were combined into one category.

While all subjects in the sample identify as non-heterosexual, variability does exist in terms of the identity label. Response choices in the survey were “gay”, “lesbian”, “bisexual”, “pansexual”, "queer", "asexual", "other" and “not sure/questioning”. “Bisexual” and “pansexual” were combined into one category, and “queer”, “asexual” and “other” were combined into a final “other” category.

Psychosocial Risk Factors. To ascertain the impact of one form of deliberate self-harming behavior among their social network, respondents were asked, “Thinking about all of your friends, which would you say is true?” The question had a response set from *None of my friends have attempted suicide* to *Most of my friends have attempted suicide*. Two questions were included in the models regarding mental health. The first asked whether the youth had experienced sad feelings in the past year to the point that they curtailed some of their usual pleasurable activities, and the second, about anxiety, asked whether they had experienced being worried, tense, or anxious for at least one month in the past year. Both response sets were *yes* or *no*.

Survey participants were asked three questions to determine if they had experienced a spell of homelessness within the last year. They were asked to indicate the number of times they had stayed in a homeless shelter, slept outside, or slept on someone else’s couch because they had nowhere to stay. A dichotomous variable was constructed from these three questions to indicate whether the respondent had been homeless during the previous year.

Religious Tradition and Religiosity. To determine religious tradition, participants were asked, “What religion do you consider yourself?” with a response set of *Buddhist, Christian,*

Hindu, Islamic, Jewish, No religious belief/agnostic/atheist, and *other* which allowed a write-in answer. Responses to *other* were examined and recoded to one of the existing categories or allowed to remain in *other* if not clearly classifiable. Because of low frequencies, religious tradition was then re-coded into *Christian, secular*, and *other*. To capture religiosity, a question was asked about the guidance received from religion, "How much guidance would you say your religion provides to you in your day-to-day life?" The response set included *little or no guidance, some guidance, quite a bit of guidance,* and *a great deal of guidance.*

Finally, the dependent variable, non-suicidal self-injury, was captured using a question that asked, "Which of the following best describes how often you have engaged in the following behaviors?" and then listed ten specific forms of self-harming behaviors: cut yourself, burned yourself, bitten yourself, hit yourself, hit something else (like a wall), rubbed your skin until it hurt, ate or drank something that would hurt you, inhaled something that would hurt you, cut off the circulation to a part of your body until it hurt, and cut off some part of your body. The response set for each of the behaviors was *0 times*, *1 time*, *2 or 3 times*, *4 or 5 times*, or *6 or more times*. The dichotomous independent variable was created by combining the information from all ten behaviors. If the youth had engaged in any of the behaviors at least once, the variable was coded as a 1, otherwise, it was coded as a 0.

Procedure

Rainbow Alley – a program of the Gay, Lesbian, Bisexual, and Transgender Community Center of Colorado (The Center) – provides support, education, advocacy, youth leadership and social activities for sexual minority youth and their allies. Support is provided through open-topic groups facilitated by trained volunteers, informal case management, peer-to-peer support programming, and a drop-in center. Educational support includes access to homework assistance,

GED preparation guides, and basic computer skills trainings. Social activities have included talent nights, drag shows, dinner and movie nights, and annual events like prom and weekend camping trips. The program is built on a youth-adult partnership model whereby staff members engage youth in decision-making roles for programming, policies, and administrative changes.

As part of its annual programmatic evaluation, program staff at Rainbow Alley conduct a survey of youth. Historically administered as a pen and paper survey, the survey has typically targeted only youth receiving services at Rainbow Alley. In 2006, staff decided to utilize an online survey format, and to make the survey available to a wider audience of sexual minority youth to better understand the social service needs of Colorado's sexual minority youth who were not receiving services in order to provide direction for future program development. As such, youth were recruited to participate in the survey through a number of activities.

Staff directly requested that youth receiving services at Rainbow Alley take part in the survey, explaining that participation was voluntary, and that decisions not to participate would not influence the youth's relationship with the program. Finally, information about the survey was prominently displayed on The Center's webpage with a link inviting sexual minority youth and young adults to participate to allow those not associated with youth-serving agencies to access the survey. The online survey consisted of ten screens, each made up of four to fifteen questions regarding a specific topic, and took approximately 20 minutes to complete. Topics included school experiences, mental health issues, identity, levels of outness, drug and alcohol usage, among others. Measures were modeled after questions from the National Youth Risk Behavior Surveillance survey (Centers for Disease Control and Prevention, 2004) and the GLSEN 2003 National Climate Survey (Kosciw, 2004). Data were collected anonymously with no identifying information collected and all respondents had to electronically sign a consent form

prior to completing the survey. Data used in the current study are from the 2010 programmatic evaluation and planning survey. IRB approval was sought and obtained for analyses of the dataset as secondary data analyses as the data were originally collected for evaluation and planning purposes by The Center as part of its annual programmatic review and evaluation process.

Results

Descriptive Statistics

Respondents used a variety of sexual identity labels to identify their sexual orientation. In the sample, 36.8% (*n*=92) identified as gay, followed by 34.0% (*n*=85) who identified as bisexual or pansexual. Those identifying as lesbian made up 19.5% (*n*=49) of the sample, followed by 6.0% (*n*=15) who were questioning their sexual identity, and 3.6% (*n*=9) who identified with other identity labels (e.g., queer, asexual).

In terms of the psychosocial risk factors, 30.0% (*n*=75) indicated that none of their four best friends had attempted suicide in the last year, with 44.0% (*n*=110) indicating that one friend among the four had done so. Among respondents, 14.8% (*n*=37) reported that two friends had attempted, 8.4% (*n*=21) reported that three friends had attempted, and 2.8% (*n*=7) reported that all four of their best friends had attempted suicide in the last year. Almost 3/4ths (72.8%, *n*=182) reported experiencing anxiety in the previous year, while 54.0% (*n*=135) reported experiencing depression. One-third (33.6%, *n*=84) of the respondents reported that they had experienced at least one night of homelessness in the prior year.

Turning our attention to the religion variables of interest in this study, we find that the largest percentage of youth and young adults reported that they had no religious beliefs, were

agnostic or atheist (55.2%, *n*=138). The next largest percentage, at 31.2% (*n*=78) identified with the Christian faith tradition, and the remaining 13.6% (*n*=34) with a religious tradition other than Christianity. Most of the respondents (58.8%, *n*=147) reported that their religious beliefs gave them little to no guidance in their everyday life, 20.0% (*n*=50) reported some guidance from their beliefs, 12.4% (*n*=31) reported quite a bit of guidance, and 8.8% (*n*=22) reported a great deal of guidance.

Overview of the Analyses

Three multivariate logistic regression models were used to test the likelihood of engaging in self-harming behavior among sexual minority youth based on religious tradition and religiosity, taking into consideration two clusters of control variables. To establish a baseline, the first model examined demographic variables including gender, age, race/ethnicity, and sexual orientation. The second model controlled for psychosocial risk factors identified in the extant literature as well as the above-mentioned demographic variables. The final model controlled for both the demographic variables and psychosocial risk factors, and added the variables of interest to this study related to religious tradition and religiosity. Each subsequent model provided a significant increase in the variance explained of the dependent variable.

Model 1—Demographic Variables.

The initial model examined the demographic variables of gender, age, race/ethnicity, and sexual orientation, as correlates of self-harming behaviors. No differences in likelihood were found with regard to age, race/ethnicity or sexual orientation. Those identifying as female, however, were 3.0 times more likely to self-harm than those who identified as male ($p<.05$), and transgender respondents were 6.7 times more likely than male respondents to self harm ($p<.05$).

With an R^2 of .097, the model explains almost 10% of the variance in likelihood of engaging in self-harming behavior. All regression models are reported in Table 1.

Model 2—Psychosocial Risk Factors.

Model 2 consisted of the demographic variables from Model 1 in addition to the following psychosocial risk factors: suicide attempts among network of friends, feelings of anxiety, feelings of sadness and hopelessness, and homelessness. The psychosocial risk variables were selected based on previous literature regarding self-harming behavior among sexual minority youth and young adults (Walls, Laser et al., 2010). In this model, no differences in likelihood of self-harm were found with regard to age, race/ethnicity, and sexual orientation. It is important to note that when the psychosocial risk variables were added to the model, transgender respondents were no longer significantly more likely than male respondents to engage in NSSI, although the difference is still at least marginally significant ($p<.10$). This suggests that the difference between transgender identified participants and male identified participants found in Model 1 is the result of one or a combination of more than one of the psychosocial risk variables added in Model 2. With the addition of the psychosocial variables, we also find some differentiation starting to take place in terms of race/ethnicity and sexual identity, although the differences only reach a level of marginal significance ($p<.10$). For example, those participants who identify as bi-/multi-racial and those who identify as American Indian, Pacific Islander, or other appear to be less likely to engage in NSSI than those in the White reference group, although, again, this is only at a level of marginal significance. Likewise, lesbian identified respondents appear to be marginally less likely to engage in NSSI than those who are gay identified ($p<.10$).

Sexual minority youth who had experienced anxiety in the previous year were not significantly more or less likely to engage in NSSI than those who had not, controlling for all variables in the model. However, with each increase in the number of friends who had attempted suicide among their social network, the likelihood of engaging in self-harm increases by almost 2.0 times (*OR*=1.97; $p<.01$). This suggests that those who reported that *most* of their friends had attempted suicide are slightly more than 15 times more likely to engage in self-harm behaviors than those who reported that *none* of their friends had attempted suicide. Those who had felt depressed in the past year were 7.4 times more likely to self-harm than those who had not felt depressed ($p<.001$). Finally, those youth who had experienced a spell of homelessness were almost 3.7 times more likely to self-harm than those who had not ($p<.01$). Model 2 explains 35% of the variance in likelihood of engaging in self-harming behavior. Using the likelihood ratio test to compare the two models, we find that the new model represents a statistically significant improvement in the model ($\chi^2=79.74$, $p<.000$).

Model 3—Religious Tradition and Religiosity.

The final logistic regression model directly examines the research question by investigating the additional explanatory contribution of religious tradition and religiosity on self-harming behaviors in sexual minority youth. The new variables included in this model are religious tradition (Christian, secular, other; with Christian used as the reference category), and level of guidance received from one's religion (*little to no*, *some*, *quite a bit*, and *a great deal*). The demographic variables relationship with NSSI stay the same as the previous model with the exception that bi-/multi-racial respondents are no longer marginally significantly different than White respondents in likelihood of engaging in NSSI. Likewise the patterns uncovered in Model 2 with regard to the psychosocial predictors stay similar.

When controlling for demographic and psychosocial risk factors, we find that both a secular religious tradition and level of religious guidance are significant correlates of engaging in self-harming behaviors. Individuals who identified as secular were 3.8 times more likely than those who identified as Christian to self-harm ($p<.01$), while those at each level of increased guidance from religion were 2.1 times more likely to self-harm than those at the previous level of guidance ($p<.01$). Individuals who received *a great deal* of guidance from their religious beliefs are then, approximately 9.3 times more likely to have engaged in self-harming behaviors than those who received *a little to no* guidance from their beliefs. An R^2 of .384 for this model indicates that the variables included explain slightly more than 38% of the variance in the likelihood of engaging in self-harming behaviors among the respondents. Using the likelihood ratio test to compare Models 2 and 3 we find that Model 3 is a statistically significant improvement over Model 2 ($\chi^2=11.73$, $p<.01$).

Discussion

The results of the present study suggest that religion potentially plays both a protective and harmful role for sexual minority youth in terms of risks for engagement in self-harming behaviors. The significance found regarding the religious tradition variable (secular) combined with that of the religious guidance variable reveals a complex relationship between religion and self-harming behaviors. First, it is important to note that the vast majority of the seculars (85.5%) in the sample indicated that they receive *little to no* guidance from their religious beliefs, which is logical given that they identify as having no religious beliefs, as atheists, or as agnostics. The number of seculars who indicated that they received *some*, *quite a bit*, or *a great deal* of guidance from their religious beliefs were less than 10% ($n=12$), less than 5% ($n=6$), and less than 2% ($n=2$) of the sample respectively, too few to be robust. Given this, we calculated the

predicted probability of engaging in self-harming behaviors only for seculars who receive *little to no* guidance to be .78. For the reference group of Christians, however, we find a distribution across the different levels of religiosity. The predicted probability of engaging in NSSI is .49 for Christians who receive *little to no* guidance, .66 for Christians who receive *some* guidance, .80 for Christians who receive *quite a bit* of guidance, and .89 for Christians who receive *a great deal* of guidance from their religious beliefs. Increases in religiosity among sexual minority youth who identify as Christian is associated with greater risk of NSSI. To illustrate the relationship, we have presented the predicted values in Figure 1.

Overall, the predicted values suggest that those who reported being secular are at greater risk for self-harming behaviors than those who reported being Christian with *little to no* or *some* guidance from their religious beliefs. However, Christians who receive *quite a bit* or *a great deal* of guidance from their religious beliefs are at greater risk for self-harming behaviors than those who identify as secular, an association that is more complex than we had predicted.

In order to unpack this layered relationship between religion and self-harming behaviors, it is necessary to consider the unique climate that is present for religious sexual minority youth. The messages perceived by sexual minorities coming from some religious traditions may create a tendency to feel marginalized and shamed within one's religious community (Schuck & Liddle, 2001). This may lead to an internal conflict or "competing selves" (Sherry et al., 2010). While in that case, religion may be meeting existential needs; it is, at the same time, asking the sexual minority youth to be someone different than who he/she identifies to be, suggesting that being a sexual minority is sinful or unnatural. Tan's (2005) discussion of the difference between religious well-being and existential well-being, combined with our findings, seems to offer a plausible explanation for our findings. It may very well be that sexual minority youth Christians

with low guidance from their religion may be meeting their existential needs and are, thus, at less of a risk for self-harm than those who are secular who may lack a framework for coping with existential issues. Because of the low guidance religion is playing for them, it seems likely that they have less attachment to the dogma of their religion. On the other hand, Christians with high religious guidance may be more attached to religious dogma and internalize messages condemning their sexual orientation, creating a greater risk for self-harm which may not be outweighed by the support offered through their religious framework for managing existential issues. These theoretical relationships need further research to determine their veracity.

Beyond providing a framework for existential struggles and the anxiety stemming from such struggles, studies have demonstrated the general coping value of religion. Plante et al. (2000) indicated a number of coping skills that were related to religious faith in their sample of college students. As suggested by our findings, this idea of religion as a source of coping may very well be a balancing act for sexual minority youth.

The present findings are also consistent with other studies. Harris, Cook, and Kashubeck-West's findings (2008), for example, regarding post-conventional religious reasoning may also play a role in our current results. Uncritical acceptance of one's religious beliefs is likely accompanied by acceptance of negative feelings about being gay or lesbian. Those, then, who have high religious guidance may have less critical evaluations of religious teaching and may accept assertions of immorality in relation to their own sexuality, leading to a negative view of oneself as a sexual minority. Self-harm may be a behavioral manifestation of internalized homophobia and a method of coping with the dissonance created.

Another possibility, along the same lines is that those with lower levels of religiosity may be more syncretic in their religious beliefs – accepting some aspects of their Christian faith's

ideology while rejecting others, particularly those which frame same-sex sexuality as immoral. Syncretism among American Christians is a well-documented contemporary phenomenon (Pew Forum on Religion and Public Life, 2009; Yamane, 2007), leading Yamane (2007) to argue that the American religious context is best characterized by a pattern of "belonging without believing" (p. 40). Those sexual minorities who are able to belong without believing all of the teachings may have less internal conflict, shame, and self-loathing while finding some psychological benefit from the religious context.

As noted above in the literature review, the curvilinear pattern related to religiosity and risks for NSSI mirrors findings in other risk and resilience literature on the impact of religiosity (Harris, Cook, & Kashubeck-West, 2008; Tan, 2005; Rowatt, LaBouff, Johnson, Froese, & Tsang, 2009). However, the pattern has not been documented until now within the context of sexual minority youth.

Implications for Practice

In line with existing scholarship, clinicians need to be mindful of the increased risk for self-harming behaviors among sexual minority youth (Almeida, Johnson, Corliss, Molnar, & Azrae, 2009; Skegg, Nada-Raya, Dickson, Paul, & Williams, 2003; Walls, Freedenthal, & Wisneski, 2008; Walls, Laser et al., 2010). The results of the present study provide some suggestions on how to work differentially with those who identify as religious and those who identify as secular. For Christian sexual minority youth, gaining a sense of how much guidance religion provides in their day-to-day life, including their knowledge of and feelings about their religion's teachings regarding a same-sex orientation and behavior seems particularly important. Supporting the client in grappling with what their religious beliefs mean for them as lesbian, gay, or bisexual individuals may bring to light unresolved conflicts which can be explored more

intentionally. For these clients, using cognitive techniques to expand their vision of what it means to be both religious and gay or lesbian may help to avoid negative assumptions about themselves and bring about identity integration. Clients may view church doctrine as religious absolutes, and may not be aware of the variability of attitudes regarding homosexuality within a single tradition, or across different traditions Therefore, it may be important to connect clients with gay-affirming religious leaders or contacts that can shed light on passages of the bible often used for condemnation of same-sex sexuality, that highlight a primary theology of the conscience and love, and that decry the idea that sexual minorities are innately sinful or disordered. In essence, promoting an intentional discernment process has the potential to lead to what Moon (2004) terms an "everyday theology" that supports an understanding of one's religious belief system through one's lived experiences.

For secular sexual minority youth, the therapeutic focus may be on finding ways to address existential concerns that do not rely on religious frameworks. Helping these client find meaning and purpose in their lives while concomitantly developing coping strategies for managing life stressors, may be particularly important, particularly given the role of NSSI behavior as a coping mechanism among youth in general (Babiker & Arnold, 1997; Simeon & Favazza, 2001) and gay and lesbian youth in particular (Walls, Kane, & Wisneski, 2010; Walls, Laser et al., 2010).

Limitations and Suggestions for Future Research

The findings of this study suggest that religion – both in terms of religious tradition and religiosity may function in complex ways for sexual minority youth. However, because of data limitations and sample size, we are unable to explore what underlying mechanisms might be operational in the pattern that emerged. A larger sample size with more denominational diversity

would allow exploration of different religious traditions within Christianity. In addition, it is important to note that the sample collected was from a program that serves youth seeking assistance. The youth who utilize the services of Rainbow Alley may not be representative of the larger population of sexual minority youth.

Using a framework such as that proposed by Steensland et al. (2000), future scholarship could compare, for example, liberal Protestants with conservative Protestants. If our supposition that some of the increased psychosocial risk is a result of adherence to anti-gay/lesbian dogma, we would anticipate seeing higher rates of psychosocial risks among more religious conservative Protestants than more religious liberal Protestants. In addition, in order to more thoroughly understand the function of religiosity, survey questions that capture the multidimensionality of the construct might be particularly illuminating. Such questions may focus on the respondents' level of adherence to and belief in the dogma of their particular denomination, providing information on whether or not the degree of syncretism is explanatory for some of the variability in risks. Questions exploring the religious tradition of families of origin versus current beliefs may illuminate some of the impact of shifts in religious beliefs. Survey questions on coping with existential dilemmas may, likewise, shed light on whether this particular aspect of the protective nature of religious belief is potentially driving the higher rates of risk for secular sexual minority youth.

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Table 1

Logistic Regression of Self-Harming Behaviors on Demographics, Psychosocial Risk Factors, and Religious Tradition and Religiosity: Odds Ratios and Standard Error

Variable	Model 1	Model 2	Model 3
Female	3.05*(1.59)	4.63*(.10)	5.75*(4.07)
Transgender	6.71*(6.09)	10.22(12.52)	7.08(8.27)
Age	.93(.05)	.98(.06)	.96(.07)
Asian	.55(.40)	.44(.48)	.60(.65)
African American	.58(.62)	.47(.62)	.64(.85)
Latino/a	.73(.30)	.68(.33)	.80(.42)
Biracial	.55(.25)	.36(.21)	.38(.24)
Other Race/Ethnicity	.76(.52)	.21(.18)	.19(.18)
Bisexual	1.51(.70)	.61(.37)	.57(.36)
Other Sexuality	1.02(1.03)	.36(.51)	.25(.33)
Questioning	3.18(2.68)	1.05(.99)	1.12(1.07)
Lesbian	.55(.35)	.24(.20)	.20(.17)
Friend's Suicide Attempt		1.97**(.47)	1.82*(.44)
Sadness		7.35**(2.98)	8.94**(3.85)
Anxiety		1.91(.75)	1.70(.71)
Homelessness		3.67**(1.71)	4.28**(2.12)
Secular			3.76**(1.91)
Religion Other			2.35(1.60)
Religious Guidance			2.05**(.55)
N	250	250	250
Log Likelihood	-144.11	-104.25	-98.38
Pseudo R^2	.10	.35	.38

Note: Standard error of odds ratios in parentheses. *$p<.05$. **$p<.01$

Figure 1. Predicted Probabilities of Self-Harming Behaviors, Religious Tradition by Religiosity Levels